

# **INFORMING EQUALITY**

## **A RESOURCE DOCUMENT FOR SUBSTANCE MISUSE SERVICES IN WEST LoTHIAN**

### **Drug, Alcohol and Tobacco Misuse**

QuickTime™ and a  
TIFF (Uncompressed) decompressor  
are needed to see this picture.

**Fiona Myers  
Niki Kandirikirira  
Engender  
December 2009**

## **Contents**

<b>1.</b>	<b>Introduction to the Resource Document</b>	<b>3</b>
<b>2.</b>	<b>West Lothian's Population</b>	<b>7</b>
<b>3.</b>	<b>Drug misuse</b>	<b>11</b>
3.1	Scottish Policy Context	11
3.2	The population-wide picture of drug misuse	11
3.3	Gender and drug misuse	12
3.4	Age and drug misuse	18
3.5	Disability and drug misuse	19
3.6	Race and ethnicity and drug misuse	22
3.7	Sexual orientation and drug misuse	23
3.8	Religion, belief and drug misuse	25
<b>4.</b>	<b>Alcohol misuse</b>	<b>27</b>
4.1	Scottish Policy Context	27
4.2	The population-wide picture of alcohol misuse	27
4.3	Gender and alcohol misuse	28
4.4	Age and alcohol misuse	34
4.5	Disability and alcohol misuse	38
4.6	Race and ethnicity and alcohol misuse	39
4.7	Sexual orientation and alcohol misuse	41
4.8	Religion, belief and alcohol misuse	44
<b>5.</b>	<b>Smoking and Tobacco misuse</b>	<b>45</b>
5.1	Scottish Policy Context	45
5.2	The population-wide picture on smoking	45
5.3	Gender and smoking	47
5.4	Age and smoking	52
5.5	Disability and smoking	56
5.6	Race and ethnicity and smoking	57
5.7	Sexual orientation and smoking	61
5.8	Religion, belief and smoking	62
	<b>References</b>	<b>63</b>
	<b>Appendix 1 Types of tobacco used in some black and minority ethnic communities</b>	<b>79</b>

**[Frontcover from: Charnwood Group Diversity initiative]**

## 1. INTRODUCTION TO THE RESOURCE DOCUMENT

Welcome to 'Informing Equality', a resource document to help all agencies working with or for people who misuse alcohol or drugs or smoke or use tobacco.

The resource is intended as a very broad overview of some of the issues to consider when thinking about what your service is doing, or can do more of to eliminate discrimination and harassment and promote equality of opportunity within and between different groups.

This includes thinking about:

- Factors influencing the levels of need for services, and the sort of things that may be influential on need, such as the impact of homophobia, or racist abuse or childhood sexual abuse
- Factors that may impact on how accessible a service is. This is not just about whether it is physically accessible in terms of geographic location, but also whether, for example it can be used by someone with a mobility or other impairment, when it is provided and how it communicates with services users
- Whether the model of service is appropriate and sensitive toward the needs of different groups
- Whether the way the service is designed and delivered achieves equally positive outcomes for users from different groups

### ***The legislative context***

By 'groups' we mean people who are at risk of being discriminated against on the basis of their:

Gender: men, women (and people who are transgender)

Age

Disability

Sexual orientation (people who are lesbian, gay or bisexual)

Race or ethnicity (people who are from black or minority ethnic communities)

Religion or belief

These groups are defined in different pieces of equalities legislation (summarised in box 1.1 below).

### **Box 1.1 Equalities Legislation and Regulations**

**UK law is now mainly contained in the following legislation (as amended, where appropriate, in brackets):**

- Equal Pay Act 1970;
- Sex Discrimination Act 1975;
- Race Relations Act 1976; (2000)
- Disability Discrimination Act 1995; (2005)
- Employment Equality (Religion or Belief) Regulations 2003;
- Employment Equality (Sexual Orientation) Regulations 2003;
- Gender Recognition Act 2004
- Employment Equality (Age) Regulations 2006;
- Equality Act 2006, Part 2;
- Equality Act (Sexual Orientation) Regulations 2007.

**European Directives affecting domestic discrimination legislation are:**

- Council Directive 75/117/EEC on the approximation of the laws of the Member States relating to the application of the principle of equal pay for men and women;
- Council Directive 76/207/EEC on the implementation of the principle of equal treatment for men and women as regards access to employment, vocational training and promotion, and working conditions, as amended by the European Parliament and Council Directive 2002/73/EC;
- Council Directive 2000/43/EC implementing the principle of equal treatment between persons irrespective of racial or ethnic origin;
- Council Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation;
- Council Directive 2004/113/EC implementing the principle of equal treatment between men and women in the access to and supply of goods and services;
- European Parliament and Council Directive 2006/54/EC (as recast) on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation.
- Article 141 of the Treaty Establishing the European Community. (Official Journal C 325/33 of 24 December 2002).

Under the Race Relations (Amendment) Act 2000, the Disability Discrimination Act 2005 and the Equalities Act 2006 public authorities have what are called 'general' and 'specific' duties to eliminate discrimination and promote equality of opportunity with regard to race, gender (including transgender) and disability

(including mental health). The 'specific' duties include the preparation of Equality Schemes in relation to each of these three equalities groups.

There are proposals for simplifying the legislation. These include introducing an equality duty that brings together the different strands of existing equality legislation and a new public sector duty aimed at reducing discrimination based on socio-economic disadvantage (Government Equalities Office, 2009).

***To provide effective drug and alcohol services which meet the needs of everyone in West Lothian who require them means providing services that promote equality and eliminate discrimination***

Providing services that promote equality of opportunity and eliminate discrimination is not just about meeting legal requirements or promoting social justice, important though these are: it also means providing services that are more effective and efficient - services that meet the needs of the 'target populations' in ways that support positive outcomes.

This resource document brings together information from local, national and international studies on drug and alcohol misuse and smoking to provide examples of the sort of issues that may be relevant for service providers to consider to ensure that they provide a high quality service that promotes equality of opportunity and eliminates discrimination. These include:

- The risk factors for drug and alcohol abuse to which different groups may be exposed
- The different patterns of drug and alcohol abuse within and across groups
- The factors that may act as barriers (or support) take up of services by different groups
- The possible implications for service design and delivery.

It is not a systematic review of evidence, nor does it make any claims to comprehensiveness. It is just to help you begin to think about whether your own service reaches out to and supports people from different equalities groups, or whether, unintentionally, or indirectly, it may unwittingly discriminate because of the way it is promoted, designed or delivered.

***Some caveats***

- The resource document is illustrative and provisional - a 'starter for 10'. It is just as important that services feel able to add to it, update it (or correct it), as they acquire more knowledge through their own direct contact with individuals or organisations who represent or work for different equalities groups, either locally, across Lothian or across Scotland (or beyond)
- The focus of the resource document is primarily on service users, and not service staff and providers. But action to ensure equality of opportunity and

eliminate discrimination applies just as much to staff as employees and also as management board or committee members, with implications for recruitment and working practices

- A 'social model' of disadvantage is assumed here. That is, where there are identified high rates of 'need' among particular groups, this is not because, for example, they are black, or female or gay, but reflects directly or indirectly the social and economic disadvantages or life experiences that people may experience as a result of discrimination, prejudice or stigma due to others' attitudes towards this aspect of their identity
- People also have a number of different identities, and may be at risk of experiencing multiple sources of discrimination or disadvantage. It is also important not to pigeonhole people on the basis of some assumed identity – this is also discrimination.

**Finally, as researchers are fond of saying, an absence of evidence should not be taken as evidence of absence. That is, just because there is no quantitative or qualitative evidence immediately to hand, does not mean there isn't a problem. It is important to obtain the perspective of individuals and/or organisations so that services can ensure that as far as possible they promote equality and eliminate discrimination.**

## 2. WEST LoTHIAN'S POPULATION

### Total population by age and sex

According to mid year population estimates for June 2008 (GROS, 2009a) West Lothian has a population of around 169,500 people, of whom just over one-half are women.

Table 2.1 West Lothian's Population based on mid-2008 estimates

Age (years)	Group	Males	Females	All
0 - 4		5688	5444	11132
5 - 14		10744	10668	21412
15 -24		11019	10439	21458
25 - 49		30092	32161	62253
50 - 64		15153	16005	31158
65 - 79		8003	9432	17435
80+		1651	3011	4662
<b>Total</b>		<b>82350</b>	<b>87160</b>	<b>169510</b>

(Source: GROS Mid-2008 Population Estimates)

### People from black and minority ethnic communities

A mapping exercise commissioned by West Lothian Community Planning Partnership analysed where people from ethnic minority communities were living and working in West Lothian (ODS Consulting, 2008). Based on 2001 census data, this showed that:

- Just under 5,000 people, or around 3% of the population, were identified as being from an ethnic minority community
- The largest groups were 'other white' and white Irish who comprised one-third and one-quarter of the ethnic minority community respectively
- The next largest group were Pakistani, 'mixed', Chinese and Indian (16%, 7%, 5% and 4% respectively of the ethnic minority community)
- Around half of the people from the six largest ethnic minority communities were living in Livingston.

(ODS Consulting, 2008)

To identify the numbers of people from the 'A8' countries - i.e. the eight predominantly Eastern European countries who have joined the European Union

since 2004<sup>1</sup> - the researchers looked at the numbers from these countries registering for work in West Lothian. The analysis shows that:

- Over the three financial years 2004/05 to 2006/07 a total of 2,290 people from the A8 countries registered for work in West Lothian - the largest numbers registering in 2006/07
- Almost three-quarters of these migrant workers were from Poland (1,700 people)
- Because this is based on registration for work, this may not be an accurate picture of the actual number of people from these countries in West Lothian: people may have registered in West Lothian and moved out, or registered elsewhere and moved in to West Lothian or not registered. The figures also do not include workers' dependents who do not register (ODS Consulting, 2008).

The researchers also analysed data on the total number of children attending West Lothian schools whose home language was not English. This showed that:

- In September 2007 across all schools (primary and secondary) there were 539 children for whom English was not their home language
- Of these, the five main home languages were Polish (180 children), Other European, (112) Urdu (81 children), Punjabi, (78 children) and Cantonese (29) (ODS Consulting, 2008).

### **People with long-term limiting illnesses or who are disabled**

Data on numbers of people with disabilities come from different sources, use different definitions, and are collected for different purposes (Macpherson and Bond, 2009). There is also a distinction between people with disabilities and those with long term limiting illnesses. The Scottish Household Survey (SHS), for example, distinguishes between people with a disability, long standing illness or health problem and those who have both (or neither).

The findings of the SHS for 2007 suggest that one-third of households across Scotland have at least one member with a long-standing illness, health problem or disability. The proportion increases with households comprised of older people, but is more or less the same between men and women (Scottish Government, 2008a).

---

<sup>1</sup> These countries are Poland, Estonia, Latvia, Hungary, Czech Republic, Lithuania, Slovak Republic, Slovenia

Data specifically for West Lothian is harder to find. Information provided by West Lothian Social Policy Information Team, drawing on evidence from Scottish Neighbourhood Statistics on numbers claiming welfare benefits ([www.sns.gov.uk](http://www.sns.gov.uk)) suggests that in 2007 around 9620 people aged over 16 years were claiming Severe Disability Allowance and Incapacity Benefits, i.e. around 7.2% of the adult population.

## **Sexual orientation, transgender, religion and belief**

There is very little national or local data on the numbers of people who are lesbian, gay, bisexual or transgender. Information on religion and belief is also difficult to find.

The 2011 census will help to generate more detailed as well as more up to date information relating to sexual orientation, religion and belief and race and ethnicity.

## **Other sources of data**

Across all the equality groups, the *High Level Summary of Equality Statistics: Key Trends in Scotland* (Scottish Executive, 2006) and the more recent review of research on equality issues in Scotland between 2000 and 2008 (Macpherson and Bond, 2009), present some of the available national level data as well as describing some of the limitations of this material.

The Equalities and Human Rights Commission (EHRC)<sup>2</sup> has recently developed an Equalities Measurement Framework (EMF) to help measure progress towards achieving equality and human rights across 10 domains of contemporary life, including health. The measurement framework aims to address three distinct aspects of inequality that can arise between individuals and groups across these 10 domains:

- Inequality of outcome
- Inequality of process
- Inequality of autonomy.

Through a 'substantive freedom matrix', the EMF both illustrates the complexity and multi-layered nature of equalities as well as providing a way of unpacking

---

<sup>2</sup> The Equalities and Human Rights Commission (EHRC) was set up in October 2007. This brought together the Equal Opportunities Commission, Disability Rights Commission and Commission for Racial Equality. The role of the EHRC is to protect, enforce and promote equalities across the seven 'protected grounds' of age, gender, transgender, sexual orientation, religion and belief, race and ethnicity. It also a responsibility to promote human rights (<http://www.equalityhumanrights.com/>).

and thinking about which groups or individuals may be exposed to which aspect(s) of these three aspects of inequality in which of the important domains of their lives (<http://www.equalityhumanrights.com/fairer-britain/equality-measurement-framework/>).

### **3. DRUG MISUSE**

#### **3.1 Scottish policy context**

In 2008 the Scottish Government launched its strategy and action plan to tackle drug misuse - *The Road to Recovery: A new approach to tackling Scotland's drug problem* (Scottish Government, 2008b). This focuses on four main areas for action:

- Preventing drug use
- Promoting recovery
- Law enforcement
- Getting it right for children affected by substance misusing families.

#### **3.2 The population-wide picture of drug misuse**

Figures reproduced in *The Road to Recovery* suggest that an estimated 52,00 people, or 1 in 50 of the population aged between 15 - 54 are experiencing or causing problems because of their use of opiates such as heroin and benzodiazepines. This rate is higher not only than that in England but also higher than in other similar European countries such as Ireland, Finland or Denmark (Scottish Government, 2008b). A study undertaken in 2004 to estimate the prevalence of drug misuse in Scotland suggested that in the region of 1,025 people in West Lothian aged between 15 - 54 were problem drug users (a prevalence rate of about 1.11) (Hay et al, 2005).

In 2008 15 drug-related deaths were recorded in West Lothian (GROS, 2009b), of which nine were specifically attributable to drug abuse. This was the highest number of drug-related deaths over the 10-year period 1998 - 2008. Between 1996 and 2000 there was an annual average of six drug-related deaths in the council area, this increased to nine over the four-year period 2004 - 2008, that is, 0.06 deaths per 1000 population. Over this same four-year period the Scotland-wide figure was 0.08 average drug-related deaths per 1000 population.

#### **3.3 Gender and drug misuse**

##### ***Some facts and figures***

Estimates for 2003 suggest that there were in the region of 232 female and 793 male problem drug users among those aged 15 - 54 years in West Lothian (Hay et al, 2005).

Findings from other more recent Scotland-wide and European-wide studies similarly suggest the gendered pattern of drug misuse. The 2006 Scottish Crime

and Victimization Survey (Brown and Bolling, 2007) found that around 43% of men had ever taken any drug and around 10% had taken them in the last month. By comparison 31% of women had ever taken any drug and only 6% had used them in the last month. The types of drugs taken also varied. Men were more likely to have tried a Class A drug such as cocaine, crack, ecstasy or heroin than women (22%, compared with 13%). Men were more likely than women to have taken LSD, magic mushrooms or ecstasy as their first type of drug. Women were more likely than men to have taken amphetamines as their first drug.

Looking at both age and gender, the analysis found that, apart from 16 - 19 year olds, men were more likely than women in each age cohort to have taken one or more drug. Among 16-19 year olds, however, it appears that marginally more women than men reported having taken one or more drugs. The authors, however, comment that the small sample numbers mean that the difference is not statistically significant (Brown and Bolling, 2007).

Analysis of data from across the European Union undertaken by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) also indicates not just gender differentials in the usage of illicit drugs, but also differences between men and women according to age, the type of drugs used and the pattern of drug use (EMCDDA, 2005).

By age, the gap between males and females for lifetime experience of cannabis use is lower between male and female school students than between males and females in the adult population (15 - 64 years), further, the gap between males and females of school age may be narrowing, with a greater increase in drug use among girls than among boys (EMCDDA, 2005).

In terms of type of drugs, males outnumber females in estimates of cannabis use but females outnumber males in estimates for the use of pharmaceutical tranquilisers and sedatives. Males are predominant among those with recent or frequent drug use, rather than occasional or experimental usage (EMCDDA, 2005).

The EMCDDA study also reveals the higher usage of drug treatment services among men compared with women: women comprise only around 20% of clients. The lowest users were women aged between 20 - 40 years. Although possibly due to methods of data collection the report questions whether this could also be due to drug treatment services being less efficacious for female clients in this age group, which also covers child-rearing years, or whether female patterns of drug use differ markedly from male patterns.

Reflecting the gendered patterns of drug misuse, data from Scotland suggest that men disproportionately outnumber women in drug-related deaths as a result of drug abuse. For Scotland as a whole, in 2008 drug abuse accounted for 304 male drug-related deaths, compared with 66 female (GROS, 2009b).

## ***Women and drug misuse***

Preparatory to International Women's Day in March 2009 EMCDDA published a collection of narratives from women facing drug-related problems in Europe. Drawing from research studies, government reports and other 'grey literature' the report's compilers feel that the quotations and testimonies illustrate one overarching theme: "the struggle that female drug users face in fulfilling their social roles and the need for holistic interventions for female drug users" (EMCDDA, Fact sheet, 2009).

Particular issues identified are the:

- Confusion and desperation that mothers experience when their own children develop drug problems
- Deprivation and abuse that characterizes the lives of many women who go on to develop drug problems
- Difficulties faced by drug-using women who are attempting to fulfill societal roles as mothers and provide the sort of childcare they and 'society' wish for children
- The plight of women drug users in prison — who are among the most vulnerable of all women
- Stigma, policies and practices that make it generally difficult for women to access treatment.

These issues, particularly the relationship between experiences of abuse and the onset, or worsening of drug problems, the vulnerability of women drug users who enter the criminal justice system, and the barriers to accessing appropriate treatment, are reflected across the literature. For example:

- Studies suggest that the extent of childhood physical and sexual abuse is higher among women who misuse drugs than men, and that women can subsequently be caught up in a cycle of 'victimization' One literature review, for example, found that women may turn to substance use as a way of coping with the psychological consequences of abuse. Once they begin to abuse substances they are at further risk of domestic violence and sexual assault, which may lead to continued misuse and dependence on substances (Gutierrez and Van Puymbroeck, 2006)
- One study of people accessing drug treatment services in Scotland found that nearly two thirds (62%) of female drug users reported having been physically abused and over a third (36%) reported having been sexually abused. The comparable figures among male drug users were 22% and 7% for physical and sexual abuse respectively (McKeganey, Neale and Robertson, 2005)

- It has also been found that in addition to experiencing violence from sexual partners, women drug users provide sex in exchange for housing, sustenance and protection and practice unsafe sex, putting them at risk of sexual transmitted infections, including HIV (Pinkham and Malinowska-Sempruch, 2008)
- Studies have also found an association between substance abuse, victimization and women offending and re-offending (Taylor, 2008). Those women who misuse drugs and enter the criminal justice system have also been found to have a different and more severe drug abuse profile than men, to experience more associated problem behaviours, but also to make less use of drug treatment. A study in Birmingham of people in police custody seen by Drug Arrest Referral workers for example found higher levels of overall risk<sup>3</sup> and higher drug spend among the female offenders who used drugs, but lower levels of treatment engagement than males (Best et al, 2008; Holloway and Bennett, 2007)
- The quotations from women who misuse drugs reproduced in the EMCDDA study illustrate the particular problems experienced by women who become pregnant and have childcare responsibilities (EMCDDA Fact sheet, 2009). Accounts given by pregnant drug users, including those of women in Glasgow, suggest that partners could become abusive or violent when the women continued using drugs during pregnancy, that drug dealers could sometimes refuse to sell to women who were visibly pregnant and that partners, family and friends could put pressure on them to obtain an abortion (Pinkham and Malinowska-Sempruch, 2008). Pinkham and Malinowska-Sempruch also found that the stigma experienced by pregnant drug users can force the women into riskier practices, including injecting alone or getting someone else to obtain their drugs, attempting to conceal their pregnancy or engaging in high risk forms of sex work
- Women can also experience difficulties in obtaining appropriate drug treatment and support throughout the pregnancy or in the post-natal period or of being able to access resources to enable them to stay with their children while undergoing detoxification or rehabilitation
- Some women may experience multiple disadvantages. A small study of illicit drug use among Bangladeshi women in East London found that Bengali female drug users constituted a hidden population that engaged in high-risk behaviours, especially unsafe sex. Cultural constructs relating to 'izzat', honour and gender role expectations resulted in women feeling the need to conceal their drug problems or risk stigmatization. The need for concealment

---

<sup>3</sup> Risk was assessed in terms of 'drug spend', current offending and arrest history and three warning categories of lack of drug treatment engagement, history of violence and/or of weapons in the last 12 months.

presents barriers to treatment. When they did access services this often involved a coercive element either from their family or social services (Cottew and Oyefeso, 2005).

### *Factors relevant to service design and delivery for women who misuse drugs*

*"Whilst most drug services are designed with male drug users in mind — as they are the predominant client group — it is widely accepted that drug policy and programme effectiveness is enhanced when sex differences are acknowledged and the different needs of women and men are addressed (Hankins, 2008; Becker and Duffy, 2002). Gender responsiveness is anchored in principles that include the views of drug users themselves." (EMCDDA, 2009)*

It has been suggested that gender-related factors not only increase women drug users vulnerability, but also limit their access to harm reduction, drug treatment and sexual and reproductive health services.

Factors limiting access are related both to the design and delivery of services which, according to EMCDDA, tend to be designed with male drug users in mind. These barriers include lack of childcare services or flexible hours to enable women to fit attendance around their childcare responsibilities. Factors felt to improve women's access to services include:

- Policies that encourage women to seek drug treatment and harm reduction rather than punishing or stigmatizing them for drug use during pregnancy or motherhood
- Non-judgemental attitudes on the part of specialist and mainstream service providers such as specialist health visitors providing postnatal support to women (Smith and Gibb, 2007)
- Creating a woman friendly environment
- Gender-sensitive drug treatment
- Incorporation of sexual and reproductive health and other women's services into harm reduction programmes
- Flexible, low-threshold services that are more convenient for women with children
- Links between harm reduction, drug treatment, rape crisis, women's refuges and violence prevention services.

EMCDDA (2009) and Pinkham and Malinowska-Sempruch, (2008) suggest that the involvement of women drug-users in the design, planning, implementation and evaluation of gender-sensitive drug treatment services not only supports the empowerment of the women, but also helps to improve service effectiveness and efficiency. In an Australian survey, for example, women were less likely to drop out of drug treatment programmes that were flexible, had few rules and offered individualized care (Swift, Copeland and Hall (1995), cited in Pinkham and Malinowska-Sempruch, 2008).

### ***Men and drug misuse***

As the section on women suggests, in some respects men are the default population in terms of drug misuse: more men than women engage in drug misuse use and, as a result, comprise a higher proportion of those who die from drug-related causes and are the greatest users of drug-treatment services.

Perhaps because of this default position there is less analysis of gender specific impacts on patterns of male drug misuse, such as gender role assumptions around 'masculinity', or the implications of male gender for service design or delivery. Related to this there is also little consideration of the impact of, for example, the parenting roles or other caring responsibilities of men who misuse drugs on access to treatment services, or the pattern of (positive) social supports men can draw upon. The absence of evidence though should not be taken to mean that there is no issue - just that the question has not been asked.

### ***People who are transgender and drug misuse***

Statistical data on drug misuse among people who are transgender is difficult to find. However, one study of young lesbian, gay, bisexual and transgender people found that those who were transgender reported higher levels of drugs and alcohol misuse than their lesbian, gay and bisexual peers (Carolan and Redmond, 2003).

An (international) literature review on women, harm reduction and HIV suggests that there is evidence of risky behaviour during illicit drug, hormone and silicone use by transgender women, for example, injecting drugs using a needle that was not new or clean. The authors suggest that for a variety of reasons, including (in some countries) lack of access to affordable, legal hormone therapy and plastic surgery, some transgender women use contaminated needles for illicit hormone or silicone injections, putting them at risk of HIV and other blood-borne illnesses. (Pinkham and Malinowska-Sempruch, 2008).

The literature review also suggests that the stigma experienced by transgender people can be a barrier to help seeking. The issue of stigma has also been identified as a barrier to health care more generally, as well as the perceived lack

of transgender friendly and transgender-knowledgeable service providers. A Europe-wide survey of the transgender experience of health care (Whittle et al, 2008) reports that trans people (the term used in the report to encompass people who identify as transgender, transsexual or gender variant in any way<sup>4</sup>) avoided accessing routine healthcare because they anticipated prejudicial treatment from healthcare professionals. A similar UK study found that nearly 30% of respondents felt that being trans affected the way they were treated by healthcare professionals (Whittle et al, 2007).

In Scotland, a survey undertaken by the Scottish Transgender Alliance (STA), found that the NHS services people were least satisfied with were NHS 24 and mental health services. Out of hours services were of concern because of uncertainty about how an unfamiliar NHS person may react to any revelation about transgender background or identity. In relation to mental health services respondents described the perceived lack of understanding and knowledge on the part of general mental health specialists, potentially resulting in inappropriate services (STA, 2008). Trans people also experienced problems getting their health service records updated to correctly reflect a change in gender - with implications for how people were referred to by, for example, practice receptionists by pharmacists and/or on prescriptions.

Confidentiality, whether as patients or as members of staff can also be a concern. Under the Gender Recognition Act 2004 (which applies after someone has been living as the acquired gender for two years), it is, however, a criminal offence, to reveal someone's gender history without their consent (other than under certain specified circumstances).

To support service providers a paper, commissioned by Press for Change, a campaigning body for trans people (<http://www.pfc.org.uk>), suggests ways for evaluating care approaches and services for trans people (Burns, 2005). This includes seven principles:

- Not sick but different
- Different ways to be different
- Help to be, rather than to 'not be'
- Autonomy and independence requires choice
- Where care begins and ends, succeeds and fails
- Determining responsibility - Achieving partnership
- Second opinions

And seven practical tests of services:

- Accessibility

---

<sup>4</sup> For more information on transgender and gender identity, see the Scottish Transgender Alliance (STA) Introductory Guide [http://www.scottishtrans.org/Uploads/Resources/sta\\_gender\\_identity\\_introduutory\\_guide.pdf](http://www.scottishtrans.org/Uploads/Resources/sta_gender_identity_introduutory_guide.pdf).

- Timeliness
- Empowerment and choice
- Respect and dignity
- Equality and partnership
- Autonomy and independence
- The right to complain.

While not specific to drug treatment services these principles and 'tests' may provide a way of thinking through what this would mean for the design and delivery of services from the perspective of trans people who misuse drugs. Using these principles and 'tests' could also provide a structure for thinking about what services would look like from the perspective of other equality groups.

### **3.4 Age and drug misuse**

The analysis of the Scottish Crime and Victimization Survey demonstrates the skewed pattern of drug usage by age, with this being predominantly, if not exclusively, associated with younger people (Brown and Bolling, 2007). Around 20% of the Survey respondents aged 40-59 had ever taken drugs (compared with 48.5% of the sample of 16-19 year olds). Only 2.8% of those in the older age group had taken drugs in the past year and only 1.6% in the past month. For those in the 16-19 year age range the comparable figures were 34.6 and 23.5%.

There is a large amount of information on adolescent drug misuse. The recent Scottish Schools Adolescent Lifestyle and Substance Abuse Survey (SALSUS) (ISD, 2009a), for example, provides information on self-reported attitudes as well as prevalence and levels of frequency of substance misuse (including drugs) and sources of supply among 13-15 year olds in schools across Scotland. This indicates, for example, that:

- Twenty-three per cent of 15 year olds and 7% of 13 year olds reported that they had ever used drugs
- 13% of all 15-year old boys, 10% of all 15-year old girls, and 2% of both 13 year-old boys and 13-year old girls reported use of cannabis in the last month. Very few pupils reported using any other drug
- Fifty-one per cent of 15-year olds and 22% of 13-year olds reported that they had been offered at least one drug
- Friends were the most commonly reported source of drugs.

A study, commissioned by NHS Health Scotland, summarises the personal, social and environment factors influential on substance misuse (including drug

misuse) among adolescents in Scotland (Kirby et al, 2008).

There is, however, much less on older drug users, yet this is an ageing population - a cohort effect, as the so-called 'Trainspotting Generation' of the 1980s become long-term heroin users. The data on drug-related deaths, for example, indicate that of the 370 deaths in Scotland in 2008 as a result of drug abuse, 42.4% were in the age range 25 - 34 (157 people), one-third aged 35 - 44 (122) people and just under 11% (40 people) aged 45 years and over. For all types of drug-related deaths the average number of deaths per year for those aged 35 - 45 increased from 46 per year over the period 1996 - 2000, to 134 over the period 2004 - 2008, compared with a decrease from 83 to 77 among those aged under 25 years (ISD, 2009b).

One study of older drug users (people aged 50 - 74 years) in the North-West of England found that the average age of drug users in contact with treatment services and agency based syringe programmes was rising: increasing over the period 1998 - 2004/5 from 80 to 310 male drug users and 46 to 117 female (Beynon et al, 2007). The authors suggest that the assumption that drug and alcohol use declines with age may be incorrect. Yet, despite the ageing of the population, Beynon et al argue that drug policies still remain young-person focused and that older people may face similar barriers to accessing drug treatment services as people from black and minority ethnic communities and women. In addition, drug use among older people may be associated with poor physical health and longer hospital stays.

An American study describing a residential unit specifically for the treatment of substance misuse among older adults found two distinct subgroups of people: those who became dependent on drugs during adolescence, and those who became dependent on drugs after the age of 45 years (Guida et al, 2004). The study describes setting up special groups, including trauma and bereavement groups for the people who became dependent late in life, and poly-substance misuse and relapse prevention for lifelong users.

At present, however, older people who misuse drugs remain a largely 'hidden' population, but one whose needs will increasingly require to be considered and addressed.

### **3.5 Disability and drug misuse**

The term 'disability' covers a lot of different experiences and impairments, across all ages, including, sensory impairments (visual, auditory, speech/language); learning disabilities, mental health problems, as well as physical disabilities and conditions such as cancer.

Again, it should not be assumed that because there is little or no statistical information on the numbers of people with different disabilities who misuse drugs (other than perhaps in relation to people with a 'dual diagnosis' of mental health problems and substance misuse), nor on the usage by disabled people of drug treatment services, that this is because disabled people somehow do not experience difficulties either in relation to drug abuse or obtaining accessible treatment. On the contrary, studies (particularly from the US) demonstrate both the risk factors that disabled people experience and the barriers they face in accessing services.

### ***Physical disability***

Although studies in America and Europe disagree about whether drug abuse is comparatively higher or lower among adolescents with disabilities compared with their non-disabled peers, at least one American study suggests that physically disabled students who do misuse substances have poorer educational outcomes (Hollar and Moore, 2004). Further, some people may suffer multiple disadvantages, for example people from black and minority ethnic communities who have disabilities and misuse drugs (Beatty, 2003).

To respond to the needs of disabled people who are at risk of, or who do misuse drugs has implications both for prevention efforts, particularly those targeted at young people, as well as for staff training, treatment and accommodation (McCombs and Moore, 2002; Moore and Lorber, 2004).

### ***Learning disabilities***

Data on the prevalence of drug or substance misuse among people with learning disabilities is not routinely available. It has, however, been suggested, particularly in relation to adults, that greater community integration increases access to both alcohol and illicit substances and with it the increased risk of substance misuse disorders. For the participants in one small study of people with learning disabilities who did engage in substance misuse, this was seen as being 'self-medication against life's negative experiences' - including psychological trauma and social distance from the community. All those in the study who had been referred for mainstream substance misuse services described having had negative experiences (Taggart et al, 2007).

Again the studies indicate the need to consider the implications both for services for people with learning disabilities and 'mainstream' providers of drug and alcohol services in terms of prevention and treatment services for this group of people.

## ***Sensory impairment***

A similar story arises in relation to people who have hearing impairments (including people who are deaf, deafened or hard of hearing) or visual impairments. There is some evidence of substance abuse among these groups, but also under-identification and barriers to appropriate treatment. One study, for example, suggests that the application of services for hearing people to people who are deaf can do more harm than good (Guthmann and Graham, 2004). The studies argue that there is a need to consider both the design and delivery of service, including staff with appropriate training and language skills (e.g. British Sign Language).

## ***Mental health***

The conclusions from a Scottish study of service provision for people with 'co-morbid' mental health and substance misuse issues perhaps sums up the problems experienced by this group of people:

*"The picture that emerged from this study was one of a group of people who struggle daily with the realities of living with co-morbid mental health and substance misuse problems and for whom existing support services have often been inappropriate, inadequate and which may further undermine their already fragile self esteem and coping strategies... Services for co-morbidity varied in number and quality across the different research localities... The themes identified were lack of awareness of available help, lack of clarity about pathways for help, and a lack of ongoing support." (Hodges et al, 2006)*

Again, for some people the disadvantages are multiplied. One small study of African-Caribbean, black African and white British men in contact with health and care services in East London who had mental health problems and substance misuse issues found that their experience of services was variable - a variation based on the degree to which services addressed social and cultural needs. Further, the focus of services tended to be more on the mental health issues than the substance misuse problems. The study concluded that healthcare providers needed to:

- Re-consider the cultural capability of their services to engage hard to reach ethnic groups
- Reconsider the effectiveness of interventions for substance misuse

- Develop skills in a range of interventions that reflect the patterns of substances used by specific ethnic groups (Warfa et al 2006).

### **3.6 Race and ethnicity and drug misuse**

As with a category like 'disability', the term Black and Minority Ethnic Community (BME), is used as a catch all to cover a range of different and diverse groups of people, Pakistani, Indian, Bangladeshi, Chinese, African, Caribbean, Black, Arab, as well as people who are Gypsies/ Travellers or Polish. At present there is little data to indicate what the patterns of drug misuse are across and within different groups.

An EMCDDA commissioned study of drug misuse across the European Union and Norway, found that there was very little routine monitoring: in part due to lack of recognition or denial of the problem on the part of policy makers and researchers, and partly due to different communities hiding drug use or denying the problem due to fear of increased stigma and marginalization. Insofar as statistics are available they present a distorted picture: people from black and ethnic minority communities being under-represented in drug treatment statistics and over-represented in drug law offence statistics - patterns which reflect the nature of the discrimination people experience (Fountain et al, 2004).

Factors such as social exclusion, as well as the impact of other negative experiences e.g. as refugees or asylum seekers, may be related to substance misuse.

While social exclusion is also associated with drug misuse among across populations what studies do find are differences in the drugs used by different communities, among young people (Rodham et al, 2005) and adults, with implications for prevention, treatment needs and outcomes (Fountain et al, 2004; Galea and Rudestine, 2005; Holloway and Bennett, 2008).

The 'myths, scapegoats and stereotypes', held both by white majority populations about drug misuse among people from black and minority communities, as well as held by the different communities in relation to substance misuse in their own communities can act as barriers to the development of services (Fountain, 2004).

The EMCDDA study also draws attention to the reasons behind the under-representation of people from black and ethnic minorities using available drug treatment services. These include:

- Lack of cultural sensitivity
- Distrust that confidentiality will be maintained
- Communication problems because of language
- Lack of awareness of drug services

- The stigma attached to drug use in their communities
- The failure of drug services to target people from black and minority ethnic communities.

(Fountain et al, 2004)

Guidance produced by the Scottish Drugs Forum at the end of the 1990s suggests that the barriers to seeking help among black and minority ethnic communities in Scotland include:

- Lack of knowledge of services
- Lack of appropriate services
- Fears about confidentiality being breached
- Fear of racism
- Fears relating to the response from within their communities
- Lack of black and minority ethnic workers within specialist drug services.

(Scottish Drugs Forum, 1999)

The EMCCDA study includes examples of good practice projects from across Europe, including a research project in England which used a community engagement approach to support community organizations to undertake research within their own communities (Bashford et al, 2003 in Fountain et al, 2004).

As the examples in previous sections have also highlighted, people have a number of identities, some of which because of stigma and discrimination can leave them multiply disadvantaged, for example the study of Bangladeshi women in East London (Cottew and Oyefeso, 2005), or the men from black and minority ethnic communities with a 'dual diagnosis' of mental health problems and substance misuse issues (Warfa et al 2006).

### **3.7 Sexual orientation and drug misuse**

The category LGB encompasses people who are lesbian, gay or bisexual<sup>5</sup>. As such it is another of those umbrella terms that encompasses a range of different experiences and identities.

Evidence suggests that lesbians and gay men may have higher levels of substance misuse disorders and may be more likely to have used recreational drugs (King and McKeown, in Pointon, 2003; Marshal et al, 2009). One American analysis of 18 studies found that young people who were lesbian, gay or bisexual were between 2 - 5 times more likely to use drugs and alcohol than

---

<sup>5</sup> In some contexts, the term used in LGBT to encompass people who are transgender. Here transgender has been included in the context of gender since this reflects the diversity of gender and not sexual orientation.

their heterosexual peers (Marshal et al, 2008). A longitudinal study by the same researchers found that young lesbian, gay or bisexual people (LGB) reported higher initial rates of substance use and that this increased more rapidly over time compared with heterosexual young people. That is, the extent and nature of substance abuse among people who identify as LGB is different from that of people who identify as heterosexual (Marshal et al, 2009).

Closer to home, a needs assessment among users of a Centre for Health and Well-being in Edinburgh found that 60 people (nearly one-quarter of survey respondents) used, or sometimes used non-prescription drugs as part of their home or social life (Aitken et al, 2007).

A GB-wide survey found that lesbian and bisexual women were five times more likely than women in general to have taken drugs. Around one-third of respondents had smoked marijuana in the past year - 50% more than women in general. Further 9% had taken cocaine, compared with 3% of women in general (Hunt and Fish, 2008).

It has been suggested that higher levels of drug use among gay men, compared with heterosexual men could be related to the nature of the gay 'scene' which has tended to focus around club and pub culture, and for gay men it can be difficult to avoid if they want to take part in the 'scene'<sup>6</sup>.

Pinkham and Malinowska-Sempruch (2008), drawing on research conducted in the United States, suggest that there is a fairly high prevalence of same-sex sexual behaviour among women intravenous drug users and a high prevalence of risky sexual and drug use practices among women who have sex with women<sup>7</sup> who also misuse drugs. One study in particular identified markedly higher HIV rates among women who have sex with women than among other injectors. This it was suggested was due to the multiple forms of marginalisation that promote unsafe sexual and injection practices.

The issue of marginalisation and the experience of homophobia, including 'internalised' homophobia, that is, internalizing societal anti-homosexual attitudes, are seen as key risk factors for higher rates of drug (and alcohol) misuse among people who identify as gay or lesbian, impacting on self-esteem and generating emotional distress ([www.stonewall.org.uk/what\\_we\\_do/research\\_and\\_policy/health\\_and\\_healthcare/3467.asp](http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/3467.asp)).

---

<sup>6</sup> It has also been suggested that because studies often recruit samples of LGB people from areas where they meet and socialise, this may inflate the data on numbers who misuse substances - whether drugs or alcohol.

<sup>7</sup> The terms 'women who have sex with women', or 'men who have sex with men', do not necessarily mean that the people concerned self-identify as lesbian or gay. For a glossary of terms, see Stonewall Scotland (2008) *Getting Started: A route map for public services in Scotland* [http://www.stonewallscotland.org.uk/documents/routemap\\_final\\_version\\_2.pdf](http://www.stonewallscotland.org.uk/documents/routemap_final_version_2.pdf)

One American study of lesbians, for example, found that homophobic 'events' were significantly related to past-year illicit substance use (and alcohol dependence symptoms) (Harmon, 2008). Another American study of young lesbian and bisexual women found that young 'butch' women reported drinking alcohol more frequently and in greater quantity, smoking more cigarettes, and using marijuana more frequently than young femme women (Rosario et al, 2008). The authors suggest that this was largely due to the gay-related stressful events, internalized homophobia, and emotional distress experienced by the butch women. A study of lesbian and gay men in Glasgow, undertaken at the end of the 1990s, found that among those reporting an addiction or dependence on alcohol or drugs over one-half felt this was directly related to their own or others' feelings about their sexuality (John and Patrick, 1999).

The specific cultural contexts of consumption, such as the clubs, as well as the specific experiences that may act as risk factors for substance misuse such as homophobic incidents and internalized homophobia have implications for prevention and treatment. Studies looking at access to health services generally have found that LGB people are reluctant to disclose their sexual orientation to health care professionals because of a fear of discrimination or negative experience. But it is not just a perception - in some studies people have reported actual negative experiences of homophobia or discrimination within health services (see Myers et al, 2005).

Although no studies of good practice in LGB drug treatment services have been identified there are a number of guides to support the development of services. These include Stonewall Scotland's 'route map' for public services in Scotland (Stonewall, 2008-  
[http://www.stonewallscotland.org.uk/documents/routemap\\_final\\_version\\_2.pdf](http://www.stonewallscotland.org.uk/documents/routemap_final_version_2.pdf)), the earlier Inclusion Scotland guide to 'Good LGBT Practice in the NHS' and the LGBT equality impact assessment, produced under the earlier NHS 'Fair for All Strategy' (<http://www.lgbthealthscotland.org.uk/EQIA/>).

Common themes in these resources, relevant both to LGB service users *and* LGB staff, are the need to consider:

- Language and communication
- Staff training and skills development dedicated to LGB issues
- Engagement with the LGB community
- Monitoring and evaluation of impact.

### **3.8 Religion and belief and drug misuse**

Research in the US suggests that religiosity or spirituality may have implications both for whether people misuse substances and for drug treatment outcomes. But in the context of an assessment of the equalities impacts the key issues are

about ensuring people are not directly or indirectly discriminated against on the basis of religion or belief.

In the context of drug misuse and treatment some of the key issues to consider are:

- Differential patterns of drug misuse. One Scottish study compared young people of Punjabi origin with non-Asian peers to identify if religion or culture affected patterns of substance misuse. This found that Asians were more abstinent at age 14 - 15 years compared with non-Asians, for alcohol, drugs and smoking - and particularly in relation to alcohol among Muslims and smoking among Sikhs. The authors argue that continued abstinence at age 18 - 20 years reflects the "specific influence of ascetic religious traditions" (Bradby and Williams, 2006).
- The additional stigma and marginalisation that people from faith communities who do misuse substances may experience both from within and outwith their communities
- The need for cultural sensitivity in the design and delivery of services.

Although not specific to drug treatment, NHS Education for Scotland has produced a multi-faith resource for NHS staff (<http://www.healthscotland.com/uploads/documents/6310-Multifaith%20Resource%20for%20Healthcare%20staff.pdf>.) This provides information on issues such as diet, attitudes to health and illness, religious practices etc. for a number of faith communities in Scotland including:

- Baha'i faith
- Brahma Kumaris
- Buddhism
- Chinese (not a 'religion', but refers to practices that are specifically Chinese)
- Christianity
- Church of Jesus Christ of Latter-day Saints (Mormon)
- Hinduism
- Humanism
- Islam
- Jehovah's Witnesses
- Judaism
- Paganism
- Sikhism.

An information resource for healthcare staff *Religion and Belief Matter* produced under the auspices of the NHS *Fair for All Equality and Diversity Strategy*, aims to raise awareness of, and provide information on, the links between religion, spirituality and health

(<http://www.healthscotland.com/uploads/documents/6311-Religion%20and%20Belief%20Matter.pdf>). This includes the findings from focus groups with representatives from different faith groups illustrative of the difficulties they experienced in having their religious needs met in healthcare contexts.

#### **4. ALCOHOL MISUSE**

##### **4.1 Scottish policy context**

*Changing Scotland's Relationship with Alcohol*, published by the Scottish Government in February 2009, is setting the current strategic direction for tackling the high levels of alcohol-related harms in Scotland. This sets out proposals for action under four main areas:

- Reduced consumption, including through changes in legislation and consideration of minimum pricing per unit of alcohol
- Supporting families and communities, including, for example improving substance misuse education in schools, improving the identification and assessment of those affected by substance misuse, enabling Local Licensing Boards to consider raising the minimum age of off-sales purchases to 21 years in their areas
- Positive attitudes and positive choices, including action on promotion and marketing of alcohol
- Improved support and treatment, including a target for the delivery of alcohol brief interventions and additional investment to support the development and capacity of treatment and support services.

(Scottish Government, 2009)

##### **4.2 Population-wide picture of alcohol misuse**

'Sensible drinking' guidelines for adults are based on 'units' of alcohol. Current guidelines for adults are a limit for men up to 21 units of alcohol each week (and no more than 3 - 4 units per day), with one to two alcohol-free days per week; for women up to 14 units each week (no more than 2 - 3 units per day) with 1 or 2 alcohol free days per week. There is no standard definition of 'binge drinking', but a recent report produced by the Scottish Public Health Observatory (ScotPho) uses the parameters of 8 or more units for men and 6 or more units for women consumed in one session (Catto, 2009).

Revised alcohol consumption statistics from data from the 2003 Scottish Health Survey indicate that:

- 72% of men and 58% of women reported that they had drunk alcohol in the last week
- Men were more likely than women to drink almost every day (14% compared to 8%)
- Among those who had drunk alcohol in the past week, 63% of men and 64% of women drank more than the recommended daily limits on their heaviest drinking day
- On the heaviest drinking day in the past week, 40% of men and 33% of women who had drunk in the previous week reported 'binge drinking'
- In general, men are more likely than women to 'binge drink' except for 16-24 year olds, of whom 60% of both sexes reported drinking more than twice the recommended daily limits
- Among current drinkers, 69% of men and 80% of women who responded to the CAGE<sup>8</sup> questionnaire reported no problem indicators associated with their drinking. Thirteen per cent of men and 7% of women answered yes to two or more questions, indicating possible problem drinking.

(ISD, 2009b)

The direct and indirect impacts of alcohol misuse across the population in Scotland include high levels of alcohol-related morbidity and mortality as well as social harms (ISD 2009b; ISD 2009c). Scotland, for example has one of the fastest growing rates of liver disease and cirrhosis in the world (Scottish Government, 2009a). The patterns of consumption, and associated direct and indirect harms, including on families and wider communities is differentially distributed:

*"Alcohol use and drinking patterns differ significantly between men and women, age groups, ethnic and religious groups, cultures and levels of socioeconomic development. The burden of disease attributable to alcohol use is higher in males compared to females."* (WHO, 2005)

### **4.3 Gender and alcohol misuse**

---

<sup>8</sup> CAGE is a 4-item questionnaire designed to indicate whether a person might have alcohol problems/be alcohol dependent. Two or more positive answers to these questions suggests dependence.

As the figures above indicate, patterns of alcohol consumption and of misuse are different between men and women. In general men drink more and more often than women:

- Revised alcohol estimates for 2003 suggest that in a typical week, over a third (34%) of all men drank in excess of the 21 units per week and just under a quarter (23%) of all women drank over the recommended 14 units per week. On average, men drank 20.3 units of alcohol per week, and women drank 9.1 units. (ISD, 2009b)

But the number of women drinking at harmful levels has significantly increased to the extent that alcohol related-mortality among Scottish women is now higher than that of English men (McAuley, 2009).

Men and women drink different types of alcoholic beverage:

- The majority of units consumed by men are accounted for by normal strength beer (9 units), wine (5 units) and spirits (4 units) and for women wine (5 units) and spirits (2 units) (ISD, 2009b).

And they drink in different environments: women are more likely to drink in private rather than in public spaces (WHO, 2005). A qualitative study of influences and attitudes towards drinking in Scotland found that:

- Social drinking in domestic situations was particularly common among women especially in middle-age, and mirrored male social drinking in pub settings
- Women chose to consume alcohol in home settings for a range of reasons in addition to cost, including childcare and other domestic responsibilities, safety considerations, and in some cases a reluctance to mix with men or to be in public places
- Drinking in pubs was also common in most groups, but especially in deprived areas, where male drinking predominated.

(MacAskill et al, 2008)

Women and men are also affected differently by health and social alcohol related harms.

Based on 2007/2008 data, indicators of the gendered pattern of health-related harms include:

- Of the 28,586 patients discharged from a general hospital with an alcohol-related diagnosis 71% of discharges were male

- Approximately three-quarters of discharges from general hospitals for alcohol-related mental and behavioural disorders were males
- Approximately two-thirds of discharges for alcoholic liver disease were for males
- The majority of discharges from general acute hospitals for the toxic effect of alcohol were females
- More men than women died of alcohol-related conditions in 2007. The figures for alcohol as an 'underlying cause' are 959 deaths for men and 440 deaths for women
- The male standardised mortality rate for alcohol related deaths was more than twice that for women (35.2 per 100,000 population compared to 14.8 per 100,000 population respectively)
- There were 3,257 patients discharged from a psychiatric hospital with an alcohol related diagnosis: 67% of discharges were males.

(ISD, 2009b)

In addition data suggest that:

- Over a third of older people who misuse alcohol developed the habit after the age of sixty. Out of the 1095 alcohol related deaths in the 60+ age group in Scotland in 2005, 315 were women. This is set to rise given the increase in alcohol consumption for women in younger age groups (GINA factsheet)
- There is an increased risk of breast cancer among women regularly drinking as little as seven units per week (Scottish Government, 2008b)
- Excessive alcohol consumption during pregnancy increases the risk of adverse health affects on both mother and baby, in particular Foetal Alcohol Syndrome (FAS) and other Foetal Alcohol Spectrum Disorders (FASD). However, there are difficulties accurately estimating the incidence and prevalence of FASD (McAuley, 2009).

The distribution of the social harms associated with alcohol misuse including offending, road traffic accidents and assaults is also gendered including the distribution of those who perpetrate these harms and those who are affected:

- Personal violence is more common among men, especially among intoxicated men. Among 16 - 24 year olds, for example, assault comprises one of the top three causes of alcohol attributable deaths (the other two comprising road traffic accidents and intentional harm) (ISD, 2009c)

- Women can also be the target of alcohol-related aggressive behaviours by men, including domestic violence: 62% of domestic abuse cases involved alcohol in 2003 (Scottish Government 2008b)
- Research has suggested that women with alcohol problems are more likely than other women to be in a violent relationship including being forced to having sex against their will
- Adolescent girls as well as adult women who are intoxicated are more vulnerable to sexual abuse
- 65,000 Scottish children are estimated to live with a parent whose drinking is problematic, and one quarter of children on the Child Protection Register are estimated to be there due to parental alcohol or drug misuse (Scottish Government, 2008b).

Given the gender differentials, in patterns of alcohol misuse and in terms of its personal, family and community effects, a report by WHO argues that "Policies must... consider how alcohol use and abuse affects men and women differently" (WHO 2005).

### ***Women and alcohol misuse***

Because of women's lower absorption of alcohol, which becomes lower still as women become older, the same amount of alcohol as that drunk by a man will make a woman more likely to become drunk, more quickly and to potentially experience harm. But, in looking at the impacts and effects of women's alcohol misuse it is important not to perpetuate the stigma and discrimination, or 'double standard' that women experience more than men in relation to alcohol consumption. It is also important not to 'blame the victim' where women who have alcohol problems are subject to sexual abuse or violence by men, including by intimate partners.

Clearly the factors influencing alcohol misuse among women are multiple and variable. Young women, for example, describe the 'push factors' such as the pleasure and sense of empowerment that drinking is felt to bring (HEBS, 2000). Others have expressed it in terms of gender equality - of 'drinking like a guy', but also to emphasis their (hetero) sexuality (Young et al, 2005). Young women may also feel under pressure to drink more heavily to make an impression on their male peers (Young et al, 2005).

Among older women factors such as the effects of retirement, bereavement, widowhood, children leaving home and social isolation have been suggested as influential on alcohol misuse (GINA fact sheet).

In addition to the impact of social and cultural pressures and the impact of life transitions, research has demonstrated an association between childhood abuse and the development of alcohol problems in women (HEBS, 2000). In studies on women who misuse substances, rates of childhood abuse can range from 47% to 90% (HEBS, 2000). Childhood abuse is also implicated in dual diagnosis of psychiatric disorders and substance misuse.

Although an association has been made between substance misuse and domestic violence it is far from straightforward and has a number of dimensions. These include whether the victim and/or the perpetrator are misusing substances and/or whether drugs and/or alcohol are implicated in the abuse itself (Humphreys et al, 2005). Alcohol misuse by victims of domestic abuse may be a response to the abuse or a personal survival or coping strategy, and therefore a consequence rather than a cause (Davison, 2007). Substance abuse, however, may increase the risk of being abused. Women who misuse substances are more likely to have partners who also misuse substances, which may increase their risks of being abused.

Although significant proportions of perpetrators of domestic violence also have substance misuse issues the causal relationship between the disinhibiting effects of alcohol or drug misuse and domestic violence have not been substantiated (Humphreys et al, 2005).

The potential impact of alcohol on foetal health has meant that one gender differentiated area that has received a fair amount of attention is women's consumption of alcohol while pregnant. In Scotland, alcohol consumption during pregnancy is common, with studies reporting between 25% and 50% of women drinking whilst pregnant. Despite this, the levels of consumption appear to be low, although this may be influenced by under-reporting - particularly given the stigma associated with drinking while pregnant (McAulay, 2009). To screen and provide support for women with alcohol problems antenatal settings are included in the Scottish Government's target for the NHS to deliver 149,449 Alcohol Brief Interventions (the other settings are primary care, and accident and emergency units) (Scottish Government, 2009).

There are 'internal and external' factors discouraging women's access to treatment for alcohol problems (Thom, 1986, in HEBS, 2000). Internal factors include shame, powerlessness, helplessness and fear of losing children. The external factors relate to health professionals' lack of awareness of alcohol as an issue for women. In addition there are fewer treatment options, particularly delivery options that take into account women's caring responsibilities. These barriers have implications for health prevention/promotion initiatives, early identification and brief interventions as well as the design and delivery of specialist alcohol services.

According to the WHO (2005), for alcohol prevention strategies to be effective priority should be given to:

- Developing gender-specific messages
- Involving women in the development of prevention programmes
- Incorporating prevention initiatives in services targeted at women.

In addition WHO suggests the need for capacity building among service providers to identify alcohol misuse and other related problems such as intimate partner violence (WHO, 2005).

In relation to treatment and rehabilitation services, WHO suggests that:

- Treatment programmes should be gender-specific
- Health workers should be equipped with skills to detect alcohol related problems among women who have contact with the health care system
- Constructive and non-judgmental programmes to improve health-seeking behaviour especially among women (WHO 2005).

The HEBS report suggests, that rather than the more restrictive 'gender-specific' services, which can also homogenize women's experiences, 'gender sensitive' services may be more appropriate "This would help ensure that existing services become more responsive to the needs of both female and male clients" (HEBS, 2000). As an illustration, the report describes a Health Visitor service which targeted alcohol screening and brief intervention at women aged 18 - 45 years (HEBS, 2000).

### ***Men and alcohol misuse***

As the statistics indicate, men drink more and more frequently than women, and at above 'safe' levels. As a corollary, they are vulnerable to a range of alcohol related health and social harms: including alcohol attributable mental and behavioural disorders, alcoholic liver disease, oesophageal cancer and cardiac arrhythmias. In addition men are vulnerable to injury as a result of alcohol-attributable assaults (ISD, 2009c).

Although not a specifically gendered analysis, the qualitative study on 'Drinking in Scotland' by MacAskill et al (2008), draws attention to the different environments in which men and women drink. For men, particularly in deprived areas, the pub can perform an important social function. This also emerges in a study of Irish men in London which draws attention both to the economic role of the pub and

alcohol for men in the construction industry, and its function as a way of coping with isolation, homesickness and a hostile environment. For this group of men alcohol could be a culturally sanctioned coping strategy (Tilki, 2006).

Cultural influences on men's drinking are therefore different from those affecting women's alcohol consumption. The impact on young men, particularly of issues of masculinity, may also be a factor.

Young men are more likely to binge drink than other groups, with implications for negative outcomes, and increased risk of becoming adult binge drinkers. A study in London found that the sample of young men surveyed had ambivalent attitudes to drinking (De Visser and Smith, 2006). The study found that the motives *for* drinking could also be seen (by the same people) as motives *against* drinking. The only motives for not drinking that were not also seen as reasons for drinking were violence, alcoholism and cost. The study also revealed differences in motives between the young men: while among some drinkers, drinking could be seen as part of identity and a way of demonstrating masculinity, other young men, including people who drank, rejected this association. The study suggests that in a "wet" culture in which drinking is normative for young men, it may be difficult to be a non-drinker, even for those who have a motive not to drink. The researchers suggest that this ambivalence and the fact that negative motives could also be positive motives for drinking has implications for the design of health prevention programmes. They suggest that greater attention is paid to the three "uncomplicated motives" for not drinking (violence, alcoholism and cost) (De Visser and Smith, 2006).

Given the higher rates of alcohol misuse among men it is not surprising that they comprise the highest proportion of alcohol treatment services. There is a risk though, that this lends itself to 'homogenizing' men in the way that it was suggested that 'gender specific' services may under-estimate differences among women. Men's potential role as carers, for example, may be overlooked. While studies do not specifically address this it should not be taken as evidence for reinforcing gender stereotypes.

### ***People who are transgender and alcohol misuse***

In the study of young LGBT people, referred to in the context of drug misuse, people who were transgender reported higher levels of alcohol misuse than their lesbian, gay and bisexual peers (Carolan and Redmond, 2003). But, as in the case of drug misuse, statistical data on patterns of alcohol misuse among people who are transgender are difficult to find.

The same principles and 'tests' for evaluating health care services would, however, be as applicable for alcohol treatment services as for other services<sup>9</sup>

---

<sup>9</sup><http://pfc.org.uk/node/632>

described in the context of trans people and drug misuse treatment services above.

#### **4.4 Age and alcohol misuse**

Data from the most recent Scottish Schools Alcohol Lifestyle and Substance Use Survey (SALSUS) (ISD, 2009a), found that:

- Fifty two percent of 13 year olds and 82% of 15 year olds have had at least one alcoholic drink
- Over the period 2006 - 2008 there has been a decrease in the proportion of pupils reporting that they had a drink in the last week. The proportion of 13 year olds has declined from 14% to 11% and, for 15 year olds from 36% to 31%
- Half of 13 year olds who had ever had an alcoholic drink reported having been 'really drunk' at least once, compared with 72% of 15 year olds. Among 15 year olds who had ever had an alcoholic drink, girls were more likely to report having been 'really drunk' (74% of girls compared with 71% of boys)
- Among 13 year olds who had consumed alcohol in the last week 46% had been drunk in the last week and around one-third had deliberately tried to get drunk. The figures for 15 year olds were 64% and 48%
- The two most commonly reported drink-related effects were: 'vomiting', experienced by 26% of 13-year olds and 39% of 15-year olds; and having an argument, reported by one-quarter of 13 year olds and just under 40% of 15-year olds. More girls than boys in both age groups reported 'having an argument'. Boys were more likely to report being in trouble with the police.

(ISD 2009a)

A literature review and secondary analysis of data from the Health Behaviour of School-aged Children survey (HBSC) identified the different 'substance use profiles' for boys and girls (Kirby et al, 2008). Both boys and girls who drink alcohol weekly reported:

- Having friends who use substances
  - Not liking school
  - Poor school performance relative to their classmates
  - Skipping school
  - Feeling pressured by schoolwork
-

- Lower educational aspirations
- Living in a low socio-economic status neighbourhood.

Girls, though, were more likely to report poorer health and low life satisfaction.

Among the older age group of 16-24 year olds, data on alcohol consumption suggests that:

- 60% of both men and women age 16 to 24 years reported 'binge drinking' on their heaviest drinking day in the last week (more than 6 units for women and more than 8 units for men)
- Among women, those aged 16 to 24 years old were most likely to report drinking more than the recommended weekly limits, with 32% drinking more than 14 units a week. Among men, the proportion drinking more than the weekly recommended limit was highest in the 45 to 54 age group with 38% drinking over 21 units a week.

(ISD 2009b)

Data on Alcohol attributable mortality and morbidity, suggest that among young men aged 16-24 years:

- The three highest causes of alcohol attributable patient-specific discharges were mental and behavioural disorders, assaults and fall injuries
- The three top causes of alcohol attributable deaths were road traffic accidents, intentional self-harm and assault.

For women aged 16 - 24 years:

- The three highest causes of alcohol attributable patient-specific discharges were mental and behavioural disorders, intentional self harm and epilepsy
- The three top causes of alcohol attributable deaths were intentional self-harm, road traffic accidents and epilepsy.

(ISD, 2009b)

Although consumption of alcohol is lower among older people and the proportionate number of deaths attributable to alcohol also commensurately lower, with the coming of (older) age of the 'baby boom' generation, that is those born between 1945 - 1965, the numbers of older people (those aged 60+) who drink above the recommended levels is expected to increase (Health Scotland, 2006). This will include both people who have had alcohol problems for some

time as well as 'late onset' drinkers. Alcohol abuse also occurs more frequently among older men, including among frail elderly men.

Physiological changes mean that older people in general, and older women in particular are more sensitive to the physical effects of alcohol. Negative interactions between alcohol with other medications may also disproportionately impact on older people.

Data from 2003 indicate that among men aged 64 - 74 years, 8.0% of hospital discharges were alcohol attributable, and for those aged 75 and over, the figure was just over 6.2%. The equivalent figures for women were 5.0% and just under 4% respectively (ISD, 2009b). The rate of admissions for alcohol-related reasons is also increasing over time, as is the rate of alcohol-attributed deaths (Health Scotland, 2006). Older 'at risk' drinkers may also engage in other harmful health-related behaviours (Moore et al, 2001) and this may contribute to self-neglect (Blondell, 1999). Factors influential on alcohol consumption among older people include:

- The greater acceptability of drinking in public, with particular implications for women
- Older people see alcohol as an enjoyable social activity and its effects positive, but are less likely to have heard of alcohol units
- Older people are more likely to drink alone
- Stressful age related life events which may cause relapse for those with established alcohol problems.

(Health Scotland, 2006)

For older women, isolation and 'lifestyle changes' may also be implicated (GINA fact sheet).

The nature and extent of alcohol problems among older people has largely been 'hidden'. In part, because older people drink more often on their own, but also because alcohol problems may be undiagnosed or misdiagnosed, particularly among older women. There has also been less focus on the development and evaluation of 'age-specific' treatments.

From a health promotion/prevention perspective, there is a need to target health information, including on units of alcohol at older people, in formats that support visibility and retention (GINA fact sheet). Treatments for older people may also need to be appropriate in terms of content in order to address life stage issues and in terms of therapeutic style and pace (Epstein et al, 2007).

Social work practitioners attached to an older person's team in Scotland interviewed about their experiences with older people who misuse alcohol included among their suggestions for age-specific services:

- Providing longer term support in older people's own homes
- Using a specialised support worker
- Increased staff training on alcohol use among older people (Shaw and Palattiyil, 2008).

One American study suggests that age-specific cognitive behavioural approaches and 'less confrontational' treatment approaches can help to achieve positive outcomes for older people with alcohol related problems (Cummings et al, 2008).

#### **4.5 Disability and alcohol misuse**

In general people with a disability are more likely to have a less healthy lifestyle (Macpherson and Bond, 2009). Specifically in relation to alcohol, an analysis of Scottish Health Survey data suggests that in terms of the mean number of units consumed in the week before there was little difference between men with and without limiting long-standing health conditions. There was, however, a significant difference between women: women with limiting long-standing conditions drank only 5.1 units compared with 7.1 among women without a long-term condition. For both men and women though the relative likelihood of drinking above the recommended limits was lower for those with limiting long-standing illnesses (Loretto and Taylor, 2007).

Among young people, however, one European study comparing patterns of substance abuse among physically disabled and non-disabled adolescents found that those who were physically disabled drank more often and for different reasons than their non-disabled peers (Janekovic, 2003).

Whatever the actual level of consumption, people with disabilities who misuse alcohol may experience multiple risks. An American study found that young people with mobility impairments, learning disabilities or 'emotional disabilities' were more involved in a range of risk behaviours (including alcohol). But while the risk and protective factors were the same between disabled and non-disabled young people, the young people with disabilities were more exposed to risk factors and significantly fewer protective factors (Blum et al, 2001). Another American study of adults suggests that adults who had a disability and misused substances were more likely to be victimized by physical abuse and domestic abuse than their non-disabled peers (Wolf-Branigin 2007).

A common theme among the few studies that have looked at the experiences of people with disabilities who misuse substances (including people with learning disabilities and mental health problems), are the barriers they experience both to health promotion/prevention services and also to treatment services.

The inquiry panel following the formal investigation by the (then) Disability Rights Commission (DRC) into physical health inequalities experienced by people with learning disabilities and/or mental health problems commented that:

*"We are alarmed by the apparent lack of appropriate, accessible and targeted information and support to encourage and enable people with learning disabilities and/or mental health problems to improve their physical health, particularly where they are in residential settings such as residential care homes and hospitals". (DRC, 2006)*

The panel included among its recommendations that the support offered to people with learning disabilities and/or mental health problems should include information, advice and support, in an accessible relevant and targeted form on how to quit smoking, on good diet, on sexual health, on **alcohol**, on street drugs and on physical exercise.

People with disabilities who have alcohol-related problems may also experience barriers to accessing appropriate treatment. As was described in the chapter on drug misuse these may include:

- Ineffective identification of the problem
- Ineffective treatment that does not fully take into account the disability - for example, just providing a service for hearing people to people who are deaf or have hearing impairments
- And a lack of knowledge or experience among staff in relation to treating people with disabilities.

As a result people with disabilities may be indirectly excluded from, or experience discrimination in access to, appropriate services.

#### **4.6 Race and ethnicity and alcohol misuse**

A report published in March 2009, summarises the available data sources for information on alcohol consumption on black and minority ethnic groups and recent immigrants to Scotland (Jarvis, 2009). This concluded that there was a need to gather more robust and meaningful information. However, some data are collected from local and (UK-wide) national surveys, which although not easily generalisable across Scotland or to other smaller, less urban areas,

indicate different patterns of consumption, but also different needs for education, information and treatment services.

These surveys (summarised in Jarvis, 2009) indicate that:

- Self-reported consumption of alcohol was much lower among people from the black and minority ethnic communities surveyed, than among the general population (NHS Greater Glasgow, 2006)
- More European respondents reported current alcohol consumption than those in minority ethnic groups such as 'Indian', 'Bangladeshi', 'Pakistani' and 'Chinese'. In surveys which looked at religion fewer Muslim participants reported drinking alcohol than other groups (Bhopal, et al, 2004)
- A survey of Chinese, Pakistani and Indian young people aged 16 - 25 years living in Glasgow found that Muslim participants had the lowest level of reported alcohol consumption. However, Muslims who did drink alcohol reported a higher level of consumption than other religious groups, although this was only statistically significant when compared to the non-religious participants (Heim et al, 2004).
- Health Surveys for England run in 1999 and 2004 found that men and women from all ethnic minority groups (except Irish) were more likely to report being non-drinkers. All minority ethnic groups who did report drinking, drank less frequently than the general population. Levels of alcohol consumption - both weekly and on the heaviest drinking day were lower among all minority ethnic groups except Irish people.
- Data on alcohol consumption among recent migrants is not currently routinely available.

Other studies, both in America and in England, similarly suggest that alcohol consumption may be lower among people from black and minority ethnic communities (including young people) than their white British or Irish peers. The risk and social factors influencing drinking patterns may though, also be different between groups:

- One American study of young people ('pre-teens') found that, compared with other groups, young black people who witnessed violence in their home before they were aged 10 were three times more likely to start drinking before they were 13 years. Conversely, white students who reported higher levels of social support at school were 50% less likely to start drinking before they were 13 years (Bossarte and Swahn, 2008).
- A study of British university students found that although British Asian students consume alcohol at similar levels to British white students they may

be doing so for social rather than 'emotional self-regulatory' purposes (Spada and Moneta, 2004).

Although there is very little routinely collected data on use of treatment services by people from black and minority ethnic communities (or recent migrants), one study found that among young people from black and minority ethnic communities, just over one-half felt that alcohol problems should be treated in 'mainstream' drug and alcohol services, rather than specialist services for people from black and minority ethnic communities. Concerns were that people would be treated differently or that their confidentiality could not be assured in specialist services. At the same time the young people suggested that education campaigns needed to draw attention to the fact that alcohol problems were not just a white problem, but that issues of language and culture also needed to be considered (Bakshi et al, 2002, in Jarvis, 2009).

A needs assessment in London of provision of drug and alcohol services for people from black and minority ethnic communities found:

- Differences in access to services by people from minority ethnic groups
- Variations between groups in attitudes towards drug and alcohol misuse and in the perceived underlying factors
- An expressed need for culturally competent services.

(Luger and Sookhoo, 2004).

In addition are those people who are at risk of multiple disadvantages e.g. women from black and minority ethnic communities. The HEBS report (2000) summarises the work of the Ethnic Alcohol Counselling in Harrow (EACH) service. Nearly half of the service users were women, mostly the partners of male problem drinkers. The services specifically targeted at women included crèche facilities, women counsellors and women only groups, and home visits for women who felt they could not attend the project. Counselling was also available in the five main Asian languages. Because of unfamiliarity with the concepts of counselling and therapy, the service worked to increase awareness of the service in the community.

What the available data suggest is the need to consider the different risk and promotive factors that different black and minority groups might face in relation to excessive alcohol consumption, with implications for health promotion and prevention messages. For those who do experience problems, thought also needs to be given to the design and delivery of services to enable people to access and use services. This will become increasingly important if there are changes in the influences, behaviours and attitudes among young people from black and minority ethnic communities growing up in Scotland compared to that

of older generations (Jarvis, 2009). A survey of Chinese, Indian and Pakistani young people, for example, found that having friends outside their own ethnic community and having friends within their own ethnic community who drank alcohol were both positively associated with alcohol consumption (Heim et al, 2004, in Jarvis, 2009).

#### **4.7 Sexual orientation and alcohol misuse**

Concern has been expressed about data suggesting comparatively higher rates of alcohol consumption among people who are lesbian, gay or bisexual because of the way in which the data are collected. Studies have tended to rely on samples recruited from the bars and clubs that constitute the 'scene'. This may inflate the data to some extent. There may also be differences between and within the different sub-groups collapsed into the category 'lesbian, gay and bisexual'.

What the studies based on broader population-based (and predominantly American) data do suggest is that:

- Lesbians may have higher levels of drinking than heterosexual women. Data reproduced in the Inclusion Report (Inclusion, 2003) suggests that 49% of lesbian/bisexual women drink more than 14 units of alcohol per week, 17% drink more than 22 units per week. Fewer lesbian than heterosexual women abstain from alcohol. A More recent GB-wide survey found that nearly nine out of 10 lesbian and bisexual respondents drank alcohol. One one-quarter had *not* had a drink in the last week, compared with two-fifths of women in general. Among the lesbian and bisexual women, two-fifths had drunk on three or more days in a week, compared with one-quarter of women in general (Hunt and Fish, 2008)
- Within groups, an American study comparing exclusively heterosexual, mostly heterosexual, bisexual, mostly lesbian, and exclusively lesbian women, found that 'exclusively heterosexual' women reported less childhood sexual abuse, early alcohol use, and depression. Bisexual women reported more hazardous drinking indicators and depression than did exclusively or mostly lesbian. (Wilsnack et al, 2008). Another study comparing young women and men found a similar pattern among the young women but that while 'mostly heterosexual' boys were at greater risk, there was no difference between gay or bisexual boys and their heterosexual peers (Ziyadeh et al, 2007).

What the studies also reveal are the different risk factors that may be implicated in alcohol misuse among people who are lesbian, bisexual or gay. These include:

- The impact of internalised homophobia. There is felt to be a strong link between the sense of 'shame' felt due to the internalisation of negative attitudes toward those who are lesbian, gay or bisexual. This is felt to be associated with 'self-destructive' behaviours including alcohol abuse. Alcohol has been described as a way of easing this sense of 'shame' - "Alcohol Allows You To Not Be Yourself" (Peralta, 2008)
- The experience of internalized homophobia as well as alcohol abuse may also extend into older age. One study looking at the mental health of lesbian, gay and bisexual people aged between 60 - 90 years, found that compared with the women in the sample, men reported significantly more internalized homophobia, alcohol abuse and suicidality (D'Augelli et al, 2001)
- In addition is the impact of external homophobia and discrimination. One study of workplace harassment, gender identity and alcohol found that that lesbian/bisexual women did not differ significantly from heterosexual women in their experiences of workplace harassment. But there were stronger links between this experience of harassment and increased alcohol consumption and alcohol-related problems than among heterosexual women. Gay/bisexual men, on the other hand, experienced significantly more sexual harassment than heterosexual men, but did not report an associated increase in alcohol use and misuse (Nawyn, et al, 1999)
- Childhood sexual or physical abuse. Studies of lesbian women have found a relationship between the experience of childhood sexual abuse, or physical abuse and excessive drinking, or drink related problems in adulthood
- Impact of culture or the 'scene'. Although possibly changing, the culture of the 'scene' around bars and clubs, a response to a lack of alternative space places for LGB people to meet other LGB people, may have put an emphasis on alcohol consumption. One Swedish study does suggest, for example, that alcohol plays a more substantial role at the core of the gay and lesbian community than for other sub-groups (Bergmark et al, 1999).

The different factors that may influence alcohol misuse among lesbian, gay and bisexual people have implications for:

- Health education and prevention. The Stonewall website ([http://www.stonewall.org.uk/what\\_we\\_do/research\\_and\\_policy/health\\_and\\_healthcare/3464.asp](http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/3464.asp)), for example, suggests that preventative health messages and campaigns are generally only targeted at heterosexual people and do not necessarily address or appear relevant to the concerns of lesbian, gay or bisexual people.
- Access to services. As discussed above in the context of substance misuse, people who are lesbian, gay or bisexual may be reluctant to disclose their

sexual identity to a health practitioner because they are fearful of discrimination or receiving a negative response. Additionally they may be reluctant to disclose that they have a problem with drinking, compounding barriers to services

- The need for service design and delivery to be sensitive to issues of sexual identity as well as responsive to factors such as direct or indirect homophobia which may be a factor in the development of alcohol problems.

#### **4.8 Religion and belief and alcohol misuse**

Much of the (predominantly American) research on religion and alcohol misuse is focused on the potential for religious belief to act as a mediator, reducing the risk of alcohol misuse. A study undertaken in the Lebanon, for example, comparing alcohol use between Christian, Muslim and Druze students suggest that religiosity (irrespective of actual religion) may act as a protective factors against an alcohol use disorder. The study, however, also found differences between the religious groups with the Christian groups more likely to have drunk alcohol, to have started drinking earlier, and more likely to be diagnosed as having an abuse disorder (Ghandour et al, 2009).

Little work has been done on patterns of alcohol consumption across the main religious and faith groups in Scotland. The one study that does touch on the impact of religion and alcohol is a survey of Chinese, Indian and Pakistani young people (16 - 25 years) living in the Greater Glasgow area (Heim et al, 2004, in Jarvis, 2009). Reflecting the findings in the international studies, this survey found that the self reported importance of religion was negatively associated with alcohol consumption. The young people who were Muslim were the least likely to report alcohol consumption while those who were Christian were the most likely to have drunk alcohol. Among those who did drink, however, Muslims reported drinking the highest number of units of alcohol per week (13.7 units) and Christians the least (3.9). The findings are, however, based on very small samples (Heim et al, 2004, in Jarvis, 2009).

Although the data is sparse, it does suggest different patterns in consumption between different religious groups: with implications for the nature of prevention campaigns, but also for ensuring that the design and delivery of treatment services are sensitive to religion and belief, including the role of religion and belief in individual recovery.

## 5 SMOKING AND TOBACCO MISUSE

### 5.1 Scottish policy context

There have been a number of strategies and policies aimed at reducing smoking rates and smoking related harms. These include:

- *A Breath of Fresh Air for Scotland: the Tobacco Control Action Plan* (Scottish Executive, 2004)

This set out a programme of action for NHS Boards and national organisations to tackle smoking including smoking prevention and education, tobacco control and the expansion smoking cessation services. It also sought to address the issue of passive smoking. It included a specific action for NHS Boards concerning the provision of smoking cessation support services (SCS).

- *Smoking, Health and Social Care (Scotland) Act 2005*

As part of the Tobacco Control Action Plan, and particularly with a view to reducing the impacts of passive smoking the then Scottish Executive introduced the *Smoking, Health and Social Care (Scotland) Act 2005*, which prohibits smoking in virtually all enclosed public spaces. This became operational in March 2006.

- *Scotland's Future is Smoke-Free: A Smoking Prevention Action Plan* (Scottish Government, 2008d)

In 2008, the Scottish Government issued its smoking prevention action plan. Focusing specifically on children and young people this introduced a range of actions to, on the one hand, enhance awareness and education about tobacco-related harms through health education and health promotion initiatives, and, on the other, to reduce the attractiveness, availability and affordability of tobacco products.

### 5.2 Population-wide picture of smoking and tobacco use

Annually produced data indicate that there are approximately 37,100 smokers in West Lothian (based on 2005 – 2006 data), of whom around 4.3% in 2008 attempted to quit smoking through a smoking cessation service, (ISD, 2009d). compared with a national total of 4.6% (Scotpho, 2009).

Data from the most recent Scottish Household Survey, suggest that those in the 15% most deprived areas of Scotland are considerably more likely than those in

the rest of Scotland to say that they are current smokers (42% and 23% respectively) (Scottish Government, 2008a).

Recent research commissioned by NHS Health Scotland (Scott Porter Research and Marketing, 2009) highlights the differences in the motivators and barriers to taking up local NHS smoking cessation services between and within different groups:

- Men were motivated by the prospect of greater personal control over quitting, and a greater requirement for a clear rationale of the benefits of smoking cessation services a need to understand the 'science' behind how they worked
- Women were motivated by the idea of support provided in a positive and mutually supportive environment with others sharing the same goals. Young women also placed more importance on practical consideration relating to flexibility of service provision to fit in with their lifestyles
- People from black and minority ethnic communities had a greater need for discretion and anonymity and wanted more options of services outwith their community. However, 'mainstream' services currently provided were felt to lack relevance because of differences between participants in terms of social and cultural background
- People with disabilities wanted flexibility in service provision - both for safety and comfort, but also in terms of choices of times, locations and channels.

The reports authors argue that the 'messages' for facilitating engagement with smoking cessation services need to reflect the different motivators and barriers, including:

- For men, messages focusing on personal control and ownership
- For women, an emphasis on non-judgemental and friendly atmosphere and on scope for mutual support
- For people from black and minority ethnic communities, messages and means for engagement needed to focus on building relevance and a sense of control and ownership over the process. Efforts may also need to counter cultural barriers
- Messages targeted at people with disabilities who smoke need to increase the sense that services are relevant and responsive to their practical and emotional needs.

(Scott Porter Research and Marketing, 2009)

### **5.3 Gender and smoking**

Data from the most recent Scottish Household Survey indicate that slightly more men than women smoke - 26% and 25% respectively. Younger men more commonly smoke than younger women, with the gap widest (four percentage points) between the ages of 25 and 44 years. This relationship is reversed among those aged 45 to 74 years, with a higher prevalence of female smokers to male smokers by a percentage point at this age. Men smoke more, on average, smoking a median of 15 cigarettes, compared with a median of 12 a day for women (Scottish Government, 2008a). Similar patterns are indicated in the recently published Scottish Health Survey (Corbett et al, 2009).

The Scottish Household Survey also reveals that overall, one in four full time employees smoke. Among full time workers aged 16 - 24 years, around one-third of both men and women smoke; among those aged 24 - 34 years, more men (30%) than women smoked (21%); among those aged 35 years and over in full time employment, however, 25% of women smoked compared with 22% of men (Scottish Government, 2008a)

Scotland-wide data indicate that 60% of quit attempts in 2008 were by women and 40% by men. Given that there is little difference between men and women in smoking rates this suggests that more women than men take up smoking cessation services (Scotpho, 2009).

#### ***Women and smoking***

There has been a quite considerable literature on the gendered dimensions of smoking, both in Scotland (see for example, Amos and Bostock, 2007; Hannah, Hunt and West, 2004), as well as nationally and internationally (WHO, 2003). It has not been possible to fully explore this literature, however, even a brief overview suggests a number of common themes.

The first of these themes is the apparent double standard that is applied socially/culturally to male and female smokers. As discussed further below in the context of smoking and race and ethnicity, while, in some ethnic communities there may be a degree of tolerance of men smoking, women smokers could be stigmatised (even by male smokers). This double standard however, appears to extend across communities. One study of American college students, for example, found that although males who smoked were described as looking manly, relaxed, and in control, among females, smoking was perceived as making one look 'slutty' and out of control. As a result young women monitored their own and their friends' smoking carefully and tended to smoke in groups to mitigate negative perceptions of smoking (Nichter et al, 2006).

Discrimination, not only as an effect, but as a potential *cause* of smoking has also been described in one study of American female college students. This study found that the relation between perceived sexism and binge drinking and smoking was mediated by psychological distress. In addition, there was a direct relation between the experience of sexism and smoking for weight control (Zucker and Landry, 2007)

A second related theme concerns the identified gender-related differences in attitudes and experiences concerning smoking and smoking cessation. One international study across 16 countries, for example, found that women reported more reasons for smoking and were more likely to be motivated by life changes to quit than men. In addition they were more likely to use medications or counselling for smoking cessation (Reid et al, 2009). Closer to home, Amos and Bostock (2007) undertook a qualitative study of gendered patterns of smoking among Scottish 15 - 16 year old smokers. The research found differences arising from the social worlds of the young women and men, their patterns of social relationships, interests, activities and concerns. While boys were more concerned about the impact of smoking on their fitness and sport, girls were more concerned about the impact on the ways they looked, for example their clothes and bodies smelling of smoke. The authors argue that of particular importance was how smoking related in different ways to the gendered 'identity work' that the young men and women had to undertake to achieve a socially and culturally acceptable image - differences which may suggest a need for more gender sensitive approaches to smoking prevention and smoking cessation programmes.

Another study, focusing on a slightly older age group of 17- 25 year olds (smokers and non-smokers), looking specifically at the issue of appearance, including weight and smoking found that weight gain after quitting was only a significant concern for the younger (17-year-old) women. Non-smokers of both genders expressed concern about yellowing of skin and teeth if they started smoking, and women non-smokers were concerned about skin ageing. Smokers believed that smoking made them look 'cool', mature, and sophisticated and would quit only if skin ageing and other negative effects on appearance became visible (Grogan et al, 2009).

This issue of appearance, particularly, the perceived *positive* effects of smoking in helping to control or reduce weight, recurs throughout the literature. This is an identifiably gendered attitude in the sense that this features more significantly as a factor both in smoking initiation and mitigating against smoking cessation among women than among men. A literature review, for example, focusing on the associations between body weight, concerns about body weight and smoking initiation among adolescents found that where there were positive relationships between smoking, dieting behaviours, disordered eating symptoms this more consistent among female adolescents than among male adolescents (Potter et al, 2004).

Another American study found that using a nationally representative panel of adolescents, smoking initiation was more likely among females who were overweight, who reported trying to lose weight, or who described themselves as overweight. In contrast, neither objective nor subjective measures of weight predicted smoking initiation by males. The study also found that higher cigarette prices decreased the probability of smoking initiation among males but had no impact on female smoking initiation (Cawley, Markowitz and Tauras, 2004).

The gendered dimension of smoking (and potentially a further manifestation of the smoking double standard) is most evident in relation to smoking during pregnancy. Although women may want to give up smoking when pregnant, they may be discouraged both because stressors experienced during pregnancy (Atkinson, Gilbert and Hotham, 2005), but also because of the attitudes of male partners. One study, for example, found that although there was no direct evidence of partner abuse or violence accompanying a partner's efforts to influence women's smoking while pregnant, elements of power and control were at play and appeared to cause an emotional toll and a negative impact on women's ability to freely express their views about their own tobacco use (Greaves, Kalaw and Bottorff, 2007)<sup>10</sup>. The authors conclude that elements of power and control, however subtle, are potentially important and unrecognized dimensions of women's tobacco reduction experiences, with implications for the design and delivery of smoking cessation interventions to ensure that these do not add to this use of power and control.

Another dimension of unequal power relations is perhaps suggested by a study of couples in Canada. This found that men's reliance on, and commitment to, dominant ideals of masculinity seemed to preclude them from viewing their partner's tobacco reduction or cessation for pregnancy as an opportunity for their own smoking cessation (Bottorff et al, 2006).

A fifth theme is the impact of deprivation and disadvantage on women's smoking and cessation attempts. A large survey of British women aged 20 - 34 years examined the socio-economic gradients of smoking. This found that socio-economic gradients in ever-smoking were marked across age groups. Further, with quitting more prevalent in the higher than lower socioeconomic groups, the gradients in current smoking steepened across age groups (Harman et al, 2006).

Joblessness, as an indicator of disadvantage, may also be implicated in smoking levels. An American study of the impact of employment or joblessness on young adults aged 14 - 21 years by gender and ethnicity found, for example that joblessness was more strongly associated with persistent daily smoking among women (Weden, Astone and Bishai, 2006). The study also found that the lower cessation rates among this group of women, was at least partly explicable in

---

<sup>10</sup> It is not evident from the abstract consulted whether the assertion of power and control was aimed at stopping women from smoking during pregnancy or a reaction to their attempts to quit.

terms of the fewer socio-economic resources to which they had access. but also the differential impact of smoke free policies upon women, particularly those living in disadvantaged communities.

Differential impacts may also be felt in relation to the impact of smoke-free policies. One UK study explored through focus groups how mothers living in disadvantaged areas use space within their homes to smoke while looking after children aged 0-4 years (Robinson and Kirkcaldy, 2007). This study found that many women imposed temporary and ad hoc restrictions to create a smoke-free environment for their children but that these efforts both competed with their caring responsibilities and were restricted by the limitations of the physical environment of their homes.

The potential unintended consequences of smoke-free policies for disadvantaged women is further highlighted in a literature review of the sex- and gender-based issues related to second-hand smoke exposure and the effects of second-hand smoke policies for various subpopulations of women. This found that smoke-free policies do not always have equal or even desired effects on low-income girls and women. Low-income women are more likely to be exposed to second-hand smoke, may have limited capacity to manage their exposure to second-hand smoke both at home and in the workplace, and may experience heightened stigmatization as a result of second-hand smoke policies (Greaves and Hemsing, 2009). The authors conclude that gendered roles, unequal power differences between men and women, child-caring roles, and unequal earning power, affect exposure and responses to second-hand smoke, women's capacity to control exposure, and their responses to protective policies. The authors recommendation, while specific to smoke-free policies, could perhaps apply across the different dimensions of women and smoking discussed here, which is to ensure more 'nuanced gender and diversity sensitive' frameworks are in place to develop tobacco control and smoking prevention and cessation policies and interventions.

### ***Men and smoking***

According to WHO "available evidence compellingly demonstrates that in most countries being born male is the greatest predictor for tobacco use" (WHO, 2003, p.2), and although the gap maybe closing, as the previous sub-section suggests, men and women have different attitudes towards, and experiences of smoking and smoking cessation.

The construction of masculinity has been described as a significant factor influencing male attitudes toward tobacco and smoking. Research drawn upon by the WHO suggests that men and boys feel themselves under pressure to accept the stereotype of men being rugged and strong, with implications for health behaviours and risk taking, including tobacco initiation and quitting. According to

WHO "In many countries, smoking marks the transition to manhood, and is deeply embedded in everyday male social relations, both business and personal" (p.2). This is perhaps summed up in the title of one Indonesian study of teenage boys' views about smoking: 'If I don't smoke, I'm not a real man' (Ng, Weinehall and Ohman, 2007). As noted in the previous section, conceptualisations of masculinity have also been found to be influential on men's attitudes towards smoking and smoking cessation by their pregnant partners (Bottorff, et al 2006) and among American college students, where male smokers were perceived as manly and in control (Nichter et al 2006).

But the perceived sense of obligation that can be associated with being a man, may also generate constraints which can also impact on health behaviours such as smoking. A study of masculinity, fathering and health, comparing African-Caribbean and white working class fathers in the English West Midlands, found that health was perceived as an asset that allowed them to meet their paid work and fathering obligations. But this was coupled with what the author calls "a restricted sense of personal agency" and a sense of constraint that was associated with "transgressive" consumption of alcohol, food and tobacco (Williams, 2007).

What this same study also found was that for the African-Caribbean fathers, anticipated or perceived racist prejudice, abuse or discrimination influenced their health experiences (Williams, 2007). The impact of racist harassment or abuse not just on health in general, but tobacco consumption in particular, was also found in a study of the impact of tobacco control policy initiatives on UK resident Bangladeshi male smokers (Croucher and Choudhury, 2007). This qualitative study undertaken in Tower Hamlets, London, compared the experiences of younger and older Bangladeshi men in relation to smoke-free workplace environments, access to alternative sources of tobacco, and use and availability of nicotine replacement. This found that smoking initiation and use were linked to gender, age, religion and tradition. Among the younger respondents, however, continued smoking was related to anxieties about harassment. Another factor among young and older respondents was the environments within which they worked, which was often unskilled employment in the restaurant trade - environments, which at the time of data collection in 2002, tended not to support smoking legislation. The study also found there was confusion about the purpose, availability and efficacy of nicotine replacement therapy in particular and were isolated and marginalised from tobacco control and smoking cessation initiatives more generally (Croucher and Choudhury, 2007).

The particular attitudes and experiences of people from black and minority ethnic communities towards tobacco, smoking and smoking cessation are discussed further below. What, however, the experiences of men, and of men from marginalised communities again emphasises is the need for tobacco control and smoking cessation initiatives to be both gender and culturally sensitive in order to enhance their effectiveness.

### ***Smoking and people who are transgender***

There is very little information on levels of smoking among trans people. According to the Philadelphia based Safeguards Project, rates of smoking within Trans communities may be as high or higher than those among the LGB or general population. Trans people who smoke may be at even greater risk for tobacco-related harms, because of high rates of HIV among some Trans communities and the possible additional risk factors for heart disease related to hormone therapy. The website of the Philadelphia Safeguards Project summarises some of the findings from a number of studies undertaken among the Trans community in different parts of the US. Across these studies a number of factors were identified which impact on smoking levels, the effects of smoking and access to smoking cessation among trans people. These include:

- The stress and trauma of discrimination as reasons why trans people smoked
- Discrimination, together with high levels of unemployment and suicide among the Trans population may also mean that smoking cessation programmes are not a high priority for Trans people
- Trans people who obtain their hormones from the street or other non-clinical sources may be at greater health risk if they use these hormones in combination with smoking
- Trans people experienced problems not just accessing health services, but also services for people who are lesbian or gay, which may mean they are also precluded from accessing available smoking cessation services.

(Source: The Safeguards Project, (<http://www.safeguards.org/?p=67>: accessed 11 Nov 2009)

The Safeguards Project recommends the need for Trans-inclusive or Trans-specific smoking cessation and tobacco control programmes, both through specialist LGBT services and community health services. This, however, should be located within the "larger context of Trans health and Trans rights" (The Safeguards Project: <http://www.safeguards.org/?p=67>).

### **5.4 Age and smoking**

Smoking prevalence rises from adolescence into early adulthood and declines in later adulthood. There is a peak for men in the 25–34 age group, whereas for women rates are similar across the age groups from 16 to 59 years (Scotpho, 2008a).

## ***Young people and smoking***

Overall, younger people are more likely to smoke. The most recent survey of smoking, drinking and alcohol abuse among 13 and 15 year olds also reveals that:

- While there is no gender difference in the proportions of 13 year old boys and girls who have ever smoked, among 15 year olds, boys are more likely to have *never* smoked than girls: 55% compared with 47%
- Among 'regular smokers' (defined as usually smoking at least one cigarette a week), 4.0% of 13 year olds and 15% of 15 year olds were regular smokers (ISD, 2009a). In both age groups, a slightly higher proportion of girls than boys smoked.

(ISD, 2009a)

Among those aged 16 - 24 years data from 2006 suggests that over one-quarter (28%) were regular smokers (Scotpho 2008b). Again there is some indication of gender difference:

- Among those aged 16 -19 years smoking rates tend to be higher than among young men. This reverses among 20 - 24 year olds with the rate being higher among young men.

The data also suggest differences in smoking rates among young people depending on whether they are in employment, education or not in education, employment or training (NEET), and the gendered nature of this difference among the latter group:

- Around one-half of young adult smokers were in employment (51%); 30% not in education, employment or training (NEET); 16% in further or higher education; 3% at school. *Rates* of smoking were, however highest among those in the NEET group (50%)
- The analysis includes within the NEET group young women who are looking after a home and family, of whom there are around 16,000 (but only a negligible number of young men). Among this group smoking rates are also high at 54%. Further, although young women who look after a home and family account for just 10% of all young female smokers at aged 17, this rises to more than one quarter of this group by age 24.

(Scotpho, 2008b)

Among those young people who are employed smoking rates vary by vary by industry - also revealing a gendered distribution. For example:

- More than one-quarter (27%) of young male smokers in employment work in wholesale and retail trade/repair trades, and more than one-fifth (22%) are employed in construction. Another 12% of young male smokers in work are employed in manufacturing with 13% employed in hotels and restaurants
- The largest numbers of working young female smokers are concentrated in the wholesale and retail trades; repair trades (28%) and hotels and restaurants (22%). Large numbers are also employed in health and social work (15%) and other community, social and personal service activities (10%)
- For both young men and women, the larger the industrial sector, the more young smokers it has.

(Scotpho, 2008b)

Data for 2008 also indicate that under 25 year olds account for almost 9% of quit attempts made; 25-34 year olds 17%; 35 – 44 24%; 45 – 59 31% and those aged 60 years and over, 19%. However, as noted above, smoking prevalence rates are higher in younger age groups, with males aged 16 – 24 years having the highest prevalence overall (Scotpho, 2009).

A study of the attitudes and influences on substance misuse among young people, includes not only drugs and alcohol, but also smoking - indicating the often interlinked nature of the different types of substance misuse (Kirby et al, 2008). This study also drew attention to the different substance misuse profiles of young men and women.

Current Scottish policy (Scottish Executive, 2004; Scottish Government, 2008d) include health education and promotion initiatives and actions targeted at young people to prevent them taking up smoking, targets for reducing the levels of smoking among young men and women aged 13 - 24 years as well as supporting the development of smoking cessation services. From an equalities point of view the design and delivery of these activities, including social marketing as part of smoking prevention campaigns, need to take into account the influences on, and patterns of smoking among young people, but also, the gendered nature of this distribution.

### ***Older people and smoking***

Scottish Household Survey data (Scottish Government, 2008a) indicate that around 1 in 5 60 - 74 year olds smoke. This falls to 1 in 10 among those aged 75

years and over. Marginally more women than men among those aged 60-74 year olds smoke, but similar proportions of men and women smoke among those aged 75.

A literature review commissioned by ASH Scotland, describes the (increased) health risks faced by older smokers, and some of the additional barriers to smoking cessation among this group (Brown, 2004a). These barriers include attitudes toward smoking and smoking cessation, for example:

- Positive associations with smoking, and a lower acceptance that smoking is harmful to their own, or the health of those around them. As Brown notes, many older smokers also began smoking when it was still socially acceptable and even regarded as 'health promoting'
- A feeling that the 'damage is done'. Also a tendency to be less responsive to health promotion messages - and a feeling among some older people that, given that they may soon be dead, they did not want to deny themselves 'treats'
- Smoking seen as a social activity and also as a way of responding to isolation
- Smoking was also used as a way of coping with the exigencies of life in older age.

Similar barriers were also identified in a recent Scottish study (Kerr et al, 2006).

Brown (2004a) and Kerr et al (2006) also suggest that a further barrier may be that older people are less aware of smoking cessation services and resources. They may also have not been advised to stop. Studies cited by Brown (2004a) suggest, for example, that medical and nursing staff may be less likely to advise people aged 65 and over to quit smoking. Data from the recent Scottish Health Survey also suggests differential patterns of advice giving. Across all age groups of smokers or ex-smokers aged 16 years old and over, 34% reported having been advised to give up smoking either within the last year or over a year ago. Among older men aged 65 - 41 years the rate was higher at 41%, but, at 31% slightly lower among women. Among those aged 75 years and over, however, the proportions drop to 26% for men and 21% for women (Corbett et al, 2009).

Motives for quitting among older people may not, however, be dissimilar to those for younger people, primarily health (their own or others) and cost (Brown, 2004a). One study also found that people making the transition into retirement were also more likely than those of the same age who did not retire to quit smoking (Lang et al, 2007).

Brown (2004a) suggests that there is scope for age sensitive smoking cessation strategies, promotional materials, programme content and mode of delivery.

Findings from a number of studies suggest the effectiveness of smoking cessation programmes geared to the specific experiences of older people. An American study of an 'intensive group program' run by a tobacco cessation specialist and a geriatric social worker found that older people could maintain smoking cessation if the programme addressed issues of relevance to this group of people, including social isolation and 'economic need' (Thomas et al, 2009). An Australian study also found that brief intervention and nicotine replacement was effective in supporting older adults (people aged 68 years and over), including a sub-group aged 75 years and over (Tait et al, 2007).

A further study underlined the need not just to educate older smokers about the benefits of quitting smoking, but also those who work with them, such as care managers (Schmitt et al, 2005).

## **5.5 Disability and smoking**

The Scottish Household Survey (Scottish Government 2008a) suggests that adults who most commonly smoke are those unable to work due to short-term ill-health (64%) those unemployed and seeking work (58%) those coded as 'other' and those who are permanently sick or disabled (46% and 45% respectively).

Similarly, an analysis of data from the 2003 Scottish Health Survey found that nearly one-third of adults with limiting long-standing conditions (32.1%) reported themselves to be current smokers, compared to 34% of those with non-limiting conditions and 27.9% of those without any long-term conditions (Loretto and Taylor, 2007). Among those who classed themselves as current smokers, adults with limiting long-standing conditions were the group most likely to be heavy smokers, smoking 20 or more cigarettes daily.

An American study of people with multiple sclerosis also found that although this group had lower smoking prevalence rates, those who did smoke smoked more, and had been smoking for longer (Friend et al, 2006). The study concluded that smoking cessation interventions should be developed for this group of highly nicotine-dependent smokers who also faced numerous obstacles to quitting.

Studies in America and in England have found that people with learning disabilities also have lower smoking cessation rates. A UK study of adult attenders of day centres for people with learning disabilities found that only 6.2% currently smoked, and that those who had mild learning disabilities were more likely to be smokers than non-smokers (Cutajar et al, 2004). The rates of smokers were higher than expected among those who lived in hospital/staffed housing and lower than expected among those living with parents. A similar study by Hughes and Whittaker (2003) found that only 2% of their sample smoked, and these were more likely to be people living with someone else who smoked.

Among the smokers in Cutajar et al's study (2004) those who smoked were more knowledgeable than non-smokers about the risks of smoking (controlling for level of disability), but only one third were concerned about these risks. The authors conclude that this has implications for health education. The rates of smoking among people living with others also suggests that health education has a role in targeting those professionals with whom people with learning disabilities live.

A literature review, undertaken by Ash Scotland in 2004 (Brown, 2004b) found that unlike people with physical disabilities or those with learning disabilities, smoking rates for people with mental health problems tend to be higher than average, they also tend to smoke more heavily and be more dependent than smokers without mental health problems. The prevalence of smoking related fatal diseases are also higher among people with mental health problems than the general population. Further, that although around half of smokers with mental health problems are believed to be interested in giving up smoking, people can feel excluded from 'mainstream' stop smoking campaigns. Conversely, the DRC report into physical health inequalities, found that professionals can express doubts about the value of smoking cessation advice for this group of people - notwithstanding evidence that suggests the effectiveness of interventions for this group (DRC, 2006).

According to Brown, "The challenge to those working in the fields of mental health, health promotion and tobacco control is to ensure that smokers with mental health difficulties are encouraged to quit and that they receive appropriate help in doing so" (2004, p.28).

## **5.6 Race and ethnicity and smoking**

There is very little data on smoking rates among people from black and minorities living in Scotland. Data from England shows that smoking rates are higher for men and women of Irish origin, men and women of Black-Caribbean origin and men of Pakistani or Bangladeshi origin. On the other hand, it is lower among women of African, Chinese, Indian, Pakistani and Bangladeshi origin ( (Scotpho, 2008a).

Smoking prevalence is higher among men in Poland than among men in Scotland, and similar for women. It is not known, however, whether the same pattern is replicated among people from Poland who have migrated to Scotland Tobacco smoking in S an epidemiological briefing (Scotpho, 2008a).

Among young Gypsies/Travellers, smoking rates have been estimated to be in the region of 63%, which is higher than average. (ScotPHO, 2008b).

Across Scotland, 90% of quit attempts were by people who described their ethnic group as 'White British', 'White Other' comprised nearly 2%. 'Other ethnic group' accounted for 1% of quit attempts and 'unknown' almost 7% (Scotpho, 2009).

ASH Scotland has undertaken a number of pieces of work exploring the prevalence and types of tobacco usage among people from black and minority ethnic communities, particularly in Scotland, and their access to smoking cessation services. While much of the work on tobacco usage among the general (or predominantly white population), tends to assume this is via smoking cigarettes, among people from black or minority ethnic communities this is extended to include other ways in which tobacco may be consumed. Appendix 1 lists some examples.

A literature review of ethnicity and tobacco (Brown, 2004c) undertaken by ASH Scotland as part of its Tobacco and Inequalities Project<sup>11</sup> is a key resource from a Scottish perspective (although because of the lack of Scotland-specific data draws on research undertaken in England). Issues identified in the course of the review include:

- The potentially differential health impact of smoking on people from, black and minority communities, that is, while smoking is a major health risk for all people, some diseases related to, or exacerbated by tobacco appear to be more prevalent among Britain's minority ethnic groups
- In general, smoking rates among ethnic minorities were the same, or lower, than those found in the wider population of England. There are however, differences between groups, for example, particularly high rates of smoking have been found among Bangladeshi men – nearly half of whom may smoke
- While smoking rates for men and women in the UK on the whole are converging, amongst minority ethnic groups there are still marked gender differences in smoking behaviour. Particularly low rates are found among South Asian women
- However, chewing tobacco is more socially acceptable among many South Asian communities, even amongst women
- The reasons why people start and continue to smoke, studies found these to be comparable to the reasons commonly cited by the White majority population. Young people, for example stress, or peer pressure, or for relaxation or as part of socializing among adults. As suggested earlier discrimination as a source of stress may also be implicated (William, 2007; Croucher and Choudhury, 2007)

---

<sup>11</sup> ASH Scotland - <http://www.ashscotland.org.uk/ash/7166.1582.html>

- Although aware of the health risks associated with smoking, people from black and minority ethnic communities who smoked tended to regard the perceived benefits as outweighing the potential harms
- Research undertaken in England found that in the region of 55-71% of current smokers from black and minority ethnic communities had attempted to stop smoking on one or more occasion. Figures for successful quitting were broadly in line with England as a whole, where around two thirds of smokers admitted they had attempted to give up smoking previously, but without long term success
- Research undertaken among adults in Glasgow (see below, ASH Scotland, 2000) suggests that smokers from black and minority ethnic communities were more likely to attempt to give up unaided and to seek advice on smoking cessation within their own social circles rather than through professional agencies. There was generally a low level of awareness regarding smoking cessation services or pharmacological aids (e.g. Nicotine Replacement Therapy (NRT)).

Brown's literature review draws on several Scotland specific studies undertaken or funded by ASH Scotland to explore the views of people from black and ethnic communities in Glasgow on smoking. These include a report published in 2000 which focused on the views of a sample of BME adults from the four main (visible) ethnic minority communities in Glasgow (Black, Chinese, Indian and Pakistani) and health workers on smoking patterns and prevalence within these communities (ASH Scotland, 2000). Included among its conclusions the report suggests that:

- Smoking is widespread within these black and minority communities
- There are some broad similarities between BME communities and the Scottish population as a whole. The fundamental differences arise from cultural and religious affiliations which affect how smoking is perceived and practised. Different communities also have different methods of taking tobacco
- Smoking patterns were different between the ethnic groups in the sample. The majority of the Chinese, Indian and Pakistani respondents described themselves as 'smokers', whereas the majority of black respondents indicated that they smoked 'socially'
- The main reason for wanting to quit smoking was the effects on personal health, however more than two-thirds felt that smoking was beneficial to them
- Once initiated into smoking, cultural and religious practices can raise further issues. Community perceptions, for example, may lead young people to

smoke covertly, particularly young women because of the negative perceptions of female smokers within these communities

- Concern was expressed about the ease of availability of paan and the use of the hookah. It was felt there was a lack of awareness of the harmful effects of smoking tobacco filtered through water, or adding tobacco to paan
- The study also indicated the need to ensure visual ethnic representation in smoking prevention materials and the use of community languages to ensure relevance to these communities.

A slightly later study, undertaken by the REACH Community Health Project, with funding from ASH Scotland, focused on tobacco use among young people from black and minority ethnic communities living in the south side of Glasgow (Aslam and Robinson, 2007). Based on a survey completed by 55 young people from black and minority ethnic communities, a focus group and a literature review, this study concluded that:

- The prevalence of smoking rates among young people from black and minority ethnic communities living in Southside Glasgow was high in comparison to the general population - with about half of the participants being tobacco users - mostly cigarettes
- Negative attitudes, including on the part of male study participants were identified toward young women from black and minority ethnic communities
- Current information about the dangers of smoking appeared to have little or no impact on these young people from black and minority ethnic communities. Most did not have access to information relating to the health hazards of smoking
- There was also resistance among young men to accessing smoking cessation services, or to go to health professionals to seek advice, partly reflecting other issues relating to accessing health services in general.

The report recommends that there is a need for greater awareness of the negative effects of smoking, anti-smoking campaigns and the involvement of young people from black and minority ethnic communities in the design and delivery of smoking cessation services, including sensitivity with regard to the negative attitudes held particularly toward female smokers (Aslam and Robinson, 2007).

## **5.7 Sexual orientation and smoking**

Research suggests that LGB people are more likely to smoke than heterosexual people, and lesbian and bisexual women smoke more than heterosexual people and gay men.

A recent large-scale survey of lesbian and bisexual women in England and Wales found that two-thirds of the lesbian and bisexual women had smoked, compared to one-half of women in general and just over one-quarter currently smoke (Hunt and Fish, 2008).

High smoking rates among LGB people may be due to social pressures or because LGB people use pubs and clubs for more years than heterosexual people. Women who are lesbians are also less likely to get pregnant, which can be a trigger for women to quit smoking (Stonewall website [http://www.stonewall.org.uk/what we do/research and policy/health and healthcare/3481.asp](http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/3481.asp)).

One small American study found that men who have sex with men (MSM) were more likely to use tobacco, than the general population of men, particularly young MSM (McKirnan et al, 2006). What this study also found was that depression symptoms, alcohol use and limited health access partially accounted for higher smoking rates. The authors conclude that, given the very high rates of smoking among young MSM that this group of people should be a particular target group for intervention.

It has also been suggested that smoking prevention campaigns may not address LGB people, if for example they emphasise smoking and (lack of) attractiveness to the opposite sex ([http://www.stonewall.org.uk/what we do/research and policy/health and healthcare/3481.asp](http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/3481.asp)). One study looked at young LGBT people's own recommendations for the development of smoking prevention strategies (Remafedi and Carol, 2005). The suggestions made by the study participants included: involving young LGBT people in the design and implementation of interventions; developing programmes that support positive identity formation as well as non smoking; and that the general approach to prevention should be entertaining, supportive and interactive.

More generally, one study argues that to support the development of tobacco control programmes and policies that benefit LGBT people, sexual orientation and gender identity should be considered for inclusion as variables in all major research and epidemiological studies of tobacco use (Sell and Dunn, 2008).

## **5.8 Religion and belief and smoking**

Very little information was found on the links between religion and/or belief and smoking attitudes and behaviour. Two studies, however, of young people who can trace their origins from Pakistan or India, and a study of Pakistani and Bangladeshi adults in Newcastle reveal the complex relationships between ethnicity, religion gender and age (Bradby, 2007; Bradby and Williams, 2006; Bhopal et al, 2003). Bradby (2007), for example, found that for Muslim men, while alcohol abstinence was linked to Islamic identity, cigarette smoking was tolerated. For Sikh and Hindu men Sikhs' and Hindus' avoidance of tobacco was strongly sanctioned, but smoking did not strongly jeopardise a religious identity. Sikh men's abstention indicated manly strength central to a devout identity. For women, smoking could raise issues about reputation and future marriage chances. Sanctioned by gossip this meant that women's behaviour was consistently more constrained than men's - and, unlike men, once their reputation was perceived to have been tarnished it was irrecoverable.

Among the adults studied by Bhopal et al, (2003), a similar, and differential relationship between, religion, gender, identity and age was identified. Smoking was a widely accepted practice in Pakistani, and particularly Bangladeshi men and was associated with socialising, sharing, and male identity. Among women, smoking was associated with stigma and shame. What the study, also found, however, was that, outwith the influences of gender and religion, there were also strong similarities with white people in terms of the factors influential on attitudes and behaviour, particularly among younger adults. Again the conclusion drawn by the authors is that patterns emerging should help to inform the development and appropriate targeting of smoking cessation.

## References

Aitken, S., Kealey, S., and Adamson, R. (2007), *LGBT Community Needs Assessment Report*, Edinburgh: LGBT Centre for Health and Wellbeing

Amos, A. and Bostock, Y. (2007) Young people, smoking and gender: A qualitative exploration, *Health Education Research*, 22,6, pp 770 - 781

ASH Scotland (2000) *Black and minority ethnic views on smoking: Patterns, prevalence and need in Glasgow*, Edinburgh: ASH Scotland (<http://www.ashscotland.org.uk/ash/4144.html>)

Aslam, U. and Robinson, K. (2007) *The Prevalence and patterns of tobacco use by black and minority young people living in Southside Glasgow*, Glasgow: REACH Community Health Project/ASH Scotland ([http://www.ashscotland.org.uk/ash/files/REACH\\_Inequalities\\_Wave1Final%20Project%20Report\\_Jun07.pdf](http://www.ashscotland.org.uk/ash/files/REACH_Inequalities_Wave1Final%20Project%20Report_Jun07.pdf))

Atkinson, E., Gilbert, A. and Hotham, E. (2005) Case studies of three pregnant smokers and their use of nicotine replacement therapy, *Midwifery* 21, 3, pp.224-232, Sept.

Bakshi, N., Ross, A., and Heim, D., (2002). Drug and alcohol issues affecting Pakistani, Indian and Chinese young people and their communities: A study in Greater Glasgow [no source of pub.]

Bashford, J., Buffin, J. and Patel, K. (2003) *The Department of Health's Black and Minority Ethnic Drug Misuse Needs Assessment Project. Community Engagement: Report 2: The Findings*. Preston: Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

Beatty, L. (2003) Substance abuse, disabilities, and black women: An issue worth exploring, *Women and Therapy*, 26, 3-4, pp. 223-236

Becker, J. and Duffy, C. (2002), Women drug users and drugs service provision: service-level responses to engagement and retention, DPAS Briefing Paper 17, London: UK Home Office

Bergmark, K. (1999) Drinking in the Swedish gay and lesbian community, *Drug and Alcohol Dependence*, 56, 2, pp. 133-143, Sept.

Best, D., Walker, D., Foster, a. et al (2008) Gender differences in risk and treatment uptake in drug using offenders assessed in custody suite settings, *Policing and Society*, 18, 4, pp. 474-485, Dec.

Beynon, C., McVeigh, J., and Roe, B. (2007) Problematic drug use, ageing and older people: trends in the age of drug users in northwest England, *Ageing and Society*, 27, 6, pp. 799-810, Nov.

Blondell, R. (1999) Alcohol abuse and self-neglect in the elderly, *Journal of Elder Abuse and Neglect*, 11, 2, pp. 55-75

Blum, R., Kelly, A. and Ireland, M. (2001) Health-risk behaviors and protective factors among adolescents with mobility impairments and learning and emotional disabilities, *Journal of Adolescent Health*, 28, 6, pp. 481-490, June

Bhopal, R., Bush, J., Kai, J. et al (2003) Understanding influences on smoking in Bangladeshi and Pakistani adults: Community based, qualitative study, *British Medical Journal*, 326, pp.962-965

Bhopal, R., Vettini, A., Hunt, S. et al (2004). Review of prevalence data in, and evaluation of methods for cross cultural adaptation of, UK surveys on tobacco and alcohol in ethnic minority groups. *British Medical Journal*, 328, pp. 76

Bossarte, R. and Swahn, M. (2008) Interactions between race/ethnicity and psychosocial correlates of pre-teen alcohol use initiation among seventh grade students in an urban setting, *Journal of Studies on Alcohol and Drugs*, 69, 5, pp. 660-665, Sept.

Bottofff, J., Oliffe, J., Kalaw, C., Carey, J. and Mroz, L. (2006) Men's constructions of smoking in the context of women's tobacco reduction during pregnancy and postpartum, *Social Science and Medicine*, 62, 12, pp. 3096-3108, June

Bradby, H. and Williams, R. (2006) Is religion or culture the key feature in changes in substance use after leaving school? Young Punjabis and a comparison group in Glasgow, *Ethnicity and Health*, 11, 3, pp. 307-324, Aug.

Bradby, H. (2007) Watch out for the Aunties! Young British Asians' accounts of identity and substance use, *Sociology of Health and Illness*, 29, 5, pp. 656-672

Brown, C. (2004a) *Tobacco and older adults: A literature review*, Edinburgh: ASH Scotland  
(<http://www.ashscotland.org.uk/ash/files/tobacco%20and%20older%20adults%20.pdf>)

Brown, C. (2004b) *Tobacco and mental health: A literature review*, Edinburgh: ASH Scotland  
(<http://www.ashscotland.org.uk/ash/files/tobacco%20and%20mental%20health.pdf>)

Brown, C. (2004c) *Tobacco and ethnicity: A literature review*, Edinburgh: ASH Scotland  
(<http://www.ashscotland.org.uk/ash/files/tobacco%20and%20ethnicity.pdf>)

Brown, M. and Bolling, K. (2007) *Drug misuse in Scotland: Findings from the 2006 Scottish Crime and Victimization Survey*, Edinburgh: Scottish Government Social Research  
(<http://www.scotland.gov.uk/Publications/2007/09/26163243/0>)

Burns, C. (2005) *Evaluating care approaches and services for Trans people*, (<http://pfc.org.uk/node/632>.)

Carolan, F. and Redmond, S. (2003), *Research into the needs of young people in Northern Ireland who identify as lesbian, gay bisexual and/or transgender*, Belfast: Youthnet  
(<http://www.youthnetni.org.uk>)

Catto, S. (2009) *How much are people in Scotland really drinking? A review of data from Scotland's routine national surveys*, Glasgow: Public Health Division of Health Scotland  
([http://www.healthscotland.com/uploads/documents/6696-Alcohol%20bookmark%20A4\\_%20linked.pdf](http://www.healthscotland.com/uploads/documents/6696-Alcohol%20bookmark%20A4_%20linked.pdf))

Cawley, J., Markowitz, S. and Tauras, J. (2004) Lighting up and slimming down: the effects of body weight and cigarette prices on adolescent smoking initiation, *Journal of Health Economics*, 23, 2, pp.293-311, Mar.

Corbett, J., Given, L. Gray, L et al (2009) *The Scottish Health Survey, 2008*, Edinburgh: Scottish Government  
<http://www.scotland.gov.uk/Publications/2009/09/28102003/0>

Cottew, G., and Oyefeso, A. (2005) Illicit drug use among Bangladeshi women living in the United Kingdom: An exploratory qualitative study of a hidden population in East London, *Drugs: Education, Prevention and Policy*, 12, 3, pp. 171-188, June

Croucher, R. and Choudhury, S. (2007) Tobacco control policy initiatives and UK resident Bangladeshi male smokers: Community-based, qualitative study, *Ethnicity and Health*, 12, 4, pp. 321-337, Sept.

Cummings, S., Bride, B., McClure, C and Rawlins-Shaw, A. (2008) Substance Abuse, *Journal of Gerontological Social Work*, 50, pp. 215-240

Cutajar, P., Fox, D., Standen, P., et al (2004) Smoking prevalence and knowledge of associated risks in adult attenders at day centres for people with learning disabilities, *Journal of Intellectual Disability Research*, 48, 3, pp.239-244,

Mar.

D'Augelli, A. and Grossman, A., Hershberger, S. and O'Connell, T. (2001) Aspects of mental health among older lesbian, gay, and bisexual Adults, *Aging and Mental Health*, 5, 2, pp. 149-158, May

Davison, J. (2007) Alcohol misuse: Contributor to and consequence of violence against women, *Diversity in Health and Social Care*, 4, 2, pp. 137-148, June

De Visser, R. and Smith, J. (2007). Young men's ambivalence toward alcohol, *Social Science and Medicine*, 64, 2, pp. 350-362, Jan.

DRC (2006) *Equal Treatment: Closing the Gap - A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems*, Stratford-upon Avon: Disability Rights Commission  
([http://83.137.212.42/SiteArchive/drc\\_gb/library/publications/health\\_and\\_independent\\_living/health\\_formal\\_investigation.aspx.html](http://83.137.212.42/SiteArchive/drc_gb/library/publications/health_and_independent_living/health_formal_investigation.aspx.html))

EMCDDA (2005) *Differences in patterns of drug use between men and women: Technical datasheet*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction  
(<http://www.emcdda.europa.eu/html.cfm/index34278EN.html>)

EMCDDA (2009) *Women's voices: Experiences and perceptions of women who face drug-related problems in Europe*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction  
(<http://www.emcdda.europa.eu/publications/thematic-papers/womens-voices>)

Epstein, E., Fischer-Elber, K, and Al-Otaiba, Z. (2007) Women, aging, and alcohol use disorders, *Journal of Women and Aging*, 19, 1-2, pp. 31-48, 13 June

Fountain, J., Bashford, J., Underwood, S. et al (2004), Drug use amongst black and minority ethnic communities in the European Union and Norway, *Probation Journal*, 51, 4, pp. 362 - 378

Friend, K., Mernoff, S., Block, P. and Reeve, G.( 2006) Smoking rates and smoking cessation among individuals with multiple sclerosis, *Disability and Rehabilitation*, 28,18, pp. 1135-1141, Sept.

Galea, S. and Rudestine, S. (2005) Challenges in understanding disparities in drug use and its consequences, *Journal of Urban Health*, 82, supplement 3, pp. iii5-iii12, June

Ghandour, L., Karam, E. and Maalouf, W. (2009) Lifetime alcohol use, abuse and dependence among university students in Lebanon: exploring the role of religiosity in different religious faiths, *Addiction*, 104, 6, pp. 940-948, June

GINA Fact Sheet (nd) *Older women and alcohol factsheet*, Gender Issues Network on Alcohol  
(<http://www.ginascotland.org.uk>)

Government Equalities Office (2009) *A Fairer Future: the equality bill and other actions to make equality a reality*, London: Government Equalities Office  
([http://www.equalities.gov.uk/pdf/GEO\\_A%20Fairer%20Future-%20The%20Equality%20Bill%20and%20other%20action%20to%20make%20equality%20a%20reality.pdf](http://www.equalities.gov.uk/pdf/GEO_A%20Fairer%20Future-%20The%20Equality%20Bill%20and%20other%20action%20to%20make%20equality%20a%20reality.pdf))

Greaves, L. and Hemsing, N. (2009) Sex, gender, and second-hand smoke policies: Implications for disadvantaged women, *American Journal of Preventive Medicine*, 37, 2S1, pp. S131-S137, Aug.

Greaves, L., Kalaw, C. and Bottorff, J. (2007) Case studies of power and control related to tobacco use during pregnancy, *Women's Health Issues*, 17, 5, pp. 325-332, Sept-Oct.

Grogan, S., Fry, G., Gough, B. and Conner, M. (2009) Smoking to stay thin or giving up to save face? Young men and women talk about appearance concerns and smoking, *British Journal of Health Psychology*, 14, 1, pp. 175-186, Feb.

GROS (2009a), *Mid 2008 population estimates*, Edinburgh: General Register Office for Scotland  
(<http://www.gro-scotland.gov.uk/files2/stats/gros-mid-2008-population-estimates-scotland-population-estimates-by-sex-age-and-administrative-area/gros-mid-2008-population-estimates-scotland-population-estimates.pdf>)

GROS (2009b) *Drug related deaths in Scotland in 2008*, Edinburgh: General Register Office for Scotland  
(<http://www.gro-scotland.gov.uk/statistics/publications-and-data/drug-related-deaths/drug-related-deaths-in-scotland-2008/index.html>)

Guida, F., Unterbach, A., Tivolacci, J., and Provet, P. (2004) Residential substance abuse treatment for older adults: An enhanced therapeutic community model, *Journal of Gerontological Social Work*, 44, 1-2, pp. 95-109

Guthmann, D., Graham, V. (2004), Substance abuse: A hidden problem within the d/deaf and hard of hearing communities, *Journal of Teaching in the Addictions*, 3, 1, pp. 49-64

Gutierrez, S. and Van Puymbroeck, C. (2006), Childhood and adult violence in the lives of women who misuse substances *Aggression and Violent Behavior*, 11, 5, pp. 497-513

Hankins, C. (2008), Sex, drugs and gender? High time for lived experience to inform action, *International Journal of Drug Policy*, 19, 2, Editorial

Hannah, M-K., Hunt, K. and West, P. (2004) Contextualizing smoking: masculinity, femininity and class differences in smoking in men and women from three generations in the west of Scotland, *Health Education Research* 19, 3, pp.239-249, Jun.

Harman, J., Graham, H., Francis, B., Inskip, H. and The SWS Study Group (2006) Socioeconomic gradients in smoking among young women: A British survey, *Social Science and Medicine*, 63,11, pp. 2791-2800, Dec.

Harmon, L. (2008), Gender Identity, Minority Stress, and Substance Use among Lesbians, *Dissertation Abstracts International, A: The Humanities and Social Sciences*, 68, 12, pp. 5219

Hay, G., Gannon, M., McKeganey, N. et al. (2005) *Estimating the national and local prevalence of problem drug misuse in Scotland*, Glasgow: Centre for Drug Misuse Research, University of Glasgow and Scottish Centre for Infection and Environmental Health  
(<http://www.drugmisuse.isdscotland.org/publications/local/prevreport2004.pdf>)

Health Scotland (2006) *Alcohol and ageing: Is alcohol a major threat to healthy ageing for the baby boom generation? A report by the Alcohol and Ageing Working Group*, Edinburgh and Glasgow: NHS Health Scotland  
(<http://www.healthscotland.com/documents/2134.aspx>)

HEBS (2000) *Women and alcohol: Report of an expert seminar*, Edinburgh: Health Education Board for Scotland  
(<http://www.healthscotland.com/documents/367.aspx>)

Heim, D., Hunter, S., Ross, A., et al (2004) Alcohol consumption, perceptions of community responses and attitudes to service provision: Results from a survey of Indian, Chinese and Pakistani young people in Greater Glasgow, Scotland, UK. *Alcohol and Alcoholism* 39, pp. 220-226

Hodges, C-L., Paterson, S., Taikato, M. et al (2006), *Co-morbid mental health and substance misuse in Scotland*, Edinburgh: Scottish Executive Social Research  
(<http://www.scotland.gov.uk/Publications/2006/06/05104841/0>)

Hollar, D. and Moore, D. (2004), Relationship of substance use by students with disabilities to long-term educational, employment, and social outcomes, *Substance Use and Misuse*, 39, 6, pp. 931-962, 2004

Holloway, K. and Bennett, T. (2007) Gender differences in drug misuse and related problem behaviors among arrestees in the UK, *Substance Use and Misuse*, 42, 6, pp. 899-921, May

Hughes, M. and Whittaker, S. (2003) Prevalence and influences on smoking in people with learning disabilities, *British Journal of Developmental Disabilities* 49, 2, pp.91-97, July

Humphreys, C., Regan, L., River, D. and Thiara, R. (2005) Domestic violence and substance Use: Tackling complexity, *British Journal of Social Work*, 35, 8, pp. 1303-1320, Dec.

Hunt, R. and Fish, J. (2008) *Prescription for change: Lesbian and bisexual women's health check*: Stonewall Scotland and de Montfort University Leicester ([http://www.stonewallscotland.org.uk/documents/prescription\\_for\\_change\\_1.pdf](http://www.stonewallscotland.org.uk/documents/prescription_for_change_1.pdf))

Inclusion Project (2003) *Towards a healthier LGBT Scotland*, Glasgow: Inclusion Project ([http://www.lgbthealthscotland.org.uk/documents/Towards\\_Healthier\\_LGBT\\_Scot.pdf](http://www.lgbthealthscotland.org.uk/documents/Towards_Healthier_LGBT_Scot.pdf))

ISD (2009a) *Scottish Schools Adolescent Lifestyle and Substance Abuse Survey (SALSUS) National Report: Smoking, drinking and drug use among 13 and 15 year olds in Scotland in 2008*, Edinburgh: Information Services Division Scotland, (<http://www.isdscotland.org/isd/5955.html>)

ISD (2009b) *Alcohol statistics Scotland 2009*, Edinburgh: Information Services Division Scotland ([http://www.alcoholinformation.isdscotland.org/alcohol\\_misuse/files/alcohol\\_bulletin09.pdf](http://www.alcoholinformation.isdscotland.org/alcohol_misuse/files/alcohol_bulletin09.pdf))

ISD (2009c) *Alcohol attributable mortality and morbidity: Alcohol population attributable fractions for Scotland*, Edinburgh: Information Services Division Scotland and Scottish Public Health Observatory (<http://www.scotpho.org.uk/alcoholIPAFreport/>)

Janekovic, K. (2003) Comparative research on substance abuse and self-perception among adolescents with physical handicap, *Collegium Antropologicum*, 27, 2, pp. 479-489, Dec.

Jarvis, (2009) *Alcohol consumption and black and minority ethnic groups and recent immigrants in Scotland: Current literature on available information*,

Edinburgh: Information Services Division Scotland  
([http://www.alcoholinformation.isdscotland.org/alcohol\\_misuse/files/bme\\_and\\_alcohol\\_report\\_final.pdf](http://www.alcoholinformation.isdscotland.org/alcohol_misuse/files/bme_and_alcohol_report_final.pdf))

John, S. and Patrick, A. (1999) *Poverty and social exclusion of lesbians and gay men in Glasgow, Draft Report*, Glasgow: Glasgow Women's Library

Kerr, S., Watson, H., Tolson, D. et al (2006) Smoking after the age of 65 years: A qualitative exploration of older current and former smokers' views on smoking, stopping smoking, and smoking cessation resources and services, *Health and Social Care in the Community*, 14, 6, pp. 572-582, Nov.

King, M. and McKeown, E. (2003) *Mental health and social well-being of gay men, lesbians and bisexuals in England and Wales*, London: MIND  
(<http://www.mmind.org.uk>)

Kirby, J., van der Sluijs, W. and Inchley, J. (2008) *Young people and substance use: The influence of personal, social and environmental factors on substance use among adolescents in Scotland*, Edinburgh Child and Adolescent Health Research Unit, University of Edinburgh and Health Scotland  
(<http://www.healthscotland.com/uploads/documents/9160-Young%20people%20and%20Substance%20Use%20-%20FINAL%20REPORT.pdf>)

Lang, I., Rice, N., Wallace, R., et al (2007) Smoking cessation and transition into retirement: Analyses from the English Longitudinal Study of Ageing, *Age and Ageing*, 36, 6, pp. 638-643, Nov.

Loretto, W. and Taylor, M (2007) *Characteristics of adults in Scotland with long-term health conditions: An analysis of Scottish Household and Scottish Health Surveys*, Edinburgh: Scottish Government Social Research

Luger, L. and Sookhoo, D. (2005) Rapid needs assessment of the provision of drug and alcohol services for people from minority ethnic groups with drug and alcohol Problems, *Diversity in Health and Social Care*, 2, 3, pp. 167-176

McAuley, A. (2009) *Alcohol consumption among pregnant women and brief interventions in the antenatal setting*, Edinburgh: Health Scotland  
(<http://www.healthscotland.com/documents/3440.aspx>)

MacAskill, S. Eadie, D., Gordon, R. and Heim, D. (2008) *Drinking in Scotland: Qualitative insights into influences, attitudes and behaviours*, Edinburgh: Health Scotland

McCombs, K. and Moore, D. (2002), Substance abuse prevention and intervention for students with disabilities: A call to educators. ERIC Digest.

Report: EDO-EC-05, Aug

McKeganey, N., Bloor, M., Robertson, M., et al (2006) Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland Study *Drugs: Education, Prevention and Policy*, 13, 6, pp. 537-550, Dec.

McKirnan, D., Tolou-Shams, M., Turner, L. et al (2006) Elevated risk for tobacco use among men who have sex with men is mediated by demographic and psychosocial variables, *Substance Use and Misuse*, 41, 8, pp. 1197-1208

Macpherson, S. and Bond, S. (2009) *Equality issues in Scotland: A review of research 2000-2008*, Manchester: Equality and Human Rights Commission ([http://www.equalityhumanrights.com/uploaded\\_files/Scotland/equality\\_issues\\_in\\_scotland\\_a\\_review\\_of\\_research.pdf](http://www.equalityhumanrights.com/uploaded_files/Scotland/equality_issues_in_scotland_a_review_of_research.pdf))

Marshal M., Friedman M., Stall R., et al (2008) Sexual orientation and adolescent substance use: A meta-analysis and methodological review, *Addiction*, 103, pp. 546–56

Marshal, M., Friedman, M, Stall, R. and Thompson, A. (2009) Individual trajectories of substance use in lesbian, gay and bisexual youth and heterosexual youth, *Addiction*, 104, pp. 974 - 981

Moore, D. and Lorber, C. (2004) Clinical characteristics and staff training needs of two substance use disorder treatment programs specialized for persons with disabilities, *Journal of Teaching in the Addictions*, 3, 1, pp. 3-20

Moore, A., Morgenstern, H., Harawa, N. et al (2001) Are older hazardous and harmful drinkers less likely to participate in health-related behaviors and practices as compared with non hazardous drinkers? *Journal of the American Geriatrics Society*, 49, 4, pp.421-30, Apr.

Myers, F., McCollam, A., and Woodhouse, A. (2005) *Equal Minds: Addressing mental health inequalities in Scotland*, Edinburgh: Scottish Executive National Programme for Improving Mental Health and Well-Being (<http://www.wellscotland.info/research-papers.html>)

Nawyn, S. Richman, J. Rospenda, K., Hughes, T. (2000) Sexual identity and alcohol-related outcomes: Contributions of workplace harassment, *Journal of Substance Abuse*, 11, 3, pp. 289-304

NES (nd) *A Multi-faith resource for healthcare staff* (<http://www.healthscotland.com/uploads/documents/6310-Multifaith%20Resource%20for%20Healthcare%20staff.pdf>)

Ng, N., Weinehall, L. and Ohman, A. (2007) 'If I don't smoke, I'm not a real man'- Indonesian teenage boys' views about smoking, *Health Education Research*, 22, 6, pp. 794-804, Dec.

Nichter, M., Nichter, M., Lloyd-Richardson, E., Flaherty, B., Carkoglu, A. and Taylor, N. (2006) Gendered dimensions of smoking among college students, *Journal of Adolescent Research*, 21, 3, May, pp. 215-243

NHS (nd) Fair for All LGBT: LGBT Equality Impact Assessment (<http://www.lgbthealthscotland.org.uk/EQIA/>)

NHS Greater Glasgow (2006) *Black and minority ethnic health in Glasgow*, Glasgow: NHS Greater Glasgow

ODS Consulting (2008) *Mapping minority ethnic communities in West Lothian. Final Report*, Glasgow: ODS Consulting

Peralta, R. (2008) "Alcohol allows you to not be yourself": Toward a structured understanding of alcohol use and gender difference among gay, lesbian, and heterosexual youth, *Journal of Drug Issues*, 38, 2, pp. 373-400, Spring

Pinkham, S. and Malinowska-Sempruch, K. (2008) Women, Harm reduction and HIV, *Reproductive Health Matters*, 16, 31, pp. 168-181, May

Pointon, C. (2003) *Lesbian, gay and bisexual mental health*, CPJ, October

Potter, B., Pederson, L., Chan, S., Aubut, J-A. and Koval, J. (2004) Does a relationship exist between body weight, concerns about weight, and smoking among adolescents? An integration of the literature with an emphasis on gender, *Nicotine and Tobacco Research*, 6, 3, pp. 397-425, Jun.

Remafedi, G. and Carol, H. (2005) Preventing tobacco use among lesbian, gay, bisexual, and transgender youths, *Nicotine and Tobacco Research*, 7, 2, pp. 249-256, Apr.

Reid, R., Pipe, A., Riley, D. and Sorensen, M. (2009) Sex differences in attitudes and experiences concerning smoking and cessation: Results from an international survey, *Patient Education and Counseling*, 76, 1, pp. 99-105, July

Robinson, J. and Kirkcaldy, A. (2007) Disadvantaged mothers, young children and smoking in the home: Mother's use of space within their homes, *Health and Place*, 13, 4, pp. 894-903, Dec.

Rosario, M., Scrimshaw, E. and Hunter, J. (2008), Butch/femme differences in substance use and abuse among young lesbian and bisexual women:

Examination and potential explanations, *Substance Use and Misuse*, 43, 8, pp. 1002-1015, July

Schmitt, E., Tsoh, J., Dowling, G. and Hall, S. (2005) Older adults' and case managers' perceptions of smoking and smoking cessation, *Journal of Aging and Health*, 17, 6, pp. 717-733, Dec.

Scotpho (2008a) *Tobacco smoking in Scotland: An epidemiology briefing*, Edinburgh: Scottish Public Health Observatory  
([http://www.scotpho.org.uk/home/Publications/scotphoreports/pub\\_tobaccobriefing.asp](http://www.scotpho.org.uk/home/Publications/scotphoreports/pub_tobaccobriefing.asp))

Scotpho (2008b) *Young adult smokers in Scotland*, Edinburgh: Scottish Public Health Observatory  
(<http://www.scotpho.org.uk/nmsruntime/saveasdialog.asp?IID=4733&SID=4092>)

Scotpho (2009) *NHS smoking cessation statistics (Scotland) 1 Jan - 31 December 2008*, Edinburgh: Scottish Public Health Observatory  
(<http://www.scotpho.org.uk/nmsruntime/saveasdialog.asp?IID=5246&SID=4539>)

Scottish Drugs Forum (1999) *Drug services and black and minority ethnic communities in Scotland: Guidance on positive action*, Glasgow and Edinburgh: Scottish Drugs Forum  
(available on request from Scottish Drug Forum (<http://www.sdf.org.uk>))

Scottish Executive (2004) *A Breath of Fresh Air for Scotland: the Tobacco Control Action Plan*, Edinburgh: Scottish Executive  
(<http://www.scotland.gov.uk/Publications/2004/01/18736/31541>)

Scottish Executive (2006) *High Level Summary of Equality Statistics: Key trends for Scotland* Edinburgh: Scottish Executive  
(<http://www.scotland.gov.uk/Publications/2006/11/20102424/0>)

Scottish Government (2008a) *Scotland's People: Annual Report, Results from 2007, Scottish Household Survey*, Edinburgh: Scottish Government  
(<http://www.scotland.gov.uk/Resource/Doc/933/0067472.pdf>)

Scottish Government (2008b) *The Road to Recovery: A new approach to tackling Scotland's drug problem*, Edinburgh: Scottish Government  
(<http://www.scotland.gov.uk/Publications/2008/05/22161610/0>)

Scottish Government (2008c) *Changing Scotland's Relationship with Alcohol: A discussion paper on our strategic approach*, Edinburgh: Scottish Government  
(<http://www.scotland.gov.uk/Resource/Doc/227785/0061677.pdf>)

Scottish Government (2008d) *Scotland's Future is Smoke-Free: A Smoking Prevention Action Plan*, Edinburgh: Scottish Government  
(<http://www.scotland.gov.uk/Publications/2008/05/19144342/0>)

Scottish Government (2009) *Changing Scotland's Relationship with Alcohol: A framework for action*, Edinburgh: Scottish Government  
(<http://www.scotland.gov.uk/Publications/2009/03/04144703/0>)

Scottish Government Health Directorate and Scottish Inter-faith Council (nd) *Religion and Belief Matter: An information resource for healthcare staff*  
(<http://www.healthscotland.com/uploads/documents/6311-Religion%20and%20Belief%20Matter.pdf>)

Scottish Transgender Alliance (2008) *Transgender experience in Scotland: Research summary*, Edinburgh: Transgender Alliance Scotland  
(<http://www.scottishtrans.org/Uploads/Resources/staexperiencesummary03082.pdf>)

Scott Porter Research and Marketing (2009) Local NHS smoking cessation services: Exploration of motivators and barriers to engagement, Edinburgh: NHS Health Scotland  
(<http://www.healthscotland.com/uploads/documents/10564-RE044LocalNHSSmokingCessationServicesFinalReport0910.pdf>)

Sell, R. and Dunn, P. (2008) Inclusion of lesbian, gay, bisexual and transgender people in tobacco use-related surveillance and epidemiological research, *Journal of LGBT Health Research*, 4, 1, pp. 27-42

Shaw, C., and Palattiyil, G. (2008) Issues of alcohol misuse among older people: Attitudes and experiences of social work practitioners, *Practice (UK)*, 20, 3, pp. 181-193, Sept.

Smith, L. and Gibb, S. (2007) Postnatal support for drug users: Evaluation of a specialist health visiting service, *Community Practitioner*, 80, 7, pp. 24-29, July

*Smoking, Health and Social Care (Scotland) Act 2005*  
([http://www.opsi.gov.uk/legislation/Scotland/acts2005/asp\\_20050013\\_en\\_1](http://www.opsi.gov.uk/legislation/Scotland/acts2005/asp_20050013_en_1))

Spada, M. and Moneta, G. (2004) Ethnicity as a moderator of the relationship between negative emotions and alcohol use in British Asian and white university students *Journal of Ethnicity in Substance Abuse*, 3, 4, pp. 75-83

Stonewall Scotland (2008) *Getting started: A route map for public services in Scotland*  
([http://www.stonewallscotland.org.uk/documents/routemap\\_final\\_version\\_2.pdf](http://www.stonewallscotland.org.uk/documents/routemap_final_version_2.pdf))

Stonewall website

([http://www.stonewall.org.uk/what\\_we\\_do/research\\_and\\_policy/health\\_and\\_healthcare/3464.asp](http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/3464.asp))

Swift, W. Copeland, J. and Hall, W. (1995), *Characteristics and treatment needs of women with alcohol and other drug problems: Results of an Australian national survey*, National Drug Strategy Research Report Series, Canberra

Taggart, L., McLaughlin, D., Quinn, B. and McFarlane, C. (2007) Listening to people with intellectual disabilities who misuse alcohol and drugs, *Health and Social Care in the Community*, 15, 4, pp. 360-368

Tait, R., Hulse, G., Waterreus, A. et al (2007) Effectiveness of a smoking cessation intervention in older adults, *Addiction*, 102, 1, pp. 148-155, Jan.

Taylor, A. (2008) Substance use and abuse: Women's criminal re-offending in New Zealand, *Affilia*, 23, 2, pp. 167-178, Summer

The Safeguards Project (<http://www.safeguards.org/?p=67>: accessed 11 Nov 2009)

Thom, B. (1986), Sex differences in help seeking for alcohol problems: The barriers to help seeking, *British Journal of Addiction*, 81, pp. 777-88

Thomas, L., Supiano, K., Chasco, E. et al (2009) Smoking cessation programs for seniors: A group model that works, *Clinical Gerontologist*, 32,1, pp.118-12, Jan.

Warfa, N., Bhui, K., Phillips, K. et al (2006) Comparison of life events, substance misuse, service use and mental illness among African-Caribbean, Black African and White British Men in East London: A qualitative study, *Diversity in Health and Social Care*, 3, 2, pp. 111-121

Weden, M., Astone, N. and Bishai, D. (2006) Racial, ethnic, and gender differences in smoking cessation associated with employment and joblessness through young adulthood in the US, *Social Science and Medicine*, 62, 2, pp. 303-316, Jan.

Whittle, S., Turner, L., Combs, R. and Rhodes, S. (2008) *Transgender Euro Study: Legal survey and focus on the transgender experience of health care*, Brussels: ILGA Europe and Transgender Europe  
([http://www.ilga-europe.org/europe/publications/non\\_periodical/transgender\\_eurostudy\\_legal\\_survey\\_and\\_focus\\_on\\_the\\_transgender\\_experience\\_of\\_health\\_care\\_april\\_2008](http://www.ilga-europe.org/europe/publications/non_periodical/transgender_eurostudy_legal_survey_and_focus_on_the_transgender_experience_of_health_care_april_2008))

WHO (2003) *Gender, health and tobacco*, Geneva: World Health Organisation

[http://www.who.int/gender/other\\_health/Gender\\_Tobacco\\_2.pdf](http://www.who.int/gender/other_health/Gender_Tobacco_2.pdf)

WHO (2005) *Gender, health and alcohol Use*, Geneva: World Health Organisation  
(<http://www.who.int/gender/documents/Alcoholfinal.pdf>)

Williams, R. (2007) Masculinities, fathering and health: The experiences of African-Caribbean and white working class fathers, *Social Science and Medicine*, 64, 2, pp. 338-349, Jan.

Wilsnack, S., Hughes, T., Johnson, T. et al (2008) Drinking and drinking-related problems among heterosexual and sexual minority women, *Journal of Studies on Alcohol and Drugs*, 69, 1, pp. 129-139, Jan.

Wolf-Branigin, M. (2007) Disability and abuse in relation to substance abuse: A descriptive analysis, *Journal of Social Work in Disability and Rehabilitation*, 6, 3, pp. 65-74, July

Young, A., Morales, M., McCabe, S. et al (2005) Drinking like a guy: Frequent binge drinking among undergraduate women, *Substance Use and Misuse*, 40, 2, pp. 241-267

Ziyadeh, N., Prokop, L., Fisher, L. (2007) Sexual orientation, gender, and Alcohol use in a cohort study of U.S. adolescent girls and boys, *Drug and Alcohol Dependence*, 87, 2-3, pp. 119-130, 16 Mar.

Zucker, A. and Landry, L. (2007) Embodied discrimination: The relation of sexism and distress to women's drinking and smoking behaviours, *Sex Roles: A Journal of Research*, 56, 3-4, Feb., pp. 193-203

### **Other Useful Sources (and some late entries!)**

Breitenbach, E and Wasoff, F. (2007) *A Gender Audit of Statistics: Comparing the position of women and men in Scotland*, Edinburgh: Scottish Executive  
(<http://www.scotland.gov.uk/Publications/2007/03/27104103/0>)

NHS Health Scotland (2009) *The Scottish Ethnicity and Health Research Strategy Working Group*, Edinburgh: NHS Health Scotland  
<http://www.healthscotland.com/uploads/documents/11136-Health%20in%20our%20multi-ethnic%20Scotland%20-%20full%20report.pdf>

ISD Scotland, Equality and Diversity Information Programme  
<http://www.isdscotland.org/isd/3392.html>

Mitchell, M and Howarth, C. (2009) *Trans Research Review*, Manchester: Equalities and Human Rights Commission  
(<http://www.equalityhumanrights.com/fairer-britain/trans-inequalities-reviewed/>)

OSDC Ltd (c2009) *Capturing the gains of the public sector duties: A report for the Equalities and Human Rights Commission*, Glasgow: Equalities and Human Rights Commission  
(<http://www.equalityhumanrights.com/scotland/projects-and-campaigns-in-scotland/capturing-the-gains-of-the-public-sector-duties-in-scotland/>)

## **Alcohol**

Asamoah, G. and Gottfried, S. et al (2009) A randomised trial of ethnicity and stigmatised attitudes towards learning disability and alcoholism, *Ethnicity and Inequalities in Health and Social Care*, 2, 2, pp. 11 – 19, July

Hart, C. and Davey-Smith, G. (2009) Alcohol consumption and use of acute and mental health hospital services in the West of Scotland: Collaborate prospective cohort study, *Journal of Epidemiology and Community Health*, 63, 9, pp. 703 – 707, Sept.

La Brie, J. and Huchting, K. et al (2009) Preventing risky drinking in first year college women: Further validation of a specific motivational enhancement group intervention, *Journal of Studies on Alcohol and Drugs*, Supp. 16, pp. 77 – 85, July

McKinlay, W., Forsyth, A.J.M. and Khan, F. (2009) *Alcohol and violence among young male offenders in Scotland (1979 – 2009)*, Edinburgh: Scottish Prison Service  
([http://www.sps.gov.uk/MultimediaGallery/b15f898a\\_e7f9\\_417b\\_8509\\_0b609a9fc0ac.doc](http://www.sps.gov.uk/MultimediaGallery/b15f898a_e7f9_417b_8509_0b609a9fc0ac.doc).)

Moos, R., Schutte, K. et al (2009) Older adults alcohol consumption and late life drinking problems: A 20-year perspective, *Addiction*, 104, 8, pp. 1293 – 1302, Aug.

Williams, J. and Duncan, B. (2008) *'You don't even wash your face, let alone anything else': Exploring understandings of the relationship between alcohol misuse, sexual health risk and general health outcomes among Scottish women offenders*, Glasgow: Glasgow Caledonian University  
([http://www.aerc.org.uk/documents/pdfs/finalReports/AERC\\_FinalReport\\_0053.pdf](http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0053.pdf))

Wilsnack, R and Wilsnack, S. et al (2009) Gender and alcohol consumption: Patterns from the multinational GENACIS project, *Addiction*, 104, 9, pp. 1487 – 1500, Sept.

## **Examples of Practice Guides**

*Checking for Change: A building blocks approach to race equality in health* NHS Health Scotland

(<http://www.healthscotland.com/uploads/documents/6292-Checking%20for%20Change%20-%20Executive%20summary.pdf>)

*Happy to Ask, Happy to Tell: Diversity data can make a difference. Training DVD to increase understanding of diversity monitoring among frontline staff who will be asking questions of patients*, ISD/NHS Health Scotland  
(<http://www.isdscotland.org/isd/5652.html>)

LGBT Equality Impact Assessment  
(NHS Fair for All LGBT)  
(<http://www.lgbthealthscotland.org.uk/EQIA/>)

## **Appendix 1: Types of tobacco used in some black and minority ethnic communities**

- Paan, pan masala, betel quit and areca nuts: these use a betel leaf, pasted with lime paste and folded into a funnel shape into which tobacco, areca nut and other ingredients are added. The funnel is folded over and chewed or sucked. Betel quid, even without tobacco has been found to be carcinogenic
- Gutkha: Tobacco and betel nut mixed together with a range of ingredients, often packaged to look like sweets. It has been linked to a rise in pre-cancerous lesions on the mouth
- Beedies, bidis or biris: hand rolled, flavoured cigarettes. These are smaller and cheaper than commercially cigarettes, but tend not to have a filter. The type of leaf used to wrap the tobacco are not porous so the cigarettes need to be inhaled more often and more deeply to keep them alight. This has been associated with more deeply seated cancers
- Hooker, waterpipe, nargeela/arghileh/nargile, shisha/sheesha, okka, kalyan, ghelyoon or Ghalyan, or hubble-bubble. Hookahs comprise a flexible tube with a container of water at one end and a mouthpiece at the other. A bowl with a filter is placed about the container of water where charcoal and scented tobacco are placed. Scented tobacco is crumbled into the bowl of the hookah, often with flavoured water added. Drawing on the mouthpieced pulls the smoked down the stem of the tube, through the water, the tube and the mouthpiece into the lungs. Compared to a single cigarette, 45 minutes of water pipe use approximately doubles carbon dioxide and triples nicotine exposure. In addition to cardiovascular diseases and cancers, smoking water pipes has also been linked to other transmittable diseases such as air-borne tuberculosis and hepatitis A.

Source: ASH Scotland (May 2008) *Types of tobacco used in some minority ethnic groups*,  
(<http://www.ashscotland.org.uk/ash/7166.1582.html>)