Understanding the association between mental health and alcohol use among minority ethnic groups

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Contents

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Definition of terms

Term	Definition
CMD	Common mental disorder, including any anxiety or depressive disorder
Co-occurring alcohol and mental health problems	Alcohol and mental health problems existing or occurring at the same time
Hazardous drinking	Drinking at levels that is likely to cause health harms
Intersectionality	Considers the interconnected nature of minority social statuses
Minority ethnic	Any non-White British ethnic group
NHS	National Health Service
Rapid appraisal methods	Simultaneous use of research techniques to produce of quick collection and analysis of data
SMI	Severe mental illness, including bipolar disorder, schizophrenia or any other psychotic disorder
UK	United Kingdom

Executive summary

Introduction

In England and Wales, it is estimated that 81.7% of the population are White, 9.3% Asian/Asian British/Asian Welsh, 4.0% Black/Black British/Black Welsh/Caribbean/African, 2.9% Mixed, and 2.1% Other Ethnic group. In the UK, the prevalence of alcohol use is highest among White British groups, however, minority ethnic groups may experience greater harms from alcohol due to these groups being more likely to experience inequalities and being less likely to engage with formal support compared to White groups. Minority ethnic groups may also be at greater risk of experiencing poor mental health due to experiences of racial discrimination and delaying seeking support for their mental health because of the way in which it is perceived in specific communities.

It is established that alcohol and mental health problems commonly co-occur but there is little research establishing whether the association between mental health and alcohol use differs across ethnic groups. It could be argued that minority ethnic groups are at greater risk of experiencing co-occurring alcohol and mental health problems because of the associated stigma towards both problems, therefore, they may be even less likely to seek formal support. While there are recommendations in place from the Office for Health Improvement and Disparities to ensure that people with co-occurring problems have access to different services, the barriers to accessing support may be compounded for minority ethnic groups. Cultural and structural factors could increase the barriers to accessing and using services for minority ethnic groups because assumptions may be made about the likelihood of someone drinking for people from minority ethnic groups, with implications for both identification of problems and assessment of the need for specialist support.

Taken together, generally there is a lack of evidence to show the patterns of alcohol use across different minority ethnic groups, and whether some ethnic groups are more likely to drink at problematic levels if they have a mental health problem. There is also a need to understand the mechanisms behind alcohol use among minority ethnic groups who have a mental health problem, and other factors which may play a role in that. Finally, it is also necessary to understand how mental healthcare staff assess and treat alcohol and what the experiences are of minority ethnic service users. Exploring these issues will have implications on the appropriate commissioning of mental health and alcohol services and on how staff in both mental health and alcohol services assess and treat the other issue.

Therefore, this project aimed to:

1 **Establish how the prevalence of alcohol use, including non-drinking, differs across ethnic groups and to then determine the associations between alcohol use with mental health, across ethnic groups.**

2 **Understand experiences with alcohol among minority ethnic groups who have a mental health problem.**

3 **Understand how alcohol is assessed and treated within community mental healthcare services, and whether approaches are tailored for minority ethnic groups from the perspectives of those managing services, community mental health staff, and minority ethnic service users.**

Methods

Taking an intersectional approach, this project consisted of three studies using:

i. Secondary data sources to establish the prevalence and associations of alcohol use and mental health across ethnic groups

ii. Qualitative interview approach to explore experiences of alcohol use among minority ethnic groups with a mental health problem.

iii. Rapid appraisal approach in community mental health services within a single mental health trust to establish whether and how alcohol is screened and treated.

The first study used data from eight secondary datasets; 2007 and 2014 Adult Psychiatric Morbidity Survey (APMS, N=14,949), phase 1 of South-East London Community Health study (SELCoH, N=1,695), wave 8 of Next Steps (N=7,707), wave 7 of Understanding Society (N=39,377), 1999 and 2004 Health Survey for England (HSE, N=37,244), and sweep 7 of Millennium Cohort Study (MCS, N=11,859). The APMS and HSE were cross-sectional studies while SELCoH, Next Steps, Understanding Society and MCS were cohort studies. These datasets were used because they included validated measures of alcohol and mental health, and some oversampled minority ethnic groups allowing for statistical analysis. Ethnic categories were determined based on using the most specific ethnic category available and were consistently measured across all datasets (e.g. Indian, Pakistani, Bangladeshi). Where ethnic groups were vague (e.g. any other ethnic group), these were removed from the analysis.

Pooled proportions and associations were calculated of individuals from specific ethnic groups who reported being a i) non-drinker, ii) low-risk drinker, iii) hazardous drinker, or iv) binge-drinker which were then re-calculated by whether individuals from specific ethnic groups were or were not experiencing poor mental health.

The second study used qualitative interviews to explore experiences with alcohol among minority ethnic groups who had a diagnosed mental health problem, and who either drank at hazardous and above levels or no longer drank alcohol. A framework analysis was conducted to explore experiences across different minority ethnic, religious and demographic groups.

The third and final study used rapid appraisal methods where individuals who manage support services, NHS community mental health staff, and minority ethnic service users with community mental healthcare services were either interviewed in a one-to-one setting or through focus groups. These methods were used to understand how alcohol was screened and treated within a mental healthcare or support service setting, and the experiences of this from a range of perspectives. A framework analysis was conducted to explore these experiences across staff and minority ethnic service users.

The project also involved a project advisory group and public involvement group. The project advisory group comprised of representatives from mental health services, minority ethnic support services, Office for Health Improvement and Disparities, and academics with expertise in the alcohol field. The public involvement group comprised of minority ethnic individuals who have lived experience of alcohol and/or mental health problems. Both groups were involved in development of the research design and interpretation of results throughout the project and its work packages.

Findings
Work package 1

How common is alcohol use across ethnic groups, and what are the associations with mental health?

There were difficulties in exploring associations across Mixed and other Asian groups (e.g. Chinese) due to issues with small numbers and inconsistent categorisation of ethnicity across datasets.

Combining data from the APMS, SELCoH, Next Steps and Understanding Society (N = 63,728), we found the following:

Non-drinking and mental health

- We found that non-drinking was most common among Pakistani (94%) and Bangladeshi (93%) groups.
- When we examined the associations between non-drinking and mental health across ethnic groups, White British groups with mental health problems were more likely to be non-drinkers (20%), compared to White British groups without mental health problems (13%).

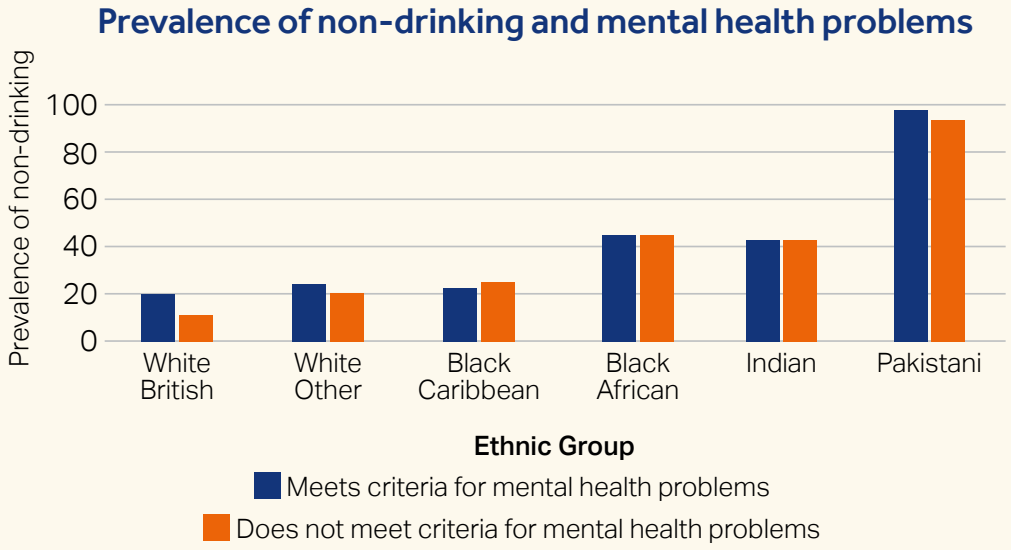


Figure 1: The pooled prevalence of non-drinking among individuals with and without mental health problems for each ethnic group

Hazardous drinking and mental health

- We found that hazardous drinking was most common among White British (36%), White Other (27%), Black Caribbean (15%), and Indian (11%) groups.
- When we examined the associations between hazardous drinking and mental health, Indian groups with mental health problems were more likely to be hazardous drinkers (19%), compared to Indian groups without mental health problems (15%).
- 13% of Black African groups with mental health problems were hazardous drinkers, compared to 6% of Black African groups without mental health problems, though this was not statistically significant.

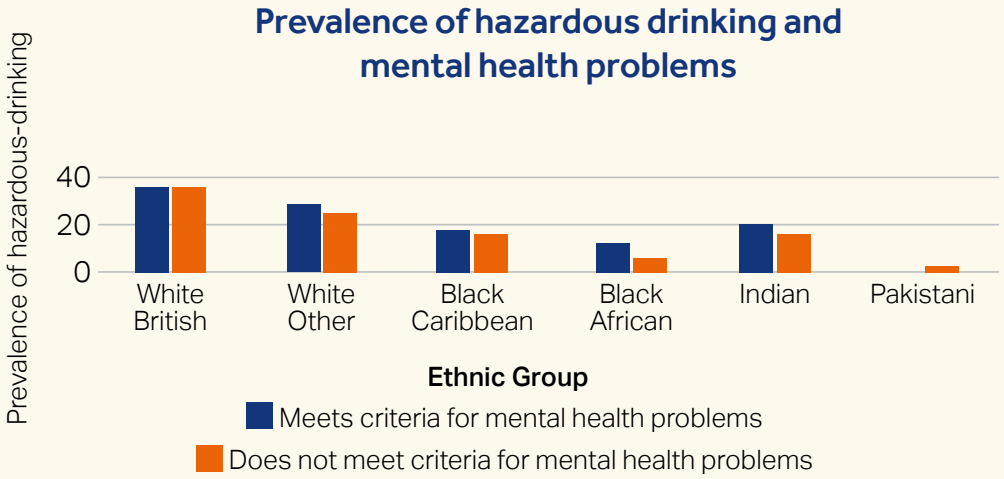


Figure 2: The pooled prevalence of hazardous drinking among individuals with and without mental health problems for each ethnic group

Work package 2

What are the experiences of alcohol use among minority ethnic groups who have a mental health problem?

Four themes were developed from interviews with 25 minority ethnic participants who had a range of common and severe mental health diagnoses:

1. Mental health literacy and implications on drinking behaviour.
2. Cultural expectations and its influence on mental health problems and drinking practices.
3. Drinking motivations.
4. Reasons for changes in drinking.

There were also differences in both the expectations of individuals and implications of drinking between ethnic groups, religious groups and genders.

Mental health literacy, and implications on drinking behaviour

Participants from a range of minority ethnic groups described the limited understanding and acknowledgement of mental health problems within their community, particularly of common problems such as depression and anxiety. This had implications on participants' ability to recognise their symptoms as indicators of poor mental health which delayed seeking formal support and relying on their own resources to manage symptoms.

> "You know most people tend to think that mental health has to do with the people that have psychosis, I know that for those us who just have depression, nobody seems to think of it as mental health.
>
> **P8ND, male, Black Caribbean**

Cultural expectations and its influence on mental health problems and drinking practices

There were unique cultural expectations among minority ethnic participants with some differences between specific religions and the gender of participants. Broadly, there were expectations of succeeding in work and of presenting to other members of the community in a certain way. Perceptions of alcohol differed between ethnic and cultural groups: alcohol use was normalised among Black or non-religious groups compared to Pakistani and some religious groups where alcohol use was forbidden. There were also implicit expectations on female participants to comply with creating a family unit and not to drink or appear intoxicated. Participants who felt that they had not met these implicit expectations experienced a decline in their mental health while women experienced particularly negative consequences from the community.

> "I managed to hide what was happening [to me] for about a year but then eventually it came out and I had no support from my family. They made me feel ashamed. I felt ashamed enough as it was, but they treated me as if I was damaged and I had lost something valuable.
>
> **P14D, female, White Other**

Drinking motivations

Prior to their diagnosis, participants drank heavily and struggled to stop drinking once they started, particularly those from Black or Pakistani groups. There were three common reasons for drinking; to cope with problems, to seek the effect of alcohol or to fit in. Some of these motivations were underpinned by the expectations of their family or community, while some women from Pakistani or White Other groups, experienced social isolation due to their drinking and mental health problems.

> They [family] thought you know that it was my fault, that I could have done more but I didn't. Like, why didn't she keep marriage going? But they thought it's me to blame but it wasn't, and they blame it on me and I just wanted something to cheer me up but it got to the point where it [alcohol use] was really bad.
>
> **P15D, female, Pakistani**

Reasons for changes in drinking

Many participants across all ethnicities began to drink less after seeking formal mental health support. This change seemed to occur when alcohol use was discussed with staff but there was a need for participants to feel comfortable in discussing their drinking habits to enable them to be open. This was particularly important for participants from Muslim groups or from religious groups. Long-term changes in drinking habits were facilitated through family members and the community being involved, though, some women continued to be isolated due to their drinking and mental health problems.

> Well my family, especially my Mum, was really happy when I told her that I was going to stop drinking. She was real happy and was very supportive from that point on, and I've become more close with my Mum... I talked a lot about my recovery problem, and she was engaging a lot about my mental health.
>
> **P9ND, non-binary, Black Caribbean**

Work package 3

How is alcohol assessed and treated within community mental health services, and how are processes tailored for minority ethnic service users?

Three themes were developed from interviews and focus groups with 29 individuals who managed support services, community mental health staff, and minority ethnic service users:

1. Barriers to disclosing and seeking support for alcohol problems.
2. Assessment but not treatment of alcohol problems.
3. Accessibility and inclusivity of alcohol services for minority ethnic service users.

Data from each participant group identified different issues for assessing and treating alcohol problems in community mental health settings which included: the way in which alcohol and mental health problems were funded, maintaining a good therapeutic relationship, and fear of the implications of disclosing alcohol problems.

Barriers to disclosing and seeking support for alcohol problems

Across all interview sources, motivation to change and engage with alcohol services was a key barrier but there were other barriers identified from different interview sources for minority ethnic service users when disclosing and seeking support for alcohol problems.

- For participants who managed support services, there were issues with the different funding streams for alcohol and mental health problems because this had implications on the scope of mental health services and staff expertise.
- For community mental health staff, the main barriers were the resources in place to facilitate discussions around alcohol, particularly when service users did not speak English and where alcohol was known to be taboo in the service user's community.
- For minority ethnic service users, there were concerns around how information around alcohol use would be managed and shared between services, and the negative implications of doing so.

> I had a lot of social workers involved in the children's lives as well, so I was dubious to tell doctors what was really going on in case of social services.
>
> **P1, service user**

Assessment but not treatment of alcohol problems

While alcohol was screened within community mental health services, there were inconsistencies in the methods used to assess alcohol.

- Both community mental health staff and minority ethnic service users described alcohol use being screened briefly during appointments, rather than through the recommended use of formal alcohol screening tools.
- Minority ethnic service users' responses to questions around alcohol use were rarely challenged by staff unless there was an immediate risk which seemed underpinned by maintaining a good rapport with minority ethnic service users.
- Interviews with participants who manage support services indicated that the limited focus on alcohol use may be due to the funding and scope of mental health services.

> But if we're just getting onto somebody for an assessment, then it's [alcohol use] something that's usually always touched on... I personally wouldn't go straight out with anything to audit somebody on alcohol and drug use, it would just be an open question like do you use alcohol?
>
> **P7, community mental health nurse and team leader**

Accessibility and inclusivity of alcohol services for minority ethnic services

It was highlighted across interview sources that alcohol problems needed to be addressed prior to engaging in mental health support but that alcohol services could be difficult to access, particularly for minority ethnic service users.

- Across all interview sources, it was highlighted that there were a limited number of alcohol services available to service users, none of which provided specific support for minority ethnic groups.
- Participants who manage support services and community mental health staff highlighted issues with the referral process and the need for consent which disproportionately affect minority ethnic service users.
- Some minority ethnic service users who had a history of alcohol problems found alcohol services which had a lived experience or peer support element more valuable in helping to identify that they had a problem with alcohol and remaining engaged with alcohol support.

> “Some of the counsellors have been there themselves and I find they’re the ones you can engage with more because they know what you’re talking about.
>
> **P6, service user**

Recommendations

We have established that minority ethnic groups with mental health problems were more likely to drink at hazardous levels, and that there were specific reasons why minority ethnic groups drink alcohol which were exacerbated by the ways in which alcohol was perceived by their family and community, and the implicit cultural expectations of individuals. We have also shown how conversations with healthcare professionals could be beneficial in addressing alcohol use though this does not seem to be consistently assessed within some mental health settings. Further, we have shown the complexity of involving family members and the community in minority ethnic service users' care, particularly around disclosing and treating alcohol use, and where negative implications may arise from disclosing alcohol use. Therefore, the following recommendations can be implemented to ensure better reporting of alcohol use and ethnicity and encourage routine assessment of alcohol use with minority ethnic service users:

1. **Large scale UK surveys should be better representative of minority ethnic groups through financing and recruiting adequate numbers of minority ethnic groups.**

2. **A need for mental health and alcohol services to take a culturally appropriate preventative approach with minority ethnic groups to help with better identification of problems and when to seek support.**

3. **More consistent screening of alcohol use using formal alcohol tools in mental health services, and better identification of available alcohol services.**

4. **Provide culturally specific training for mental health staff and organisations who support minority ethnic groups with mental health and/or alcohol problems.**

5. **Better communication between staff and minority ethnic service users on how and why data on alcohol use is being collected.**

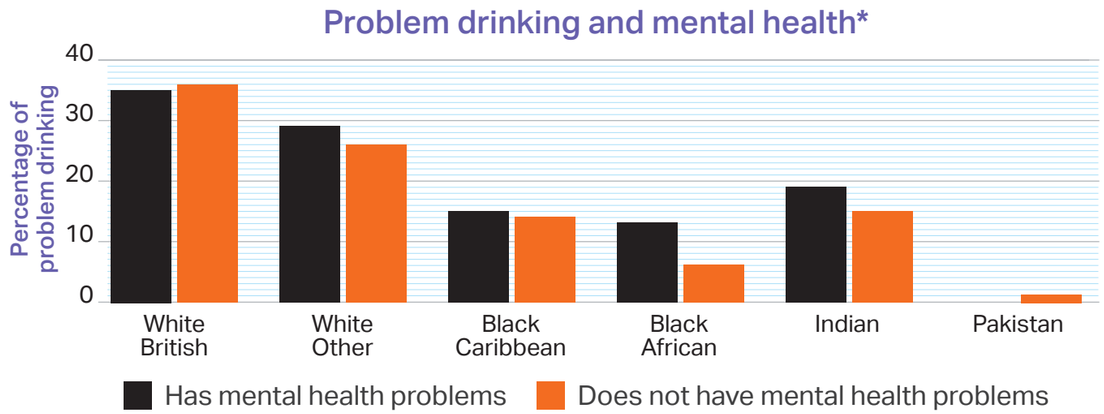
Conclusions

The findings of this project showed that hazardous drinking was most common among White British, White Other, Black Caribbean and Indian groups, and there were associations between hazardous drinking and mental health problems among Indian groups. Our findings suggest that there was limited recognition of alcohol problems, particularly among minority ethnic groups where alcohol was normalised and where seeking support was not encouraged. This was exacerbated by a limited understanding of mental health problems among some service users and lack of implementation of alcohol screening tools in community mental healthcare services. The way in which alcohol and mental health problems were perceived, combined with the implicit cultural expectations within minority ethnic groups, informed the ways in which participants drank, particularly for women or those from religious communities where alcohol was prohibited. Further, the limited availability of different types of alcohol services and resources available to facilitate discussions around alcohol with minority ethnic service users may exacerbate the reluctance to engage with formal alcohol support. With these issues in mind, our findings highlight the importance of taking a preventative approach and working with minority ethnic communities in improving the identification of alcohol problems early and increasing understanding of when to seek support and where support is available.

Alcohol and mental health problems often go together but how does this differ by ethnicity and how is alcohol addressed within mental health services?

How does drinking differ by ethnicity for those with mental health problems?

- Indian and Black African groups with a mental health problem were more likely to drink problematically than those without a mental health problem
- People from minority ethnic groups with a mental health problem may need additional support around their alcohol use



How do minority ethnic groups with a mental health problem describe their alcohol use and the reasons why they drink?

I didn't feel that I would be supported with my decisions and alcohol helped me cope with that

I liked the high feelings I got from having strong drinks

Alcohol helped me to get through times when I felt really low

I started drinking when I began making friends with people from other cultures

Alcohol is not allowed in my religion, so I drank when I was away from my community

I realized that I needed to cut down on my drinking when I was getting help and my family helped me stay on that path

How do mental health staff and minority ethnic service users feel about having conversations about drinking?

Community mental health staff

- I want to make sure that I have built up a good relationship with minority ethnic services users before I ask them about their drinking
- It can be difficult to have conversations about drinking with minority ethnic service users when other people are at consultations, so it's important to find the right time and space for these conversations

Service users

- It's important that I can relate to healthcare professionals and that they understand me
- I will only talk about my drinking if I can trust that it will not get back to other people I know and to services

What does this mean?

- Minority ethnic groups with a mental health problem were more likely to drink at a problem level
- Minority ethnic groups who drank alcohol did so for a range of reasons: to cope with their mental health, not meeting expectations of their family/community, to fit in with multi-cultural groups, or because of the feeling alcohol gave them
- Drinking can be hidden from others because of the stigma around alcohol use
- It is important for professionals to ask people about their drinking, regardless of their ethnicity, and be clear about how and when information will be shared outside of the consultation

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Based on data from representative surveys of individuals living in private households. There were small samples for other ethnic groups. Problem drinking was defined as drinking at hazardous or above levels

Introduction

Drinking and alcohol harms across different minority ethnic groups

Alcohol is associated with societal health, social and economic consequences estimated to cost between £21 and £52 billion a year in England (Public Health England, 2016), and the number of alcohol specific deaths has drastically increased in recent years (Office for National Statistics, 2022a). In the UK, alcohol is integral to social practices (Ally, Lovatt, Meier, Brennan, & Holmes, 2016) but less acceptable in other cultures. Whilst there are many research studies which have examined how alcohol use differs across different demographic and socioeconomic groups, there is a dearth of research looking at how alcohol use may differ across ethnic groups in a UK context. One reason for this is due to a lack of available population data including sufficient numbers of people from different ethnic groups (McHugh & Weiss, 2019), often due to the sampling approaches that have been used.

In England and Wales, it is estimated that 81.7% of the population are White, 9.3% are Asian, Asian British, or Asian Welsh, 4.0% are Black, Black British, Black Welsh or Caribbean or African, 2.9% are Mixed, and 2.1% are Other Ethnic group (Office for National Statistics, 2022b). Of the most recent statistics on alcohol and ethnicity in England; 22.6% of White British, 14.8% of White Other, 7.1% of Black/Black British, 3.7% of Asian/Asian British and 9.9% of Mixed/Multiple/Other ethnic groups report drinking alcohol at hazardous and above levels (defined as a score of 8 or higher on the AUDIT (Alcohol Use Disorder Identification Test), meaning that someone is drinking at a level that is likely to cause future health harms (McManus, Bebbington, Jenkins, & Brugha, 2016). However, this report used broader ethnic groups so did not allow for comparisons within such groups, for example, across Black Caribbean and Black African groups. Using better defined ethnicity categories can help us to understand specific differences between minority ethnic groups, for example, showing that Black Africans are more likely to abstain from drinking than Black Caribbeans (Bayley & Hurcombe, 2010).

While research indicates general higher levels of abstention in some minority ethnic groups (Bayley & Hurcombe, 2010), drinking practices, social and environmental factors may increase the likelihood of minority ethnic groups experiencing alcohol harms. The effects of acculturation mean that alcohol use may be increasing in some groups (Sirin, Choi, & Sin, 2022) but that this could be hidden from families and communities, particularly if alcohol use is forbidden. While evidence also suggests that minority ethnic groups are more likely to live in areas of greater deprivation (Bécares, Nazroo, & Stafford, 2011), and so may subsequently be at an increased risk of alcohol harms (Public Health England,

2018). Further, minority ethnic groups may also be more likely to experience alcohol harms due to a reluctance to engage with formal services and from hiding their drinking within their community due to the perceived stigma of having a problem with alcohol (Bayley & Hurcombe, 2010). This suggests that there are likely to be increased social and health harms from alcohol in those who do drink (Chartier, Vaeth, & Caetano, 2013), highlighting the pressing need for research.

Differences in mental health and service use, and access to services

Approximately one in six people in England report a CMD (Baker, 2020) and whilst the prevalence does not differ by ethnicity in males, it does in females, with CMDs more likely to be reported by women from a Black ethnic group (McManus et al., 2016). There is also a higher risk of a SMI in minority ethnic groups, particularly among Black African groups (Halvorsrud, Nazroo, Otis, Brown Hajdukova, & Bhui, 2019). Minority ethnic groups might be at a higher risk of experiencing poor mental health because of the additional stressors and disadvantages they experience, for example, relating to increased levels of childhood adversity, higher levels of unemployment and racial discrimination (Wallace, Nazroo, & Bécares, 2016). However, compared to White British groups, White Other, Asian and Black groups are less likely to receive treatment for their mental health (Ahmad, McManus, Cooper, Hatch, & Das-Munshi, 2022; Hahm, Cook, Ault-Brutus, & Alegría, 2015). There may be greater stigma around seeking formal mental health care while minority ethnic groups are likely to report more negative experiences of treatment compared to White British groups (Lawrence, McCombie, Nikolakopoulos, & Morgan, 2021), but some of these issues may be due to experiences of racism within services when seeking support (Kapadia, 2023).

The association between mental health and alcohol use

Population data from England has shown that people with both CMDs and SMIs are more likely to be both non-drinkers and drink at levels that might be harmful to their health, with evidence for stronger associations in individuals with an SMI (Puddephatt et al., 2021). There are some mental health problems for which the level of non-drinking is particularly high, specifically for psychosis. There are several theories explaining the association between mental health and alcohol use, with the directionality of this relationship regularly debated. Theories include that i) alcohol use increases the risk of mental health problems due to biological effects (e.g. through changes in metabolism or neurotransmitter function) or through the negative social effects of having an alcohol use disorder (AUD), ii) worsening mental health results in an increase in alcohol use and risk of AUD through using alcohol to

cope e.g. self-medication hypothesis or iii) that there may be common risk factors for both e.g. exposure to traumatic events or childhood adverse events or genetic/environmental risks. Studies looking at directionality have found stronger evidence for an association from mental health to alcohol use (Bell & Britton, 2014; Treur, Munafò, Logtenberg, Wiers, & Verweij, 2021).

There is relatively little research on co-occurring alcohol and mental health problems across specific ethnic groups, but there is a need for greater understanding given that many minority ethnic groups are less likely to receive treatment for their mental health problem and people who are not receiving the support required may be more likely to try and deal with a problem by themselves and use alcohol to cope with or numb mental health symptoms.

Integration of mental health and drug and alcohol services

Despite evidence showing how frequently mental health and alcohol problems co-occur, people with co-occurring problems can face a range of barriers in accessing services and often do not receive coordinated support to address their needs. These issues are likely compounded in minority ethnic groups given the aforementioned issues highlighted around accessing formal support. Guidance specific to England exists on provision of care for those with co-occurring problems (Public Health England, 2017) focused on: i) Everyone's job – suggesting that commissioners and providers of mental health and alcohol services have a joint responsibility to work collaboratively and ii) No wrong door – highlighting that providers in alcohol and mental health services should have an open-door policy for individuals with co-occurring problems. NICE have also recently updated their guidance on screening alcohol use and treating alcohol problems. This guidance specifies the need for service providers (including primary and secondary care, and community services) to ensure that systems are in place for practitioners to use validated alcohol screening tools when asking questions around alcohol use with service users to ensure that appropriate treatment can be identified, and that this screening process is conducted in a way that is accessible for the service user (National Institute for Health and Care Excellence, 2023).

While recent guidance on co-occurring alcohol and mental health problems, and screening for alcohol use may have been developed (National Institute for Health and Care Excellence, 2023; Public Health England, 2017), there may be cultural influences as to why people from some minority ethnic groups may be less likely to be asked about their drinking within mental health services. For example, assumptions may be made that someone does not drink because of their ethnicity or religious affiliation, and this is in the context of alcohol screening not systematically occurring within mental health services for people from any ethnic background. There are also issues with a lack of training around alcohol use and addiction in mental health services and a need for clearer referral pathways due to lack of integration between mental health and drug and alcohol services. Current provision of drug and alcohol services may also not be culturally appropriate for some ethnic groups and people may not want to risk being seen using a service for a health condition that is still more stigmatised than other mental health problems, so there are a range of explanations as to why people may not be getting the support they require.

Applying an intersectional lens to the current research

Intersectionality provides a lens for understanding the interconnected nature of minority social statuses. It is a conceptual and theoretical tool for understanding how disadvantage is experienced by minority groups (Bauer, 2014). In the context of alcohol use and mental health among minority ethnic groups, an intersectional lens considers the differences in the experiences within specific ethnic groups, and how other statuses, such as gender and religion, interact and contribute towards alcohol use and mental health (Crenshaw, 1991). For example, alcohol is more accepted in some religious communities within the same ethnic group, compared to others (Gleeson, Thom, Bayley, & McQuarrie, 2019). While second and third generations may have different beliefs around drinking and mental health compared to first generation groups who migrated to England. With this in mind, the intersectionality theory suggests that a multiplicative approach should not be taken in understanding the impact of having multiple disadvantaged statuses, i.e. we should not try to pick apart the independent effects of individual minority statuses on an individual's health.

What are the current gaps in the literature and the limitations of existing data?

1. There is a lack of representative data in England on how the level of alcohol use differs across different minority ethnic groups and this is important for commissioning services appropriately, particularly given people from minority ethnic groups appear to be under-represented in drug and alcohol service data.
2. There is a need to understand whether people from some ethnic groups are more likely to use alcohol at a hazardous and above level if they have a mental health problem, compared to those without a mental health problem.
3. Further understanding of the motivations for drinking alcohol among people with a mental health problem from minority ethnic groups is required, including the factors that may help people to reduce their drinking so that this can be used to support other people to cut down.
4. Finally, we need to understand how alcohol is treated and addressed in mental health services in regions with greater ethnic diversity and to understand service users' experiences of how alcohol has been asked about when they sought help.

Project aims

1. To establish how the prevalence of alcohol use, including non-drinking, differs across ethnic groups and to then determine the associations between alcohol use with mental health, across ethnic groups.
2. To understand experiences with alcohol among minority ethnic groups who have a mental health problem.
3. To understand how alcohol use is screened and treated within community mental healthcare services, and whether approaches are tailored for minority ethnic groups from the perspectives of those managing services, community mental health staff, and minority ethnic service users.

Work Package 1

What is the prevalence of alcohol use across ethnic groups in England, and how do the associations between alcohol and mental health problems differ across these groups?

Foreword

Section 2 of this report outlined the limited understanding of how alcohol and mental health problems co-occur across ethnic groups even though it has been established that some ethnic groups are less likely to seek and receive formal support for alcohol problems. The first study of this project aimed to establish how common alcohol use is across ethnic groups, and whether there are significant associations with mental health problems across these groups. The findings of this study would be used to inform the later work packages of the project, for example, whether to focus on specific minority ethnic groups.

Background

It is known that the prevalence of hazardous drinking is more common among White British groups compared to minority ethnic groups (McManus et al., 2016) while non-drinking is higher among many minority ethnic groups (Bayley & Hurcombe, 2010). An early review of the literature found that patterns of drinking are changing among minority ethnic groups; for example, frequent and heavy drinking has increased among Indian women and Chinese men (Bayley & Hurcombe, 2010). However, due to small numbers, research has often grouped specific minority ethnic groups into broader categories to allow for statistical analysis (e.g. Indian, Pakistani, and Bangladeshi groups being categorised as "Asian"). This can be problematic given that patterns of drinking often differ between these specific minority ethnic groups, for example Indian ethnic groups are more likely to drink compared to Pakistani and Bangladeshi groups (Bayley & Hurcombe, 2010). Therefore, using broad categorisations of ethnicity can mask differences in the patterns of drinking and could result in those in most need of support for their drinking not being identified.

Alcohol use is known to co-occur with poor mental health (Puddephatt et al., 2021). Recent statistics have shown that the prevalence of CMD is highest among Black/Black British groups (23%) and lowest among White Other groups (14%) (Baker, 2020) while it is also known that some minority ethnic groups are less likely to seek formal mental health support (McManus et al., 2016). Taken together, the association between alcohol and mental health may be exacerbated among minority ethnic groups because of the stigma around mental health and negative experiences with healthcare professionals (Memon et al., 2016) which

may delay individuals from seeking formal support and therefore increase the likelihood of drinking alcohol to cope.

To our knowledge, the association between alcohol and mental health, including non-drinking, across specific ethnic groups has not been explored in England. To overcome aforementioned issues with small sample sizes in some minority ethnic groups (McHugh & Weiss, 2019), the current study utilised data from multiple data sources to examine the prevalence and associations between alcohol and poor mental health across specific ethnic groups in England.

Aims

Using data from eight national or regional sources in England, this study aimed to:

1. **Examine the pooled prevalence of alcohol use and binge-drinking, and how they differed by ethnicity.**

2. **Establish pooled prevalence and association of alcohol use and binge-drinking among individuals with mental health problems compared to those without mental health problems across ethnic groups.**

Methods

Design

A secondary analysis of eight data sources was conducted, these sources included i) 2007 and 2014 Adult Psychiatric Morbidity Survey (APMS), ii. phase I of South-East London Community Health survey (SELCoH), iii. wave 8 of Next Steps, iv) wave 7 of Understanding Society, v) wave 7 of Millennium Cohort Study (MCS), and vi) 1999 and 2004 Health Survey for England (HSE). These sources were chosen because they use validated measures of alcohol use, mental health, as well as data on ethnicity. Some of the sources oversampled minority ethnic groups, therefore, providing sufficient numbers for analyses.

Participants, setting and sample size

Broadly, all data sources included participants living in private households in England. Further information about the methodology of each data source and sample sizes can be found in Table 1.

Table 1: Methodology of secondary datasets included in work package 1

Dataset	Survey design	Sampling	Participants	Total sample
				N
2007 and 2014 APMS	Cross-sectional survey conducted every seven years	Multi-stage stratified probability sampling	Adults aged 16 or older living in private households in England	14,949
SELCoH (phase 1)	Cross-sectional survey	Multi-stage stratified probability sampling	Adults aged 16 or older living in private household in Southwark and Lambeth boroughs of London	1,695
Next Steps (wave 8)	Longitudinal cohort study of people born in England in 1989-1990 with recruitment starting when they were aged 13-14	Sampled young people in Year 9 of state or independent English schools, or pupil referral units. The dataset oversample minority ethnic groups and those from deprived schools	Adults aged 25 who had ever taken part in previous sweeps	7,707
Understanding Society (wave 7)	Panel survey of UK households which began in 2009-2010.	The general population sample is a clustered, and stratified probability sample of households in the UK. The ethnic minority boost sample are from households in areas of high ethnic minority concentration in the UK	Adults aged 16 or older living in private households	39,377
MCS (wave 7)	Longitudinal birth cohort study of participants in the UK born in 2000-2002.	Clustered, stratified random sample of households which oversampled areas of disadvantage or had high ethnic minority populations.	Households with a child born in 2000-2002.	11,859
1999 and 2004 HSE	Cross-sectional annual survey of private households in England	Random probability sampling of private households in England. Both datasets oversampled using random probability	The 1999 survey included participants aged 2 and older, living in private households in England whereas the age limit was lowered to 0 in 2004.	37,244

Measures

Alcohol use

Four datasets (APMS, SELCoH, Next Steps and Understanding Society) used the Alcohol Use Disorder Identification Test-Consumption (AUDIT-C) to assess alcohol consumption; MCS assessed alcohol frequency as opposed to alcohol consumption; all datasets (excluding MCS) assessed 12-month binge-drinking.

AUDIT-C: AUDIT-C is a three-item questionnaire to assess alcohol consumption and binge-drinking. Scores range from 0-12 and has been shown to be a valid measure of active alcohol abuse, dependence and heavy drinking (Bradley et al., 2007; Bush et al., 1998). Participants were categorised as a: non-drinker (AUDIT-C score of 0 or answering "no" to drinking alcohol even on special occasions), low-risk drinker (AUDIT-C score of 1-4), hazardous drinker (AUDIT-C score of 5 or more).

Binge-drinking: 12-month binge-drinking was assessed using item three on the AUDIT or AUDIT-C for the APMS, SELCoH, Next Steps, and Understanding Society datasets with a response of "Monthly", "Weekly" or "Daily or almost daily" as a cut-off for screening for binge-drinking. All non-drinkers were excluded from this analysis.

Mental health problems

Two measures were used to assess mental health problems depending on the data source: Clinical Interview Schedule-Revised (CIS-R) or General Health Questionnaire (GHQ-12). The CIS-R assesses common mental disorder and a cut-off score of 12 indicates a positive case (Lewis, Pelosi, Araya, & Dunn, 1992) whereas the GHQ-12 assesses minor psychiatric disorder and a cut off score of four indicates poor mental health. Previous research has established that the GHQ-12 is comparable with the CIS-R (Hardy, Shapiro, Haynes, & Rick, 1999).

Ethnicity

The most specific ethnic categories collected in the data sources were used (e.g. Indian, Black African), where numbers permitted. Any ethnic categories where the definition was vague (e.g. "any other ethnic group") were dropped from the analysis. As our aims sought to pool data across datasets, ethnic categories across datasets needed to be comparable, therefore, some ethnic categories were separated, merged or dropped.

Data analysis

Due to differences in the categorisation of ethnicity and measures used to assess alcohol use, only the APMS, SELCoH, Next Steps and Understanding Society data were included in the meta-analysis. We did conduct individual analyses examining the prevalence of

alcohol use, and associations with mental health separately for each dataset, however due to the report length, these are not reported here but are available on request. All analyses were conducted in STATA version 14. Odd ratios (OR) and 95% confidence intervals (CI) not overlapping with 1 were used to determine significance. An overview of the analysis is outlined, and stratified by aim, below:

1 **We calculated the pooled proportions of individuals who reported being a i) non-drinker, ii) low-risk drinker, iii) hazardous drinker, and iv) binge-drinker for each ethnic group across datasets.**

2 **We then calculated the pooled proportions for participants with and without mental health problems who reported being a i) non-drinker, ii) low-risk drinker, iii) hazardous drinker, iv) binge-drinker, for each ethnic group across datasets which were then converted to an odds ratio.**

Results

Non-drinking

The pooled prevalence of non-drinking was highest among Pakistani groups (97%, 95% CI=88%-98%) and lowest among White British groups (15%, 95% CI=12%-17%, see figure 4). However, when comparing those with and without mental health problems, only White British groups with mental health problems were more likely to be a non-drinker, compared to White British groups without (odds ratio=1.46, 95% CI=1.34-1.59, see figure 1 for prevalences). No other associations between non-drinking and mental health problems among other ethnic groups were found.

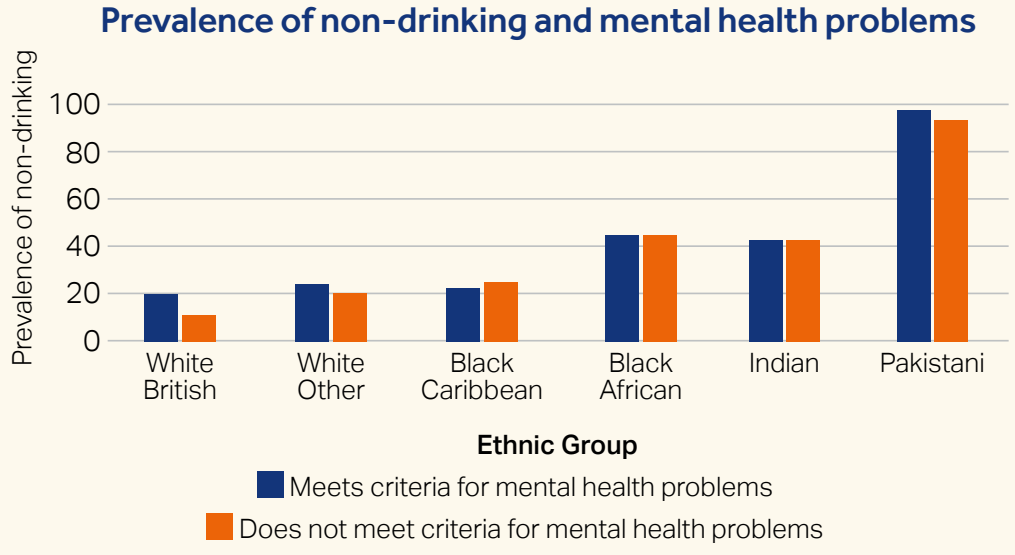

Figure 1: The pooled prevalence of non-drinking among individuals with and without mental health problems for each ethnic group

Hazardous drinking

Hazardous drinking was highest among White British groups (36%, 95% CI=33%-38%) and lowest among Pakistani (1%, 95% CI=0%-2%) and Bangladeshi groups (1%, 95% CI=0%-1%, see figure 4). When comparing those with and without mental health problems, only Indian groups with mental health problems were more likely to be a hazardous drinker, compared to Indian groups without (odds ratio=1.43, 95% CI=1.05-1.96, see figure 2 for prevalences). There was a trend towards significance among Black African groups with mental health problems (odds ratio=2.26, 95% CI=0.98-5.18), but the lack of significance may have been due to low numbers.

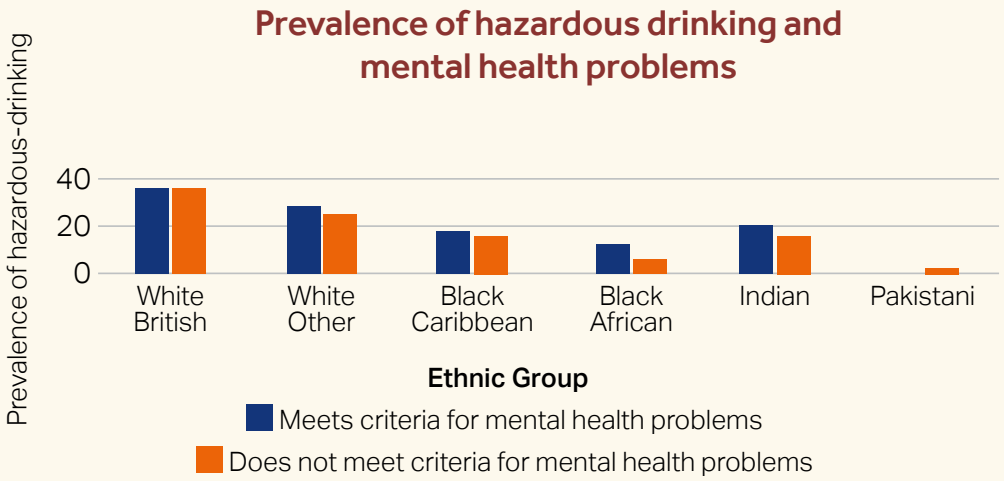

Figure 2: The pooled prevalence of hazardous drinking among individuals with and without mental health problems for each ethnic group

Binge-drinking

The prevalence of binge-drinking was highest among White British groups (30%, 95% CI=27%-33%) and lowest among Black African groups (12%, 95% CI=8%-18%, see figure 4). When comparing those with and without mental health problems, White British and Black African groups with mental health problems were more likely to be a binge-drinker compared to those without from the same ethnic group (White British: odds ratio=1.14, 95% CI=1.08-1.20); Black African: odds ratio=1.98, 95% CI=1.00-3.92, see figure 3 for prevalences).

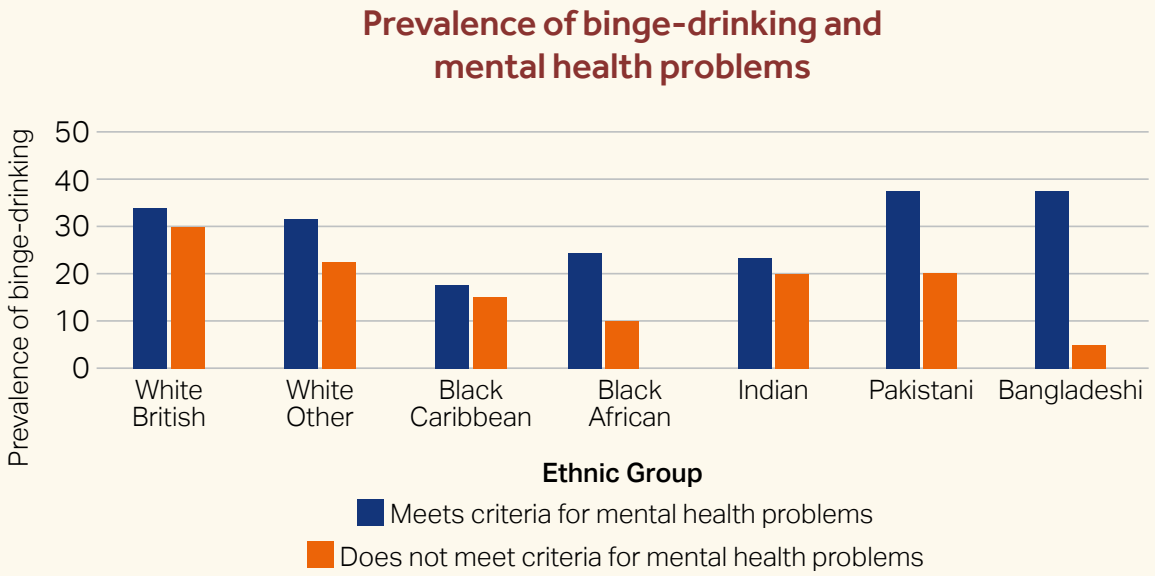

Figure 3: The pooled prevalence of binge-drinking among individuals with and without mental health problems for each ethnic group

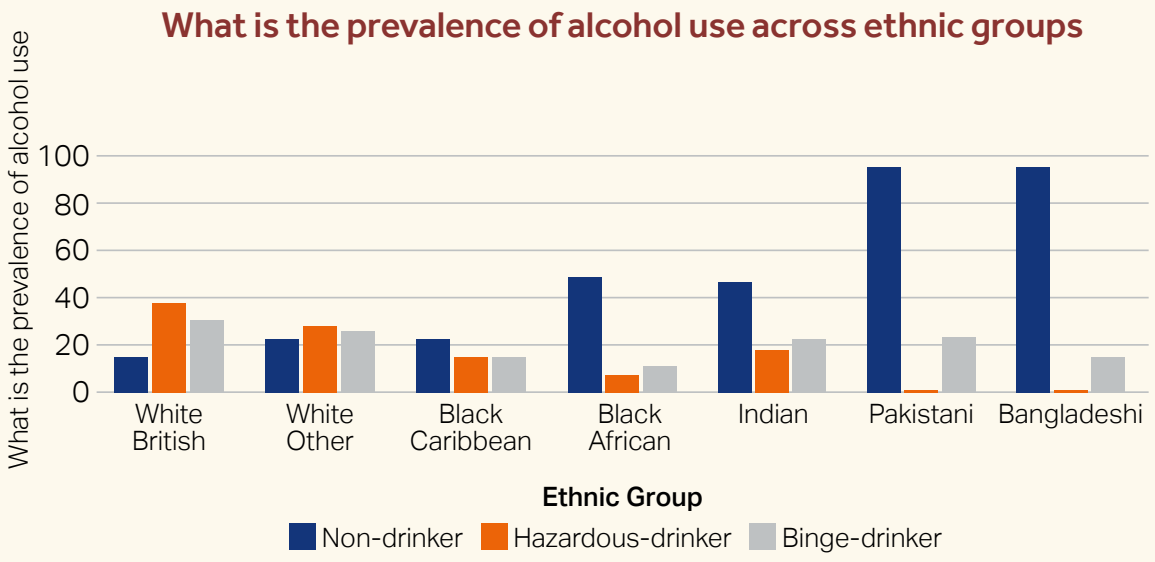

Figure 4: The pooled prevalence of non-drinking, hazardous drinking, and binge-drinking for each ethnic group

Conclusions and implications

This study is one of the first to examine the prevalence of alcohol use, including non-drinking, and the association with mental health problems across specific minority ethnic groups in England. We have shown that although hazardous drinking was higher among White British groups, hazardous drinking was also common among White Other, Black Caribbean, and Indian groups. When stratified by those with and without mental health problems, only Indian groups with mental health problems were more likely to be hazardous drinkers compared to Indian groups without poor mental health. A similar trend, though not significant, was also found among Black African groups with mental health problems. This indicates that patterns of drinking may change among some minority ethnic groups when experiencing poor mental health, and there is a need to understand the reasons for this change further.

Previous reviews of the literature have shown that patterns of drinking differ between specific minority ethnic groups (Bayley & Hurcombe, 2010) while the most recent statistics on hazardous and above levels of drinking are most common among White British groups (22.6%) and least common among Asian/Asian British groups (3.7%) (McManus et al., 2016). Through using more specific ethnic categories, our findings indicate that there are differences in the patterns of drinking within broad ethnic groups where we found that hazardous drinking was most common among White Other, Indian and Black Caribbean groups. While our meta-analysis was unable to report the prevalence of alcohol use among some minority ethnic groups (e.g. Mixed or Chinese ethnic groups), we were able to run individual analyses in the different data sources which included further minority ethnic groups and found that hazardous drinking was common among some Mixed ethnic groups (data is available on request). Nonetheless, this highlights the need for research to ensure that sufficient numbers of people from minority ethnic groups are recruited for in large surveys to allow for statistical analysis across a range of specific ethnic groups.

Previous research examining the prevalence and association of alcohol and mental health problems in England has shown that individuals with specific mental health problems were more likely to be non-drinkers or hazardous and above drinkers compared to those without the respective mental health problem (Puddephatt et al., 2021). However, when split by ethnicity, we found that only White British groups with mental health problems were more likely to be non-drinkers, and Indian groups with mental health problems were more likely to be hazardous drinkers compared to those from same ethnic groups without mental health problems. This suggests that alcohol may be used to cope with symptoms of poor mental health among some minority ethnic groups, but not in all. Due to the cross-sectional nature of the analysis, it was not possible to explore this further, and more research is needed to understand the reasons for hazardous drinking among minority ethnic groups who have mental health problems.

Taken together, our findings have several implications. First, the patterning of drinking changed among some specific minority ethnic groups with mental health problems, therefore, alcohol use and reasons for drinking should be discussed when minority ethnic groups are seeking support for their mental health to understand whether alcohol is being used to cope. Second, while hazardous drinking was common among White British groups, it was also common among White Other, Black Caribbean and Indian groups, therefore, it is important for researchers, services and policymakers to understand that alcohol may be more common across a number of different ethnic groups. Third, even though we used data from multiple data sources, we were still unable to do so across other minority ethnic groups. Therefore, new and existing surveys and research should prioritise recruiting sufficient numbers of minority ethnic groups to allow for sufficient analyses and, where feasible, use more specific ethnic categories.

Work Package 2

What are the experiences of alcohol use among minority ethnic groups who have a mental health problem?

Foreword

Section 4 of this report showed that while hazardous drinking was more common among White British, White Other, Black Caribbean, and Indian groups, only Indian groups with mental health problems were more likely to report hazardous drinking compared to Indian groups without mental health problems, and a similar trend, while not significant, was found among Black African groups. Given that there is limited research in this area and following discussions between the project team, project advisory group, and participatory involvement group, it was decided that work package 2 would explore the experiences of alcohol use across a range of minority ethnic groups who have a mental health problem, rather than Indian and Black African groups only. Further, it has been established that other factors, such as gender, may play an important role on experiences with alcohol among minority ethnic groups, therefore, this study aimed to interview minority ethnic groups from a range of demographic backgrounds.

Background

The prevalence of common mental health problems, such as depression and anxiety, are more common among some minority ethnic groups (Baker, 2020), and specific ethnic groups, such as Black African and Black Caribbean groups, are more likely to be diagnosed with a severe mental health problem (Halvorsrud et al., 2019). Mental health problems may be associated with poorer outcomes among minority ethnic groups, because of the known additional stressors and disadvantages they experience, for example, increased exposure to childhood adversity, unemployment and racial discrimination (Wallace et al., 2016). Minority ethnic groups are known to be less likely to seek formal mental health support and this may be influenced by the known stigma associated with having a mental health problem and potential lack of awareness of mental health problems (Bignall, Jeraj, Helsby, & Butt, 2019; Leamy, Bird, Boutillier, Williams, & Slade, 2011).

As mentioned in section 4 of this report, we found that hazardous drinking was common among White Other, Black Caribbean and Indian groups. Further, it has been established that alcohol and mental health problems co-occur together (Puddephatt et al., 2021), and the level and consequences of this co-occurrence may be exacerbated among minority ethnic groups due to the known stigma associated with such issues, and the cultural and religious expectations around alcohol use (Gleeson et al., 2019). Findings from section 4

showed that some minority ethnic groups with mental health problems were more likely to report hazardous drinking, compared to those of the same ethnicity without mental health problems. We found no significant associations between non-drinking and mental health problems among minority ethnic groups, but this may have been due to the overall higher levels of non-drinking among minority ethnic groups. The mechanisms which explain the increased levels of alcohol use in those with a mental health problem are difficult to understand using cross-sectional data and it is possible that there may be other factors that influence drinking patterns among minority ethnic groups who have a mental health problem.

The intersectionality theory argues that factors, such as gender, religion, and migration, should be considered when seeking to understand health behaviours and health problems (Bauer, 2014). In the context of minority ethnic groups, it is important to consider differences within groups and the role of other statuses on health-related behaviours and seeking support (Crenshaw, 1991). Research has shown that, among minority ethnic groups, there are specific expectations around alcohol use depending on the gender and religious faith of individuals and their communities (Bradby, 2007; Galvani, Manders, Wadd, & Chaudhry, 2013; Gleeson et al., 2019). However, the role of these factors on alcohol use and mental health are less clear among minority ethnic groups, therefore, it is important to understand the reasons for the different drinking patterns, and factors known to be linked with alcohol, mental health and seeking formal support.

Aims

Taking an intersectional approach, this study used qualitative methods to explore:

1. **How alcohol is used among individuals with a mental health problem from a racial and minority ethnic background, for example, how it may be used to cope.**
2. **How alcohol was used before someone received support for their mental health and issues around potential stigma and discrimination in receiving support.**
3. **How alcohol use has changed during and after receiving treatment for their mental health problem and how it relates to the level of treatment experienced.**

Methods

This study received ethical approval from Lancaster University ethics committee (ref. FHM-2022-0685-RECR-2).

Participants and sample size

Participants were recruited through gatekeepers at community mental health and minority ethnic groups organisations, such as Mary Seacole House in Liverpool, as well as through social media. Participants were invited to take part if they:

- Were non-White British.
- Had a mental health diagnosis.
- Either currently drink alcohol at hazardous or above levels (defined as having an Alcohol Use Disorder Identification Test score of 8 or above) or were former drinkers.
- Were aged 18 or older.

Participants with a recent diagnosis of an AUD were not included in the study, due to concerns regarding the participants recovery. Participants may have had a previous AUD diagnosis or be drinking heavily without a formal diagnosis. Participants were invited to take part in an online or telephone semi-structured interview and we aimed to recruit participants from a range of minority ethnic backgrounds, of different ages and genders, so that we could apply an intersectional approach to our analysis.

Interviews

Twenty-five interviews were conducted from April to September 2022. Table 2 shows the demographic characteristics of participants, including their mental health diagnosis, drinking status and AUDIT score.

Table 2: Demographic characteristics of participants included in work package 2

Characteristics		N
Drinking status	Drinker	10
	Non-drinker	15
Ethnicity	Black African	7
	Black Caribbean or Black Other	5
	Asian (Indian, Pakistani, Bangladeshi, Chinese)	7
	Mixed (Black and Asian, White and Asian, Mixed Other)	5
	White Other	1
Gender	Male	18
	Female	6
	Non-binary	1
Age (range)		23-62
Mental health diagnosis	Depression	12
	Anxiety (including Post-traumatic stress disorder and Obsessive-compulsive disorder)	10
	Bipolar disorder	2
	Schizophrenia or other psychotic disorder	3
	Personality disorder (Borderline personality disorder, Mixed personality disorder)	2
	Anorexia nervosa	1
AUDIT score	Hazardous drinker (score of 8-15)	3
	Harmful/probable dependent drinker (score of 16-40)	7

Topic guides were developed by the study team, our participatory involvement group of minority ethnic individuals with lived experience of mental health and/or alcohol problems, and our stakeholder group of members from mental health and minority ethnic organisations. The topic guide focused on typical drinking sessions which occurred before and after their mental health diagnosis, reasons for their drinking, experiences of seeking support for their mental health and alcohol use, and experiences of discrimination in seeking support. Similar questions were asked in relation to prior to, immediately after receiving their diagnosis, and their current drinking or non-drinking to explore how their experiences with alcohol changed over time in relation to accessing support and receiving their mental health diagnosis. Participants were reimbursed either a £20 high street voucher or BACS payment for their time.

Analysis

A framework analysis was conducted, which allowed for an intersectional approach to explore the experiences with alcohol before and after minority ethnic groups received their mental health diagnosis and for understanding perspectives of current hazardous drinkers and former drinkers from a range of demographic backgrounds (Gale, Heath, Cameron, Rashid, & Redwood, 2013). The analysis involved six stages; transcription and familisation, initial coding, development of analytical framework, application of analytical framework to all transcripts, charting data into a framework matrix, interpretation. Analysis was conducted in NVivo 12 and facilitated by field notes, memos and with a second postgraduate researcher (MB). Themes and subthemes were reviewed by the study team and participatory involvement group.

Findings

Four main themes were developed from the analysis:

- Mental health literacy and implications on drinking behaviour.
- Cultural expectations and its influence on mental health problems and drinking practices.
- Drinking motivations.
- Reasons for changes in drinking.

These themes reflect the importance of awareness and cultural expectations on both mental health and alcohol use, and how they influenced minority ethnic groups identifying mental health symptoms and seeking support. Further, the themes highlight the important role health services may have in improving awareness and reducing alcohol use.

Theme 1

Mental health literacy and implications on drinking

Participants, and their families and communities, seemed to have a limited understanding of mental health problems and the symptoms associated with these. Severe symptoms, such as hallucinations, were perceived as indicators of poor mental health, whereas common symptoms such as persistent low mood or lack of motivation were not. While these perceptions can also be found in the general population, regardless of ethnicity, there were differences in the perceptions on the cause of mental health problems between minority ethnic groups, such as the belief that mental health problems were a result of bad spirits among some Asian participants.

> Well [psychosis] would be talked about as a really not good thing... we actually believe a lot in some evil forces. We believe that as a person a lot of people might not be at peace with the things that are going on in your life and might actually just cause some spiritual attack.
>
> **P4ND, male, Pakistani**

The lack of awareness combined with the perception of having a mental health problem seemed to contribute towards a reluctance to seek formal support and a reliance to manage their mental health on their own. This seemed to have implications on using alcohol to cope prior to getting formal mental health support.

> ...[in my community] this belief that there is something wrong with the person that [mental health problem] is their fault somehow that there is something about them that is faulty and deficient in some way, and they're not quite complete and healthy as other people might be, so that's why there is reluctance to admit to a mental health problem.
>
> **P14D, female, White Other**

Theme 2

Cultural expectations and its influence on mental health problems and drinking practices

There were several unique implicit expectations which were informed by religious beliefs and gender roles held by the participant, family or community which differed slightly between minority ethnic groups. Among Black participants, there was the expectation to provide financially for the family and to succeed in a job, whereas among Asian participants, there was the expectation to achieve academically and build a family.

> I actually was a very, very bright kid back in school, and everybody expected a lot from me. So I think that got to me I had high expectations from friends and family, was really hard for me.
>
> **P5ND, male, Black African**

These expectations seemed to impact participants' mental health and drinking practices. Where participants believed that they were not meeting the expectations of themselves, family or communities, their mental health deteriorated. These views were more common in female participants if they deviated from the cultural norms and expectations, even if events were non-consensual, where they would become isolated from the family and community.

> I managed to hide what was happening for about a year but then eventually it came out and I had no support from my family. They made me feel ashamed. I felt ashamed enough as it was, but they treated me as if I had, I was damaged and I had lost something valuable.
>
> **P14D, female, White Other**

Acceptance, or non-acceptance, of alcohol use within the family or community informed participants' drinking practices and the context in which they drank. While alcohol use was common among Black participants and consumed alcohol in social or public settings. Participants from religious faiths, such as Muslim or devout Christian, hid their alcohol use from members of their family or community because of the implications this could have.

> They [friends] just they found it [my drinking] hard to believe. Just laughed it off. But then just carried on with other things, but I just thought they weren't being supportive anyway at all. They didn't think that I was telling the truth about really what I was drinking... it's not normal for them.
>
> **P15D, female, Pakistani**

Theme 3

Drinking motivations

There were three broad reasons for drinking among minority ethnic participants:

i. Drinking to cope with problems.

ii. Drinking to seek the effect of alcohol.

iii. Drinking to fit in.

Some of these reasons were underpinned by the cultural expectations of the family or community and there were also links between managing their mental health on their own and drinking to cope. For some participants, there were negative implications of their drinking habits on other aspects of their life, including their work and relationships, which have been long-lasting. For some former drinkers, their previous drinking habits have remained hidden indicating the stigma of drinking alcohol among some groups.

A range of problems were discussed in interviews which had had a negative impact on the participants, and their status within the family or community. Such problems included divorce, traumatic events, symptoms of poor mental health, and issues with their identity. While these issues may be frowned upon in White British groups, these problems were exacerbated by how they were perceived specifically in the context of minority ethnic communities, and alcohol seemed to be used increasingly to cope particularly with women experiencing more negative consequences compared with men.

> “They [family] thought you know that it was my fault, that I could have done more but I didn’t. Like, why didn’t she keep marriage going? But they thought it’s me to blame but it wasn’t, and they blame it on me and I just wanted something to cheer me up but it got to the point where it [alcohol use] was really bad.
>
> **P15D, female, Pakistani**

The majority of participants, and particularly Black or Mixed participants, enjoyed the high feelings alcohol gave them which reflects the heavy drinking nature of most participants' alcohol use before they received help for their mental health. Among participants whose religion prohibited the consumption of alcohol, they seemed to drink heavily because it was a new experience and seemed to struggle to stop drinking once they had started.

> After drinking some alcohol with lower alcoholic content I felt like it wasn't doing me much, it wasn't giving me that energy that I was looking for, I stepped up to more strong alcoholic drinks.
>
> **P13D, male, Mixed Other**

There were some former drinkers who only drank to fit in with certain groups where there was an expectation to drink alcohol. Therefore, their previous alcohol use was not for enjoyment but instead to be accepted by specific groups, particularly if they joined multiethnic networks and away from the social norms of their community.

> I've only occasionally drunk alcohol but I don't drink alcohol. It was just when we had a work party or something.
>
> **P12ND, female, Indian**

Theme 4

Reasons for changes in drinking

The majority of participants made reductions in their drinking or stopped drinking completely after seeking formal support for their mental health. Feeling comfortable in having conversations around alcohol use was important in overcoming some reluctance in disclosing their drinking habits, though there were mixed preferences around disclosing their alcohol use and receiving formal support from staff of the same ethnicity to them. Preferences among Asian or religious participants seemed to be underpinned by feeling better understood by people from different cultures where drinking may be more acceptable.

> "I met these people who are professionals from other cultures. It's been there from should they drink or they have drinking is not taboo in their culture, so that makes it easier for me to open up [about my drinking].
>
> **P18ND, male, Pakistani**

Participants' wider support networks were important in supporting long-term changes in their drinking, but this also had a positive impact on their relationship with their family and improving the awareness of mental health and alcohol problems across the family and wider community. However, some of these reductions in drinking and increased support from the family or community may have been facilitated by the family or community wanting to re-align the participants' behaviours with that of the family.

> "Well my family, especially my Mum, was really happy when I told her that I was going to stop drinking. She was real happy and was very supportive from that point on, and I've become more close with my Mum.
>
> **P9ND, non-binary, Black Caribbean**

There were also a minority of participants whose drinking had not changed since receiving their mental health diagnosis and this seemed compounded by either having had no changes in their social circumstances and continuing to be socially isolated from their family or community, or by a lack of recognition of the effects of alcohol.

Conclusions and implications

This study is one of the first to explore the experiences of drinking among minority ethnic groups who have a diagnosis of a mental health problem. Our findings highlight the implications of having a limited understanding of mental health problems on how individuals manage their mental health symptoms. There were also implicit cultural expectations which worsened participants' mental health but also informed the way in which they drank alcohol. We also found that, prior to their diagnosis, participants drank alcohol to cope with problems, to seek the effect of alcohol or to fit in with groups, with the majority having heavy drinking sessions and struggling to stop drinking once started. Finally, our findings suggest that changes in drinking were facilitated by discussions with professionals and supported by the wider family and community.

Previous research has established issues around mental health literacy and stigmatisation of mental health problems in minority ethnic groups and its implications on seeking formal support (Lamb, Bower, Rogers, Dowrick, & Gask, 2012; Taak, Brown, & Perski, 2021). However, less research has explored the impact of cultural expectations on mental health and drinking practices. Our findings suggest that, in the context of minority ethnic groups, not meeting cultural expectations may worsen mental health and this may reflect the importance of complying with norms within these groups. We also found that different standards were applied within ethnic groups which were underpinned by gender roles and specific cultural norms. The differences in the expectations of alcohol use between genders is consistent with previous research which has found that drinking among minority ethnic women, particularly Asian women, has negative implications on their reputation and that of their family (Bradby, 2007; Galvani et al., 2013). However, there is relatively limited research on the way in which cultural expectations can affect mental health and seeking support and there is a need to understand how such expectations can be better understood and addressed in communities and support services.

Participants drank for three reasons; to cope with problems, to seek the effect of alcohol and to fit in. These findings broadly map onto both the self-medication hypothesis (Khantzian, 1997) and drinking motives model which outline four reasons for drinking; social, enhancement, coping and conformity (Cooper, Frone, Russell, & Mudar, 1995). However, some of the reasons for drinking were underpinned by not meeting cultural expectations of specific minority ethnic groups or through engaging with groups where alcohol was expected or acceptable. This highlights the importance of considering cultural norms when supporting minority ethnic groups who are experiencing poor mental health or drinking at high levels as minority ethnic groups may require specific support which also addresses the concerns they may have around their mental health and drinking and the impact it may have on them in the community they live in.

We found that participants' experiences with reducing their drinking often took place without formal alcohol support and this is consistent with the literature where it is argued that most individuals reduce their drinking on their own (Tucker, Chandler, & Witkiewitz, 2020). However, reductions in most participants' drinking seemed to be initiated by discussions about their alcohol use with mental healthcare professionals, with long-term changes in drinking facilitated through support from the wider community. This indicates that mental healthcare professionals may play an integral role in helping minority ethnic groups identify problems with their drinking and the role of wider communities in sustaining changes.

Such findings provide further support for current recommendations and guidance around people being able to receive support from different services (Public Health England, 2017), practitioners screening for alcohol use, and the value of community support networks (National Institute for Health and Care Excellence, 2023).

There are several implications of this study. First, the limited awareness of mental health symptoms and the perceptions of mental health problems indicate that mental health professionals could work more closely with minority ethnic communities to increase the awareness of mental health symptoms and the ways in which alcohol can impact mental health while also improving links with such communities. Second, given that implicit cultural expectations could have a detrimental impact on minority ethnic groups' mental health, and inform drinking practices, both mental health and alcohol services should be more aware of the cultural norms of minority ethnic groups and the implications of this, and their willingness to engage with formal services. Third, many participants in this study began making changes to their drinking after being seen by non-alcohol specific services where drinking was briefly assessed. This indicates a need for more consistent assessment of alcohol use across non-alcohol specific services, particularly as minority ethnic groups may be less open to engaging with alcohol services.

Work Package 3

How is alcohol assessed and treated within community mental health services, and how are processes tailored for minority ethnic service users?

Foreword

Using secondary data and interviews with minority ethnic groups, the first two work packages of this project have established i) the patterning of alcohol and mental health problems across ethnic groups, ii) problems in the identification of mental health symptoms among minority ethnic groups, iii) implicit cultural expectations impacting mental health and informing drinking practices, iv) specific reasons for drinking among minority ethnic groups who have a mental health problem, and v) the potential role of mental health professionals and wider community on facilitating changes in drinking habits. However, from these work packages it is unclear how discussions around alcohol take place between mental health staff and service users, and whether approaches are tailored for minority ethnic service users. Through exploring the experiences of those managing support services, mental health staff, and minority ethnic service users, we can better understand how alcohol problems are assessed or treated within mental health settings, and the ways in which minority ethnic groups needs are or can be met when seeking support.

Background

Recent guidelines on the treatment of people with co-occurring mental health and drug/alcohol problems emphasise the joint responsibility of mental health and alcohol services to meet the needs of people with co-occurring problems and develop shared solutions while also making every contact count so that people with co-occurring problems can access support regardless of the service they present to (Public Health England, 2017). Although alcohol and mental health problems tend to be treated separately in the UK, new guidance recommends the use of validated alcohol screening questionnaires within health and social care services when discussing alcohol use with service users, and that staff are trained to deliver these tools (National Institute for Health and Care Excellence, 2023). But it is not known whether alcohol is routinely screened using such tools, and how alcohol problems are treated in community mental health services.

Findings from section 5 of this project indicated that while minority ethnic groups with a mental health problem can benefit from discussing their alcohol use with mental health staff, there may be barriers to disclosing their usage. Previous research has found that discussions around alcohol use with minority ethnic service users could be compounded by the known stigma associated with both mental health and alcohol problems or poor

self-recognition of alcohol problems (Taak et al., 2021), potential implications of disclosing problems (Lamb et al., 2012). However, it is important to consider the perspectives of those who manage or deliver support services given that the scope for the discussions may be limited due to the time pressures on staff. There has been limited research which has explored how discussions around alcohol take place from the perspectives of individuals managing support services, mental health staff and minority ethnic service users even though there are recommendations in place to have such conversations (National Institute for Health and Care Excellence, 2023; Public Health England, 2017). Understanding these perspectives could highlight a range of individual and structural issues and how these impact both mental health professionals and minority ethnic service users, and could have implications on how current consultations and pathways can be adapted to improve engagement with minority ethnic groups and accessing alcohol support.

Aims

Using rapid appraisal methods, we aimed to understand the experiences of disclosing, assessing and treating alcohol use, and how these are tailored for minority ethnic groups from:

1. **Staff managing support services.**
2. **Community mental health staff.**
3. **Minority ethnic service users engaged with community mental health services.**

Methods

This study received ethical approval from the NHS Ethics committee (REC reference: 22/NW/0155) with Lancaster University acting as sponsor.

Participants and sample size

This study purposively sampled participants who manage mental health support services, community mental health staff, or minority ethnic service users. Recruitment was supported through key staff within community mental health services and the North West Coast Clinical Research Network.

Individuals who managed support services were recruited through the project team's own networks, and these services were eligible to take part if:

- They were involved in the policymaking and commissioning decisions alcohol and/or mental health service provision, or in the delivery of services.

Community mental health staff were eligible to take part if:

- They currently work in a community mental health service in Mersey Care NHS Foundation Trust.

Minority ethnic service users were eligible to take part if they:

- Were of non-White British ethnicity.
- Either currently drink or have previously drank alcohol.
- Were engaged with community mental health services in Mersey Care NHS Foundation Trust.
- Were aged 18 or older.

Potential participants were invited to take part in either an online or telephone interview.

Focus groups with community mental health staff were conducted in a face-to-face setting at two Mersey Care NHS Foundation Trust sites.

Interviews and focus groups

In total, 29 participants took part in an interview or focus group from October 2022 to February 2023. Topic guides were developed by the project team and our participatory group of minority ethnic individuals with lived experience of mental health and alcohol problems. All topic guides broadly covered how and whether services accessed alcohol use and whether these measures were tailored for minority ethnic service users, and experiences of asking or answering questions around alcohol use. Topic guides were tailored for each participant group (staff who manage mental health support services, community mental health staff and minority ethnic service users), for example, some of the focus of interviews with staff who manage support services were around priorities of the organisation and training available for staff. All participants were reimbursed with either a £20 high street voucher or BACS payment.

Analysis

A framework analysis was conducted because we sought to understand the experiences of assessing and treating alcohol problems, and how these are tailored for minority ethnic groups among both services and service users. Framework analysis is particularly useful when seeking to identify patterns between different data sources but where key issues are explored across data sources (Gale et al., 2013). In the context of this study, a framework analysis was suitable because the study included qualitative data from three different participant groups (staff managing support services, community mental health staff, and minority ethnic service users), therefore, it was possible to explore potential similarities and differences in the needs of each group. Deductive codes were developed from Public Health England's recommendations on treating people with co-occurring mental health and drug/alcohol problems (Public Health England, 2017), and NICE guidance on the treatment of AUD (National Institute for Health and Care Excellence, 2011)(more recent guidelines from NICE were released after this study took place). Inductive codes were also developed through familiarisation with interview transcripts. Analysis was conducted in NVivo 12 and facilitated by field notes and memos. The analytical process was also facilitated by a second researcher (PM). Data from different participants groups were triangulated using the framework matrix through comparing charted data. Themes and subthemes were reviewed by the project team and participatory involvement group.

Findings

Our framework analysis developed three key themes to understand how alcohol use was screened and treated within community mental health services, and how these were tailored for minority ethnic groups:

i. Barriers to disclosing and seeking support for alcohol problems.

ii. Assessment but not treatment of alcohol problems.

iii. Accessibility and inclusivity of alcohol services for minority ethnic service users.

Theme 1

Barriers to disclosing and seeking support for alcohol problems

There were several barriers for minority ethnic service users which may inhibit the disclosure of alcohol problems and engaging with formal alcohol support. These barriers were at both a structural and individual level and were evident across all interview sources (staff managing support services, community mental health staff, and minority ethnic service users). The main barrier from the perspective of staff and support services was the support available to facilitate discussions around alcohol, particularly where minority ethnic service users did not speak English. Community mental health services used an interpretation service to book interpreters for consultations or as a last resort, family members. However, this could be problematic due to the taboo of alcohol in some ethnic and religious groups and the lack of trust with how information was managed by interpreters.

> "I just remembered asking these kind of questions for alcohol and they [service user] asked the translator to leave the room and we tried to have a conversation, very broken English about it because they had a translator who was from the same community as them went and disclosed to the community because they mentioned something about alcohol or drugs, something that was completely taboo in their community.
>
> **P16, doctor**

For minority ethnic service users, a key barrier was the involvement of other services, such as social, immigration and police services, and how disclosures around alcohol may negatively impact the service users care pathway, ability to access support services or their livelihood. This may also reflect how minority ethnic groups were treated across different services. While this barrier was also raised by staff, service users were particularly concerned about information sharing negatively impacting their livelihood and care.

> I had a lot of social workers involved in the children's lives as well, so I was dubious to tell doctors what was really going on in case of social services.
>
> **P1, service user**

Community mental health staff and those managing support services also identified difficulties in providing appropriate support to service users when there were alcohol problems but a reluctance to engage with alcohol services. While service users emphasised the importance of motivation to engage in making meaningful changes in drinking habits, there was a sense of hopelessness among staff in these cases as consent from the service user was required to begin the alcohol support process. This suggests the complexity in supporting service users with co-occurring alcohol and mental health problems which was exacerbated among minority ethnic service users who may already have additional barriers towards disclosing and seeking alcohol support.

> ...they [service users] at least have to be willing to be looking to change that [drinking] in order to access that [alcohol] service, and that if the patient is not willing to acknowledge that, then it kind of leaves us stuck for what what's their treatment now with us because we're just managing risk at that point.
>
> **P8, community mental health nurse**

Other participants who manage services specifically for minority ethnic groups, highlighted additional barriers, including the stigma of alcohol problems, cultural awareness of staff and implicit biases, which acted as a barrier for disclosing alcohol use and seek formal support for service users. Participants managing culturally specific services suggested a need for the development of specific roles to support minority ethnic groups to help navigate and engage with services.

> The challenge first is the language, the interpreter, the cultural awareness that they [staff] don't know how to speak to treat the other people and about around stigma. A lot of them [staff], they have their own stigma, what they read about, for example in newspaper or what they see in the TV about migrants, asylum seeker, they are like this, they're my community, the Gypsy, the travellers, they are this and they change like they come when they speak with someone. They come with the stigma.
>
> **P3, service provider**

Theme 2

Assessment but not treatment of alcohol problems

Community mental health staff suggested that alcohol was not formally treated within community mental health services, instead brief assessments were made to assess whether and how much a service user was drinking. Formal alcohol tools seemed to only be used where alcohol problems were queried and an alcohol referral was potentially required, or at specific physical health check appointments. This was also consistent with service users where those with a history of alcohol problems recalled their drinking being routinely assessed at appointments with the community mental health team but less so among service users without a history of alcohol problems.

> If we're just getting onto somebody for an assessment, then it's [alcohol] something that's usually always touched on... I personally wouldn't go straight out with anything to audit somebody on alcohol and drug use, it would just be an open question like do you use alcohol?
>
> **P7, community mental health nurse and team leader**

> Yeah, every time. Yeah, they just basically asked me am I'm still off the drink and cannabis... use anything else you know other than the drugs that they've given me.
>
> **P1, service user**

Service users' responses to questions around their alcohol use were rarely challenged by community mental health staff. This seemed underpinned by staff protecting their therapeutic relationship with the service user, and a hesitance in risking the rapport built (or lack thereof). This seemed particularly important when staff were working with minority ethnic service users because of their own knowledge around the stigma of drinking alcohol among these groups.

> If you get into know someone if they're on CPA level of care, then you're going to see them more regularly. You might start to notice things to then you could sort of question that a little bit more, and also you've built a bit more of a relationship with that person, so it's more comfortable if they are saying "no I don't drink" and then presenting as though they are then you can challenge that a little bit more.
>
> **P7, community mental health nurse and team leader**

The assessment rather than treatment of alcohol problems in community mental health services also seemed to be informed by the way in which the service was funded. Staff who manage support services emphasised the issue with different commissioning streams for alcohol and mental health problems because this informs the scope (including the expertise of staff employed to deliver the service) of a service.

> You're either funded through mental health grants or you're funded through addiction grants and even like Commissioners kind of look at it that way don't they? Commission services with different pots of funding... so like our service could provide support around drinking alcohol, but that's not our emphasis for permission to do mental health.
>
> **P2, service provider**

This could be particularly problematic as guidelines around the treatment of co-occurring alcohol and mental health problems recommend that people should be able to access support regardless of the service they are presenting at, however, this may not be taking place.

Theme 3

Accessibility and inclusivity of alcohol services for minority ethnic service users

Both those managing support services and community mental health staff highlighted the issue of limited alcohol services available to service users, with no specific alcohol service for minority ethnic groups. This was particularly problematic for community mental health staff due to the emphasis of treating alcohol problems first which seemed based around the perception that mental health problems can resolve when alcohol problems have been addressed. But this does not consider the known delays in accessing specialist mental health services which can make it difficult for service users to remain abstinent during this period.

There were two main alcohol services that staff, or support services would refer or signpost service users to. Staff preferred to conduct an alcohol referral rather than request service users to self-refer to alcohol services, but both of which were to mainstream alcohol services. There were problems with the alcohol referral process, with both staff and service users highlighting i) that the referral process required access to technology, and ii) some alcohol services stopped engagement when appointments were missed, which could disproportionately affect minority ethnic service users or those from more deprived backgrounds.

> “The patient can self-refer too. But sometimes, obviously you’re trying to get that first push and help them and go, or we do the professional referral wait for the phone call then, like the hard part, they phone them…
>
> **P6, community mental health nursing associate**

Some minority ethnic service users who had previous alcohol problems also believed that community mental health services had less awareness of other types of alcohol support or were less likely to signpost to some alcohol services, such as Alcoholics Anonymous. Service users valued alcohol services with staff or peers with lived experience of alcohol problems because they felt better understood.

> I think if they would have known about fellowship. Whether it be NA, AA or whatever fellowship got because they've got no knowledge about it, I probably would have (engaged with alcohol services).
>
> **P1, service user**

> Some of the counsellors have been there themselves and I find they're the ones you can engage with more because they know what you know what you're talking about. Not to say that the people who come through university and college and as in it's good. But you know, it's all about experience, life, experience.
>
> **P6, service user**

There were some examples of mental health services prioritising accessibility and inclusivity of minority ethnic groups. Such services used demographic data of their service users and worked with primary care services to identify minority ethnic groups less engaged with their service and developed strategies to improve engagement and meet the needs of minority ethnic service users.

> If we think that a client might be more suitable for a different service, often we would either signpost or refer directly to another service. But for minoritised clients we are more likely to offer an initial assessment first and have that conversation with them rather than making the decision.
>
> **P4, service provider**

Conclusions and implications

This study aimed to understand the experiences of screening and disclosing alcohol use within community mental health services, and how processes are tailored for minority ethnic service users. We found that alcohol was assessed rather than treated within community mental health services, and that there were limited alcohol services, of which none provided tailored support for minority ethnic service users. Further, we identified specific structural and individual barriers to disclosing and seeking alcohol support. These barriers were particularly problematic for some minority ethnic groups, particularly those who cannot speak English, groups where alcohol was prohibited, and asylum seekers. While barriers highlighted were broadly similar across staff managing support services, community mental health staff and minority ethnic service users, service users emphasised the importance of motivation to engage and value of lived experience when being treated for alcohol problems.

As mentioned elsewhere in this report, recent guidelines highlight the need for mental health and alcohol/drug services to work together to meet the needs of people with co-occurring problems (Public Health England, 2017) and the recommended use of formal alcohol screening tools (National Institute for Health and Care Excellence, 2023). Findings from this study indicate that formal assessment tools were rarely used in community mental health services, and only when an alcohol referral or appointment required it. Further, while community mental health services, and other mental health services, signpost to alcohol services or facilitate the referral process, there is limited scope for service users to access specialist mental health services when there are indications of alcohol problems but a reluctance to engage with alcohol services. Previous research indicates that the level of routine screening of alcohol use across other healthcare services is mixed (Klingemann et al., 2019; Sterling, Kline-Simon, Wibbelsman, Wong, & Weisner, 2012), and may depend on the type of healthcare setting (e.g. inpatient vs community) and demographics of service user (e.g. age). We found that the way in which mental health and alcohol services were funded also made it difficult for community mental health services to support people with co-occurring problems as staff were limited in their capacity and expertise to assess and treat alcohol problems.

We also found that there were limited resources in place to facilitate discussions around alcohol use with minority ethnic service users, instead there is a reliance on interpreters or family members. However, our findings suggest that there were issues with this approach. This is consistent with previous qualitative research which found that Black groups were less open to engage with formal substance services due to fears of family and peers finding out (Pinedo, Zemore, & Mulia, 2022), and the presence of other people at appointments may exacerbate this. In the context of this study, it may be that there is a need to tailor mainstream services for minority ethnic groups or for the development of minority ethnic

specific services to improve the accessibility and appropriateness of services, however, current research on this is mixed and limited (Gleeson et al., 2019; Heim et al., 2004).

Our study also indicates that motivation to change and willingness to engage with alcohol services are key to conducting referrals to alcohol services and for service users to access other specialist mental health services which has been consistently shown as barriers to seeking and engaging with alcohol treatment (Choi, DiNitto, & Marti, 2014). A lack of willingness to engage with alcohol services may be compounded by a lack of recognition of alcohol problems (Taak et al., 2021), indeed we found that minority ethnic service users who had previous problems with alcohol recognised this through engagement with individuals with lived experience of alcohol problems and it subsequently led to engagement with alcohol services. This suggests that lived experience may be important in helping minority ethnic groups to identify and engage with alcohol support. While recent guidance on screening and treating alcohol problems recommends the use of community support networks and self-help groups for those with alcohol problems (National Institute for Health and Care Excellence, 2023), our findings reflect a lack of implementation of referring to these networks in community mental health services.

There are several implications of this study. First, the limited implementation of recommendations around supporting people with co-occurring alcohol and mental health problems and consistent screening of alcohol use highlight the need to develop and deliver resources and training to support services (and staff) to screen alcohol use in a culturally appropriate way. Second, we identified some barriers to formally screen alcohol use in community mental health services, but more research is needed to understand the practicality of implementing the recommended alcohol screening guidance, particularly when screening minority ethnic service users. Third, where alcohol problems are identified with minority ethnic service users but a reluctance to engage with alcohol services, community mental health staff should discuss both formal and informal alcohol support services and identify potential barriers for the service user and develop solutions to overcome these barriers. Fourth, there is a need for a broader range of alcohol services available to minority ethnic service users, and referral processes should be adapted to address culturally specific barriers to engaging with such services.

Discussion and recommendations

This project used mixed methods to understand i) the associations between mental health and alcohol use among minority ethnic groups in the UK, ii) experiences with alcohol among minority ethnic groups who have a mental health problem, and iii. how alcohol is screened and treated in community mental health services. There are several key findings and recommendations outlined below based on the findings from each work package of this project which have implications for researchers and academics, local government, and health services.

Key findings

The prevalence of hazardous drinking is highest among White British groups, but is also common among White Other, Black Caribbean and Indian groups

After combining multiple large-scale secondary data sources together, we found that 36% of White British, 27% of White Other, 15% of Black Caribbean, and 17% of Indian groups also drank at hazardous levels. It has previously been reported that the hazardous and above levels of drinking across minority ethnic groups is lower, for example 7.1% of Black/Black British groups and 3.7% of Asian/Asian British groups (McManus et al., 2016), however, our findings suggest that there are differences in the prevalence of hazardous drinking when using more specific ethnic categories (e.g. Black Caribbean, Indian).

When comparing the prevalence of hazardous drinking between ethnic groups with and without mental health problems, we found that Indian groups with mental health problems are more likely to drink at hazardous levels compared to Indian groups without. A similar trend, though not statistically significant, was found among Black African groups with mental health problems. This indicates that ethnic groups who drank at the highest levels are not necessarily those more likely to drink at hazardous levels when experiencing mental health problems. Previous research has found that there are differences in the acceptability and drinking practices in specific minority ethnic and religious groups (Bayley & Hurcombe, 2010), and that some minority ethnic groups may be less likely to seek formal mental health support due to the stigma association with mental health and previous experiences of racism with services (Kapadia, 2023), therefore, this may reinforce the use of alcohol to cope but the nuances between specific ethnic groups have seldom been explored.

There is an under representation of minority ethnic groups recruited in large scale surveys, and there are inconsistencies in the way in which ethnicity is categorised across these surveys which has implications on the ability to conduct meaningful enquiry between ethnic groups

To understand the patterns of alcohol use and its associations with mental health across specific minority ethnic groups, it is crucial that sufficient numbers of participants from minority ethnic groups are recruited, and that the specific ethnic category is recorded in datasets (e.g. Indian). Previous research has established that there are issues with the number of specific minority ethnic groups recruited in research (McHugh & Weiss, 2019) which we tried to overcome through combining data from eight different data sources. Despite having a range of datasets to draw on, there remained discrepancies in the way in which minority ethnic groups are categorised (e.g. Mixed, White and Black Caribbean) as well as problems from small numbers for some ethnic groups making it difficult to report the prevalence and associations of alcohol and mental health among Mixed, Chinese, Arab and Other White minority ethnic groups. Such continued problems have implications on the i) ability to conduct meaningful analyses to enhance our understanding of the patterns of drinking across minority ethnic groups, and ii) allocation of support services due to the poor recording of ethnicity in existing datasets.

Minority ethnic groups drink to cope with the problems they are experiencing, to seek the feeling alcohol gives them, or to fit in

Our qualitative findings suggest that there are specific reasons why minority ethnic groups drank, which centre around drinking to cope, drinking to seek the effect of alcohol, or to fit in. These reasons broadly lend support to some psychological theories, such as the self-medication hypothesis (Khantzian, 1997) and drinking motives model (Cooper et al., 1995) but also indicate how the perception of alcohol and mental health problems, and the implicit cultural expectations impact on these issues among minority ethnic groups. Previous qualitative research among young African refugee groups found that some drank to cope with trauma while others found that the normalisation of alcohol in social groups reinforced drinking (Horyniak, Higgs, Cogger, Dietze, & Bofu, 2016) which indicates that there may be a range of reasons why minority ethnic groups drink and this should be established when assessing alcohol use.

We also found that minority ethnic women often report social isolation from their family and community if they are seen to not meet cultural expectations or are seen to be drinking. In some experiences, the expectations of women and the way in which they are treated as a result, reinforced the use of alcohol to cope. While drinking in women may be increasing

among some minority ethnic groups (Galvani et al., 2013), women continue to experience worsened consequences for drinking. There is a need further understand the reasons for drinking among minority ethnic groups who are seeking support for their mental health, and the consequences of drinking within specific ethnic groups, to establish whether other support is needed.

Screening for alcohol use in mental healthcare settings can prompt changes in drinking habits

Our qualitative findings suggest that minority ethnic groups have a limited understanding of their drinking habits and how this could impact their mental health. We also found that initial changes in drinking habits are made through the conversations around their alcohol use when seeking formal support for their mental health. While there has been new guidance which outlines the need for services and practitioners to use formal alcohol assessment tools, and where appropriate, identifying appropriate alcohol support when discussing alcohol use with service users (National Institute for Health and Care Excellence, 2023). Our findings indicate that screening for alcohol use can be beneficial for minority ethnic service users, but this is not being done routinely and that factors, such as the therapeutic relationship between staff and service users and the involvement of others, act as barriers in implementing this screening.

The availability of services for co-occurring alcohol and mental health problems depends on the funding source, priorities of the organization and expertise of staff

It is recommended that alcohol and mental health services have a joint responsibility to support people with co-occurring alcohol and mental health problems (Public Health England, 2017), however, findings from our research suggest that this is difficult when alcohol and mental health services are funded through different streams and where referral processes are reliant on service user consent and willingness to engage. This can also disproportionately effect minority ethnic service users as we found that they are concerned with how their information would be shared and used and so may be reluctant to disclose alcohol use and engage with services.

There is evidence of culturally adapted and culturally responsive mental health therapies to meet the needs of minority ethnic service users: the former is typically delivered by members of a specific group and adapts an existing therapy to a particular community whereas the latter involves staff valuing diversity and make adaptations using evidence-based (Beck, Naz, Brooks, & Jankowska, 2019). In our research, we found that there was a mixed preference for services to be delivered by minority ethnic staff, however, we found some mental health services are conducting outreach work to minority ethnic communities and primary care services to tailor their services and referral processes for minority ethnic groups, but it is not yet clear how effective this approach is.

Mental health staff are aware of the stigma associated with drinking and this can be challenging when assessing alcohol use with minority ethnic groups

We found that community mental health staff are often aware of the issues minority ethnic groups experience when disclosing their alcohol use and can be hesitant to challenge responses in case of a breakdown in the therapeutic relationship, particularly when other people were present at appointments. There has been relatively limited research on the cultural understanding of alcohol use among mental health staff, however, there is evidence to suggest that some of these issues can be compounded by the limited training and understanding mental health staff have in addressing alcohol problems or supporting service users with co-occurring problems (Deans & Soar, 2005; van Boekel, Brouwers, van Weeghel, & Garretsen, 2013). This may worsen when staff are treating minority ethnic groups where they already understand how alcohol may be perceived in the service user's community but have received less training in delivering support in culturally appropriate way. It may be that community mental health services adopt a culturally responsive approach, through delivery of cultural-specific training, which could enable staff to address potentially sensitive topics even in the presence of other people at appointments.

A need for clear communication, honesty and trust within the therapeutic relationships to enable discussions around alcohol use between staff and minority ethnic groups

Throughout this project, we found that minority ethnic service users have concerns with how their information will be used and shared with other services, and whether this will impact other aspects of their livelihood. This was particularly important in the context of minority ethnic service users whose religious backgrounds or gender may result in particularly negative consequences, or where service users may have limited access to governmental support. Our findings are consistent with previous research which has shown a level of distrust from minority ethnic service users with staff, and how information will be used (Douglass et al., 2023; Pinedo et al., 2022). Therefore, there is a need to emphasise clear and transparent communication from staff to minority ethnic service users.

Implications and recommendations

Large scale UK surveys should be better representative of minority ethnic groups through financing and recruiting adequate numbers of minority ethnic groups

Given the continued issues with establishing drinking patterns and associations with mental health across specific minority ethnic groups, researchers and academics collecting data for large-scale surveys should actively over-sample minority ethnic groups, including specific mixed ethnic groups. This will allow for more accurate analysis and representation of minority ethnic groups in mental health and alcohol research. Similarly, healthcare professionals and staff working in healthcare should accurately report ethnicity in records, and ensure that reporting of ethnic group is specific, e.g. Indian. This will allow for a more accurate reflection of service users and allow for other organisations to report ethnicity in a similar way which may also help services identify key ethnic groups not presenting to their service.

A need for mental health and alcohol services to take a culturally appropriate preventative approach with minority ethnic groups to help with better identification of problems and when to seek support

Our research suggests that there is current work under way to identify ethnic groups not presenting to their service and working with primary care services and minority ethnic communities to adapt referral processes, but this is not common practice. There needs to be further work between local government, mental health and alcohol services and minority ethnic communities to identify the barriers to recognising mental health and alcohol problems and seeking formal support. Such work should involve how barriers can be addressed, and whether processes can be tailored to improve access and engagement with minority ethnic groups. This could directly improve the level and diversity of ethnic service users seeking formal support and indirectly improve the relationships between services and minority ethnic communities.

More consistent screening of alcohol use using formal alcohol tools in mental health services, and better identification of the range of alcohol services

This project has highlighted how recommendations around the screening of alcohol problems using formal alcohol tools have not been consistently implemented in community mental health services which can have implications on future alcohol assessments and receiving appropriate support. During the write-up of this report, NICE updated their guidance on screening and treating alcohol problems (National Institute for Health and Care Excellence, 2023), and our findings provide further support of these updates as mental health staff should consistently screen for alcohol use, regardless of history of alcohol use, and report this accurately in patient records. Where problem drinking is identified or suspected, a range of alcohol services should be recommended to minority ethnic groups, including mutual support groups and organisations that can be accessed discretely. This could i) result in more accurate reporting in patient records, ii) identify people who may have started drinking, and iii) identify services that might be preferable to some minority ethnic service users.

Provide cultural-specific training for mental health staff and organisations who support minority ethnic groups with mental health and/or alcohol problems

We have highlighted how community mental health staff rarely challenge service user responses to questions around alcohol use, and how this can be problematic for minority ethnic service users who may need alcohol support but are reluctant to disclose this. We have also highlighted how services who specifically support minority ethnic groups have observed how health services are limited in the ability to communicate appropriate with some minority ethnic groups. Therefore, local governments or managers of such organisations should deliver culturally specific training around addressing and managing disclosures of alcohol use with minority ethnic service users. This could also improve minority ethnic service users' experiences with services and improve relationships with staff.

Better communication between staff and minority ethnic service users on how and why data on alcohol use is being collected

We have shown that there is a level of distrust among minority ethnic service users in disclosing alcohol use to staff, particularly in the context of whether alcohol was accepted in the community or where other people or services were involved. Therefore, community mental health staff should be clear prior to assessing alcohol use, how information will be

managed and where the information will be shared. Having transparent communication can also help to break down barriers between staff and minority ethnic service users.

Strengths and limitations

There are several unique strengths of this project and studies. First, using large-scale survey data that is representative of the general populations, we are one of the first studies to establish the drinking patterns of specific minority ethnic groups, and their associations with mental health problems. Second, using qualitative methods, we have been able to explore the mechanisms of drinking among minority ethnic groups who have a mental health diagnosis with clear indications of how and why alcohol may be used to cope. Third, through rapid appraisal methods we have been able to explore the perspectives of assessing, supporting and disclosing alcohol use from service providers, community mental health staff and minority ethnic service users. Fourth, through combining both quantitative and qualitative methods, we have been able to provide a unique insight into the relationship between alcohol and mental health problems among specific minority ethnic groups, and how gender, religion and other factors can impact how minority ethnic groups use alcohol and are treated in the community.

There are some limitations of this project and studies to highlight. To begin with, while we have established the drinking patterns and associations with mental health problems across specific minority ethnic groups, we have not been able to do so with Mixed, Arab, Chinese and other ethnic groups due to issues with small numbers and the way in which some ethnic groups are categorised in large-scale surveys. Second, we have shown nuances in the experiences with alcohol among minority ethnic groups, particularly those from some religious groups and women, however due to the broad scope of our ethnicity inclusion criteria, there may be further nuances between specific ethnic, cultural and demographic groups which warrant further exploration.

Conclusions

Using mixed research methods, we have established that there are different drinking patterns, and associations with mental health problems, across specific minority ethnic groups and the pressing need for future population research to recruit sufficient minority ethnic groups and use specific ethnic categories in population-level datasets. We have highlighted how the motivations of drinking among minority ethnic groups are centred around drinking to cope with problems, to seek the effect of alcohol, or to fit in with social groups, and the negative implications for women and those from religious groups when found to be drinking. We have also shown the limited implementation of formal alcohol screening tools in community mental health services, and factors including, stigma, involvement of other services, and use of interpreters can impact on disclosing drinking habits. This project highlights the need for mental health services to take a proactive preventative approach to improve the recognition of alcohol and mental health problems, and where minority ethnic groups can access support.

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