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Exploring experiences with alcohol and how drinking has changed over time among minority ethnic groups with a diagnosed mental health problem

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ABSTRACT

Introduction: Minority ethnic groups are more likely to experience poor mental health but less likely to seek formal support. Mental health problems and alcohol use (including non-drinking) co-occur, the reasons for this among minority ethnic groups are not well understood. This study explored i) alcohol use among minority ethnic individuals with a mental health problem,ii) how alcohol was used before individuals received support for their mental health,iii) how alcohol changed whilst and after individuals received treatment for their mental health.
Methods: Participants were purposively sampled through community/online mental health organisations. Participants took part if they i)were not White British, ii) had a mental health diagnosis, iii) drank at hazardous and above levels or former drinkers. Telephone/online semi-structured interviews were conducted. Data were analysed using framework analysis with an intersectional lens.
Results: 25 participants took part. Four themes were developed; "drinking motivations", "mental health literacy and implications on drinking behaviour", "cultural expectations and its influence on mental health problems and drinking practices", and "reasons for changes in drinking". Themes reflect reasons for drinking and the role of understanding the range of mental health problems and implicit cultural expectations. An intersectional lens indicated gendered, ethnic and religious nuances in experiences with alcohol and seeking support. Engaging with formal support prompted changes in drinking which were facilitated through wider support.
Conclusion: There were specific reasons to cope among minority ethnic individuals who have a mental health problem. Applying an intersectional lens provided an insight into the role of cultural and gendered expectations on mental health and drinking practices. Mental health literacy and implicit cultural expectations within specific minority ethnic groups can affect both mental health and drinking practices. Healthcare professionals and wider community play an important role in prompting changes in drinking among minority ethnic groups who have a mental health problem.

1. Introduction

In England and Wales, 74.4% of the population are White British, 6.2% White Other, 4% Black, 9.3% Asian, 2.9% Mixed and 2.1% Other ethnicity (Office for National Statistics). Approximately 17% of White British, 14% White Other, 23% Black/Black British, 18% Asian/Asian British, and 20% Mixed or Other ethnic groups reported a common mental disorder (defined as a depressive or anxiety disorder) in the

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United Kingdom in the past week (Baker, 2020). Compared to White populations, significantly higher risks of diagnosed severe mental illness (defined as psychoses) have been found in minority ethnic groups, with risks higher among Black African groups (Halvorsrud et al., 2019). Minority ethnic groups might be at a higher risk of experiencing poor mental health because of the additional stressors and disadvantages they experience, such as childhood adversity, higher levels of unemployment and racial discrimination (Wallace et al., 2016; Williams, 2018). However, minority ethnic groups are less likely to seek formal support for their mental health which might be exacerbated by the lack of awareness and stigma associated with having a mental health problem (Bignall et al., 2019; Leamy et al., 2011).

While the prevalence of hazardous or harmful alcohol use is lower among minority ethnic groups compared to White British groups in the United Kingdom (Institute for Alcohol Studies, 2020), there are differences in the prevalence of drinking across specific minority ethnic groups (Bayley and Hurcombe, 2010). For example, Black African groups are more likely to abstain from alcohol and drink less compared to Black Caribbean groups. It is also known that individuals experiencing poor mental health are more likely to drink at hazardous and above levels (Puddephatt et al., 2021) and associations between poor mental health and non-drinking have also been found (Puddephatt et al., 2021; Skogen et al., 2011). The causal direction between alcohol and mental health problems has been long debated. The commonly cited self-medication hypothesis argues that worsening mental health increases the use of alcohol as a means to modulate affect and alleviate symptoms of poor mental health, however, this can become a maladaptive coping technique which could increase the risk of having an alcohol use disorder (AUD (Khantzian, 1997),). Elsewhere it is argued that it is the reverse. Research which has tested the directionality between alcohol and mental health problems has shown stronger evidence of the self-medication hypothesis (Treur et al., 2021; Bell and Britton, 2014).

There has been limited research to understand patterns of alcohol use and mental health across ethnic groups. Due to the stigma associated with having a mental health problem among some minority ethnic groups, individuals from these backgrounds may seek to manage their mental health on their own which could lead to increased alcohol consumption to cope. Such drinking practices may also be hidden due to the way in which alcohol is perceived in communities (Gleeson et al., 2019). The ability to identify poor mental health and the use of alcohol to cope may be inhibited due to the provision of siloed alcohol and mental health services in England. It is also known that other factors may exacerbate mental health problems and alcohol use among minority ethnic groups, including gender, migration, and religion. For example, alcohol is more accepted in some religious communities and genders compared to others (Gleeson et al., 2019) which may be influenced by the ethnic diversity of an individual's local area (Bé et al., 2011) or social network (Heim et al., 2004). Intersectionality theory considers the differences in the experiences with specific groups, and how other statuses interact (Crenshaw, 1991). In the context of the current study and with its focus on experiences with alcohol among minority ethnic groups with a mental health problem, it is known that other statuses, such as gender and religion, play a role in both alcohol use and mental health. Intersectionality allows for a deeper understanding of how the interplay within and between statuses influence drinking behaviours, mental health and seeking support (Routen et al., 2023). Quantitative evidence has shown how an intersectional approach can identify groups less likely to engage or receive treatment for their mental health (Rhead et al., 2022) and mental health inequalities (Moreno-Agostino et al., 2023). A qualitative systematic review indicated that, for alcohol and other drug use, stigma intersected with citizenship status, race, ethnicity, and gender among migrant and minority ethnic groups (Douglass et al., 2023). Yet there has been limited qualitative research which has taken an intersectional lens to explore experiences with alcohol among minority ethnic groups with a mental health problem, while considering the interplay within and between statuses such as gender and religiosity.

Taking an intersectional approach, this study aimed to understand; i) how alcohol is used among individuals with a mental health problem from a minority ethnic background, ii) how alcohol may have been used before someone received support for their mental health, and iii) how alcohol may have changed whilst and after receiving treatment for their mental health problem and how it may relate to the level of treatment received.

2. Materials and methods

This study received ethical approval from the Lancaster University ethics committee (ref: FHM-2022-0685-RECR-2). The following methods and results are reported using the Consolidated Criteria for Reporting Qualitative Research Checklist (Tong et al., 2007).

2.1. Participants and sample size

Participants were purposively recruited through gatekeepers from community mental health and minority ethnic group organisations, such as Mary Seacole House and McPin Foundation. This was extended to online mental health organisations and social media to improve recruitment rates. Participants were eligible if they i) were non-White British, ii) had a mental health diagnosis, iii) either currently drink alcohol at hazardous or above levels (defined as having an Alcohol Use Disorder Identification Test (AUDIT) score of 8 or above) or former drinkers, iv) were aged 18 or older. Participants were eligible if they had a previous AUD diagnosis which occurred more than two years ago. Due to concerns around participation in this study and its impact on participants' recovery if they have had a recent AUD diagnosis, individuals with a self-reported current AUD or one in the last two years were excluded. As we took an intersectional approach, we aimed to recruit an equal number of current and former drinkers as well as individuals from a range of minority ethnic, and demographic backgrounds. Eligibility was confirmed by a female doctoral researcher JP, and once confirmed, the date and time of interview was arranged.

2.2. Interview topic

Topic guides were developed by the study team, participatory involvement group of minority ethnic individuals with lived experience of mental health and/or alcohol problems, and stakeholder group of members from mental health and minority ethnic organisations (see full interview topic in Supplementary Materials). 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.

2.3. Procedure

Gatekeepers of organisations and online organisations were informed of the study brief and eligibility criteria. Participants who expressed an interest in taking part were sent a participant information sheet outlining the aims and procedure, via email, by JP. Participants were encouraged to ask questions about the study before agreeing to taking part. After participants confirmed that they met criteria for the study and agreed to take part, JP sent all participants a demographic questionnaire, and for current drinkers, the AUDIT, to confirm that they drank at hazardous or above levels along with a consent form to complete these questionnaires.

Once confirmed as eligible and consent forms and questionnaires returned, the date and time of the interview was arranged. Interviews were conducted by JP and audio-recorded using a digital Dictaphone with only the researcher present. Upon completion of the interview, participants were debriefed and reimbursed with either a £20 high street

voucher or Bacs payment for their time. All participants were sent a copy of their transcript to confirm its accuracy. No relationship was established between participants and the researcher prior to the study commencement. No repeat interviews were conducted.

2.4. Analysis

As this study took an intersectional approach to explore the experiences of alcohol use before and after people received a mental health diagnosis who either currently drink at hazardous and above levels or no longer drink alcohol, a framework analysis was conducted. Framework analysis is a matrix based analytical method which is characterised by classifying and organizing data according to concepts and emerging categories (Ritchie et al., 2013). The use of framework analysis allowed us to more distinctly explore different perspectives across participants with different characteristics and how statuses, such as ethnicity, gender, and religion, interact and inform alcohol use and seeking support (Ritchie and Spencer, 2002; Gale et al., 2013).

Interview transcripts were read and re-read with notes for each participant taken to familiarise with the transcript. JP then inductively and deductively coded a minority of transcripts based on the study aims. JP developed an initial working analytical framework which was shared with a postgraduate second researcher who reviewed and coded the same transcripts. Initial coding was reviewed by JP and MB and final revisions to the analytical framework were made. JP then applied the analytical framework to all transcripts and then charted data into a framework matrix using Microsoft Excel which provided summaries of each code per transcript, including further interpretations of the data (see an example in Table S1). The data in the matrix was interpreted closely with summary reports from NVivo 12 to ensure that developing themes were an accurate reflection of raw data and potential themes were discussed with the project team. Throughout the analyses, JP made field notes during the interviews and made further reflexive notes and memos about the data (see reflexivity statement in Supplementary materials). Themes and subthemes were reviewed by the study team and participatory involvement group.

3. Results

Thirty-two participants expressed an interest in taking part, two were not eligible, one cancelled their interview without reason, and four could not be contacted. Twenty-five semi-structured interviews (ten drinkers and 15 former drinkers) were conducted by JP either online or by telephone between April and September 2022. The mean duration of interviews were 39 min and 40 s. The majority of participants were self-defined as having a Black African background, and the majority were male (see Table 1). Participants had a range of mental health diagnoses.

Four themes were developed which describe drinking motivations before participants sought support for their mental health and/or drinking, the role of understanding mental health problems and cultural expectations on mental health, and seeking formal support which influenced past and current drinking habits. Each theme and subtheme are described in more detail below though there were gender and cultural nuances in participants' experiences with alcohol and seeking support. The thematic map illustrates the links between themes (see Fig. 1).

3.1. Theme one: drinking motivations

There were different but specific motivations for drinking among current and former minority ethnic drinkers before they received their mental health diagnosis. Some of these were underpinned by the cultural expectations of the family and/or community in terms of the settings they drank in, how much and the reasons why they drank. Also underpinning this theme was the understanding of mental health problems within the family and/or community where some participants, such as men from a Black background, believed that their mental health needed to be managed on their own and, over time, drank to cope.

Table 1
Participant characteristics.

Characteristics		*N*
Drinking status	Drinker	10
	Former drinker	15
Ethnicity	Black African	7
	Black Caribbean	4
	Black Other	1
	Indian	2
	Pakistani	3
	Bangladeshi	1
	Chinese	1
	Black and Asian	1
	White and Asian	2
	Mixed other	2
	White Other	1
Gender	Male	18
	Female	6
	Non-binary	1
Age (range)		23–62
Mental health diagnosis	Depression	12
	Anxiety	6
	Bipolar disorder	2
	Post-traumatic stress disorder	1
	Obsessive-compulsive disorder	3
	Schizophrenia	1
	Borderline personality disorder	1
	Mixed personality disorder	1
	Schizoaffective disorder	1
	Thought disorder	1
	Anorexia nervosa	1
AUDIT score	Hazardous (8–15)	3
	Harmful/probable dependent drinker (16–40)	7

Before participants received their mental health diagnosis, many described extensive drinking sessions where they struggled to stop drinking once they started. Over time, most participants described their drinking habits and levels of drinking directly affecting other aspects of their life, including their work and relationships. Within this theme, there were nuances in drinking to cope with problems and drinking to seek the effect of alcohol. Women, and particularly those from a religious or Asian background, seemed to experience limited support from the wider family and community if their problems contradicted the expectations held of them and so alcohol was used as a resource to cope. Whereas alcohol use was generally known to others for participants from non-religious Black, Mixed or White Other backgrounds, but the extent of drinking was hidden from key figures. However, dismissals of concerns raised by peers or family seemed to be more accepted when the dismissal was from a man.

3.1.1. Subtheme: Drinking to cope with problems

Participants experienced a range of problems before their mental health diagnosis, including significant life events (e.g. divorce, traumatic events) and symptoms of poor mental health. Some of these issues were exacerbated by how they were perceived within their community and alcohol was used increasingly to cope with these problems because of the implications these issues could have on both them and their family.

> "I was struggling with my sexuality because I was finding it difficult to accept that I wasn't straight and I am gay an' I've come to terms with that now … but I fell into the wrong crowd, as in at university, first with drinking and [drinking] became a way of running away from my personal issues" (P18ND, man, Pakistani)

For others, they struggled to cope with significant life events before getting support for their mental health, most notably relationship breakdowns, family losses, experiencing childhood abuse and migration.

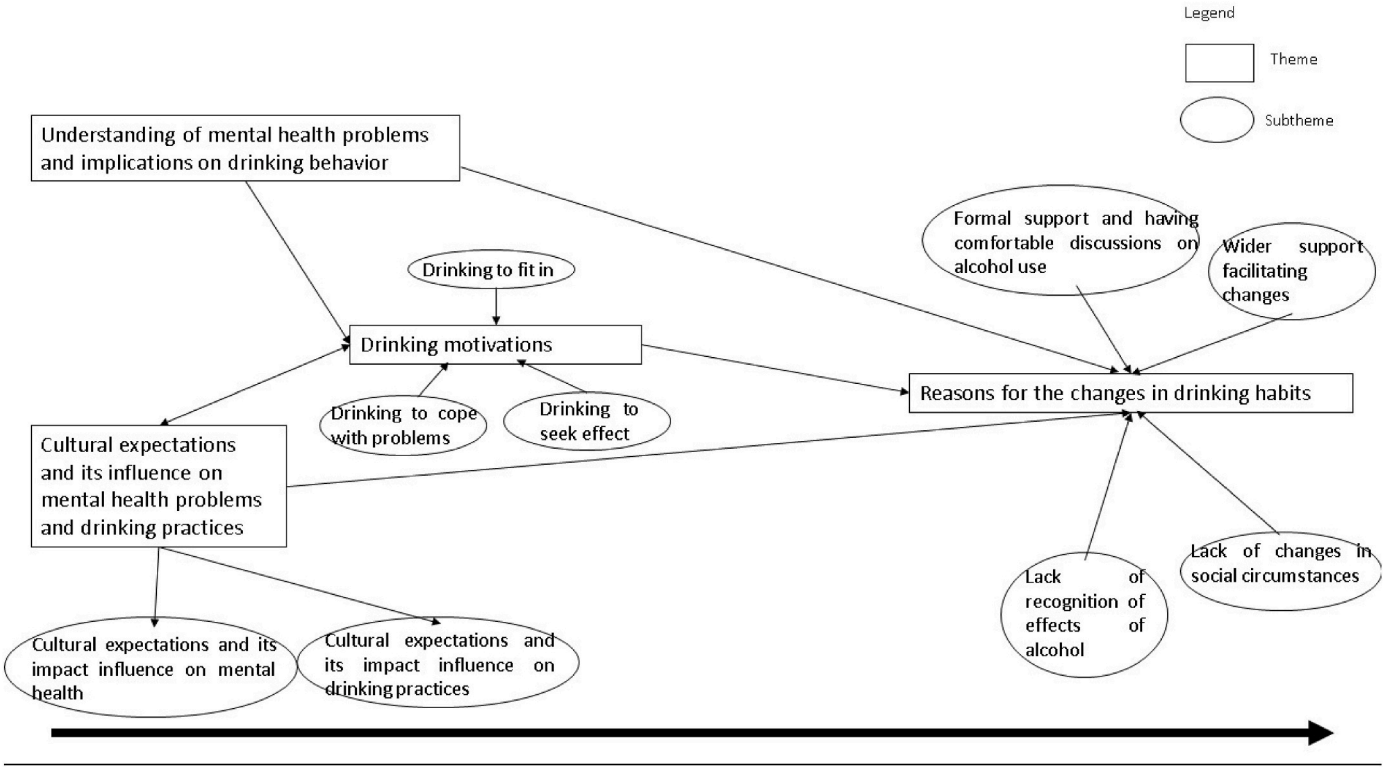

Fig. 1. Thematic map.

Alcohol was used during this time to cope with the emotions they experienced in relation to these events.

> "my drinking increased in about [year] because I was in a difficult relationship so it was quite a bit (pause), like the relationship wasn't working and then we split up" (P14D, woman, White Other)

Some of these problems were underpinned by the way in which events were perceived by the family or community whereby expectations were held of participants from specific ethnic and gender backgrounds. For example, below is an excerpt from a woman from a religious Asian background who described how alcohol was used to cope with the problems they were experiencing and how they were being treated by their family and community. Such experiences suggest a lack of support compounded problems and reinforced the use of alcohol to cope. This was less salient for men from a range of non-religious and ethnic backgrounds indicating differences in the ways in which women were perceived and supported through difficult times.

> "they [family] thought that it was my fault, that I could have done more but I didn't. Like, "why didn't she keep marriage going?" … I just wanted something to cheer me up but it got to the point where it [my drinking] was really bad." (P15D, woman, Pakistani)

Others described using alcohol to cope with specific symptoms (particularly anxiousness and low mood) that they were experiencing though this seemed more of a retrospective account because they had not recognized that their symptoms were indications of poor mental health at that time.

> "I don't think I was ever addicted physically addicted to alcohol, but I've always relied on alcohol to relieve anxiety" (P14D, woman, White Other)

3.1.2. Subtheme: Drinking to seek the effect of alcohol

Many participants enjoyed and sought the feeling they would achieve through drinking alcohol. Across interviews, such experiences were salient among men from Black or Mixed backgrounds where the feelings they achieved through drinking alcohol encouraged heavier drinking occasions before they received help for their mental health.

> "After drinking 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, man, Mixed Other)

For participants or whose family and community were religious, for example of Muslim or devout Christian faith where alcohol was prohibited, the use and effects of alcohol were new but hidden experiences. Alcohol seemed to be used in excess because participants had not previously been able to experience this before.

> "We didn't grow up with [alcohol], it was a taboo. I think it's like giving a child, a new toy … so it's almost like the excitement, of living away from home and being able to do all the things that you couldn't do at home" (P18ND, man, Pakistani)

Drinking sessions seemed purposeful in that participants sought more alcohol and experimented with different drinks so that they could achieve feelings of elatedness. The extent to which participants' drinking habits (and sessions) were generally known to family and the community varied across participants from different gender, ethnic and religious backgrounds. For example, drinking habits seemed more known to others for participants (regardless of gender) from a non-religious, Black, Mixed or White Other background. However, even where alcohol use was acceptable, the extent of drinking could be purposefully hidden from key members of the family or community due to the way in which alcohol was perceived.

> "Most times if my mum visited me in my own apartment she kind of supervised the environment, checked my fridge. Most times she kept seeing alcohol [laughs] in my fridge, she kept asking me if I was the one drinking them and I told her "no, no it's just there for my friends". Until the day that … she came in and she saw me drunk …

so that was the day she knew that I was actually the person that was consuming all of the alcohol" (P5D, man, Black African)

Where drinking was known to others, participants' peers and family had become concerned about their drinking, which were largely dismissed because participants felt that their drinking was manageable indicating differences in the perceptions of drinking habits where some participants perceived alcohol as a personal choice and one that could not become a problem. However, there was a gendered response to this dismissal; peers and family members seemed to accept this dismissal from men rather than women.

3.1.3. Subtheme: Drinking to fit in

For some non-drinkers, before their mental health diagnosis, they drank because of the people they were around and the expectation to drink alcohol indicating a need to be accepted within a group and drinking lightly.

"I've only occasionally drunk alcohol but I don't drink alcohol. It was just when we had a work party or something" (P12ND, woman, Indian)

For other religious groups or those who had migrated to England, drinking was encouraged in multiethnic social groups and there was pressure to drink in these environments. This may have been compounded by participants being removed from the norms of their community and a perceived need to fit in with groups. However, these participants placed restrictions on their drinking where alcohol was not drunk on religious days indicating a view that drinking was permissible only when it did not conflict with religious practices.

"… that would be a Friday. I have to do a special prayer on Fridays, so I really didn't drink on Fridays" (P4ND, man, Pakistani)

3.2. Theme two: Mental health literacy and implications on drinking behaviour

There was a limited understanding of mental health problems across participants which seemed to stem from the perceptions and understanding from older generations in their family and community. There were some indications of this improving among some Asian communities or where participants had relocated to multicultural communities but common mental health problems, in particular, were less understood and recognized as a mental health problem. This was particularly salient among men from a Black background where mental health problems (and symptoms) were often described as temporary issues. Such perceptions may also be compounded by the gender expectations held within ethnic and/or religious communities, for example men from a Black background described how they did not feel that it was acceptable for a man to feel low. However, for women, such problems appeared less taboo.

"So if you say you're depressed or that, they [family] tell you to get up and do something, "Be a man", because you're not supposed to show a sign of weakness" (P6ND, man, Black Caribbean)

The perceived causes of mental health problems differed between participants from different ethnic groups. Among Asian participants, mental health problems were often depicted as deriving from bad spirits and with negative connotations.

" [psychosis] would be talked about as really not good thing. 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, man, Pakistani)

"most people tend to think that mental health has to do with people that have psychosis … for those of us who just have depression, nobody seems to think of it as mental health. Just think of you as not happy." (P8ND, man, Black Caribbean)

The perception of mental health problems held by the family and community seemed to contribute towards participants', but particularly men, reluctance to seek formal support and attempt to manage their mental health on their own where alcohol was used to cope for some. This lack of understanding contributed towards delays in identification and accessing timely interventions, hence the links between themes "understanding mental health and implications on drinking behaviour" with all other themes.

"Mental problems, no talk about mental problems in Pakistan, talk to Allah. Allah have seen all situations. You feel worried, pray to Allah." (P7D, man, Pakistani)

3.3. Theme three: Cultural expectations and its influence on mental health problems and drinking practices

Among participants there was a unique set of implicit expectations which were either held by their family, community or themselves. Expectations varied across and within participants from different gender and ethnic backgrounds while nuances were found among those who had migrated to England. Among Black communities there was the expectation to provide financially for the family and do well. Among Asian communities while there was the expectation to achieve academically and settle with a family, for women there was the expectation to maintain a united positive family image.

"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, man, Black African)

"It's common within the Asian community, to be part of the norm in that aspect to be married and children and happily getting along" (P15D, woman, Pakistani)

These expectations seemed to impact on participants' mental health and drinking practices in different ways, hence two subthemes "cultural expectations and its influence on mental health" and "cultural expectations and its influence on drinking practices".

3.3.1. Subtheme: Cultural expectations and its influence on mental health

The unique expectations held by participants' family and/or community seemed to be detrimental to participants' mental health if they believed that they were not meeting these expectations. Some participants, for example men from a Black background, compared their achievements (or lack of) with other people indicating the importance of their success with others who were at a similar stage to them. For others, such as those who had migrated to England to improve their work or educational opportunities, there was an internal struggle between experiencing symptoms of poor mental health with feeling privileged to have the opportunity to improve their opportunities. This was exacerbated by the perception that their family and/or community would not understand their mental health struggles because of the opportunities that they have been given.

"I had nothing to do in my life because I was straight out of University, everything in hand, it was just getting worse, there was no good jobs to do, and get a job like everybody else had from University" (P6ND, man, Black African)

"They [my parents] said I should feel lucky and happy because I was born in such a good family and I have a lot of opportunities that others don't have. I study in the UK and I've got four degrees, when I got the PhD and my family supported me with no requirement, unconditional love" (P10ND, woman, Chinese)

For others, particularly Asian women, there was the expectation to present in certain ways to other members of their community and be part of a family unit. Women who deviated from these cultural norms experienced declines in their mental health and subsequently became isolated from the community.

> "Although it's happening in the White communities as well but not as bad as how we [Asian communities] really look at it, [Asian communities] really strongly believe it's part of the norm to get married and you're [women] just on your own then people don't want to know you." (P15D, woman, Pakistani)

3.3.2. Subtheme: Cultural expectations and its influence on drinking practices

The acceptance and views of alcohol held by the family or community informed participants' drinking practices and further influenced by the religious and gender background of the participant. For some, such as men from a Black background and/or those from a religious background, the mother was a key figure in their lives and would hide their alcohol use (or the extent of it) from them. This suggests that while there was some level of autonomy in the uptake of drinking, religious statuses and key figures also played a role in drinking practices. Participants from religious communities drank alcohol discretely, and/or did not drink on public days of religious worship.

> "I think Fridays the Muslims were very kind of conscious as a religious thing, and we know most Fridays we would refrain from drinking." (P18ND, man, Pakistani)

Among Black participants, alcohol was common particularly in non-religious communities and engrained in the community, therefore, drank openly. However, there was the perception that alcohol could not become a problem, which may be a reflection of the underlying perception that alcohol consumption is a conscious choice and seeking support is less acceptable in minority ethnic communities.

> "I don't think it's been seen as a problem in my [Black] community. There are some very similar cases of drunkenness. I think maybe the perception it's been given in my community that's why you see a lot of people of my race engaging in it." (P3ND, man, Black African)

Intoxication was frowned upon across communities from different ethnic backgrounds but there was a gendered expectation of women to not be seen intoxicated. This extended to gendered implications of drinking or a problem with alcohol; men, such as those from a Black background, could be accepted back into their faith, but this was not possible for women. This expectation seemed to inform how much women drank, particularly in social settings. Such implications may have an impact on women disclosing or seeking support for their drinking, indeed a minority of women participants had been ostracized from their community in part because of their drinking.

> "A woman is meant to behave in appropriate ways. Drinking in excess is certainly not something, it damages a woman's reputation in the community" (P15D, woman, White Other)

3.4. Theme four: Reasons for changes in drinking

The majority of participants changed their drinking habits through making reductions in their intake or stopping drinking altogether. Most participants were reluctant to seek formal sources of support (e.g. through the GP or specialist services), however, receiving this support was key to making changes as their alcohol use was usually discussed during appointments. Underpinning the ability to openly discuss their alcohol use was feeling comfortable with healthcare professionals due to concerns around being unfairly judged and their personal information being shared with other people in their community. Reductions or cessation in drinking were facilitated by the wider support participants received from their family, peers and community illustrating the importance of support in sustaining long-term changes in drinking habits among minority ethnic groups who have a mental health problem. Patterns of drinking in some current drinkers had not changed since receiving their mental health diagnosis. The lack of change seemed to be compounded by either a lack of recognition of their drinking habits or, for women across ethnic backgrounds, they continued to experience social isolation from family and wider community.

3.4.1. Subtheme: Formal support and having comfortable discussions on alcohol use

There were several issues in discussing drinking habits which reflected cultural perceptions of alcohol and the implications of being seen to have a problem with alcohol. Among religious participants, particularly of Muslim faith, they were aware of alcohol being taboo and found that being seen by professionals from different cultures overcame barriers of discussing alcohol use.

> "I met these people who are professionals from other cultures. I knew that … drinking is not taboo in their culture, so that makes it easier for me to open up." (P18ND, man, Pakistani)

Conversations about alcohol use with either a peer or healthcare professional could be uncomfortable or deemed inappropriate, particularly among men from a Black background, due to cultural perceptions around alcohol use as a personal choice and one that could not become a problem. This seemed to be exacerbated if the participant did not initially seek support for their alcohol use. As such, there may be a need to be cultural aware of raising discussions for behaviours or issues that may not be the primary reason for the person seeking support. Some of these barriers could be overcome through building rapport but this may be difficult when if there are limited opportunities to do so.

> "He [GP] talked a lot about my drinking and some of my lifestyle habits, and kind of like I just felt like criticizing your body and it seemed more like criticism … it's really not a thing from my background to criticize someone for drinking alcohol …" (P4D, man, Black African)

Linked closely with this were concerns with how information would be managed and shared with others which was of particular concern for participants from Asian or religious backgrounds, regardless of gender. Some participants felt better understood when seen by professionals of a different ethnicity to them, but for others, they were hesitant to disclose their alcohol use to anyone indicating the sensitive nature of disclosing alcohol use in minority ethnic or religious groups.

> "Yeah, more relaxed and more comfortable I was in his [White GP] presence than I was with the Asian GPs … because he seemed to understand it." (P15D, woman, Pakistani)

> "GP talked to [participant name] about drink … don't like to talk to GP, GP tell boss [participant name] drink, boss tell uncle … not good to tell people you drink … [Participant's name] is Muslim. Muslim no drink" (P7D, man, Pakistani)

Engagement with healthcare and support services seemed key in improving participants' understanding of their drinking habits and the implications this may have on their mental and physical health which many had not known or acknowledged prior to seeking support.

> "[mental health support] helped me to realize that drinking wasn't helping for me to deal with my own emotional issues and I felt that was not the answer even with all my such issues." (P18ND, man, Pakistani)

This reflects the potential importance of making every contact with service users count so to address drinking habits but doing so in a culturally appropriate way and where it is clear to service users how their data is handled.

3.4.2. Subtheme: Wider support in facilitating changes

After getting initial formal support for their mental health and/or drinking, some participants disclosed this to their family despite being hesitant to do so due to fears of adding burden or not feeling understood.

> "She [mum] was like, "Why didn't you tell me earlier? You should have told me earlier and I could have put it in my prayers." And I know that, but she would have really worried" (P6ND, man, Black African)

Wider support predominantly came from immediate family members suggesting the need to keep problems within the immediate family rather than the wider community. Such support seemed predominantly available for men (rather than women) where the mother was a key figure in sustaining their mental health and/or changing drinking habits. This provides further an indication that there may be less support provided for women from a range of ethnic and religious backgrounds. However, this improved the relationships between the participant with their family, and the family became more aware of mental health and/or drinking 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." (P9ND, non-binary, Black Caribbean)

Some of the increased support from the family and/or community may also reflect the views of these groups, particularly where they had frowned upon their behaviour or drinking habits and so supporting the participant in making changes helped to re-align their behaviour with that of the family. Therefore, this theme links with both "understanding of mental health problems and implications on drinking behaviour" and "the role of cultural expectations on mental health and alcohol" themes.

3.4.3. Subtheme: Lack of changes in social circumstances

A minority of women from a range of ethnic and religious backgrounds who had harmful/probable dependent AUDIT scores had not made changes in the way in which they drink and continue to use alcohol to cope. This seemed exacerbated by the continued repercussions from the community and family because of their disclosures and/or decisions.

> "It's [my drinking] been a bit complacent, I even kept drinking not so much, but you know before going to therapy sessions sometimes having a drink before in order to face the experience. Because I'm always scared and I'd be unable to talk …" (P14D, woman, White Other)

This indicates the potential implications of poor treatment within the community on drinking behaviours, and the importance of having social support for individuals who may have become increasingly isolated from their main social networks. This seemed particularly detrimental for women who continued to use alcohol as a coping mechanism for loneliness even if their mental health problems had become more manageable.

3.4.4. Subtheme: Lack of recognition of the effects of alcohol

A minority of men from a range of ethnic backgrounds who have a hazardous or harmful/probable dependent AUDIT scores continued to drink in the same way which seemed to reflect a lack of motivation to change their drinking habits. Such participants continue to enjoy drinking alcohol and do not feel that their drinking is a problem, however, this may have been compounded by not discussing their drinking habits with the healthcare professional when they sought support for their mental health.

> "Still drink. [participant's name] still drink, no changes, [participant's name] still drink." (P7D, man, Pakistani)

This suggests that minority ethnic groups may still drink heavily after their mental health diagnosis but there is a need to further understand the mechanisms of this, and whether having increased support may be beneficial for these groups.

4. Discussion

Our study aimed to explore experiences with alcohol among minority ethnic groups who have a mental health diagnosis, and how this has changed over time in relation to getting support for their mental health. In 25 participants, and using qualitative methods with an intersectional lens, we found motivations of drinking and reasons for changes in drinking and these were underpinned by unique expectations and perceptions of alcohol use and mental health among participants from minority ethnic backgrounds. Our findings suggest how nuances in the gender, ethnicity and religiosity of a participant and their family/community influenced drinking motivations and were detrimental to mental health. Alcohol use, in particular, was compounded by how and whether it was observed and consumed within a public environment, and the extent to which it was viewed as an active choice. Finally, we found that changes in drinking occurred around the time when minority ethnic groups sought formal support which was facilitated by wider support from the family or community. However, discussions around alcohol use were particularly sensitive for those of a particular gender, ethnicity and religion due to the lack of discussions taken place within these groups and the potential implications of disclosure on the individual. As such, there is a need to take a gendered culturally appropriate approach when assessing alcohol use with minority ethnic groups experiencing poor mental health while additional non-clinical support should be considered, particularly for women.

Taking an intersectional approach, implicit cultural expectations were identified in this study; expectations differed within and across ethnicities, genders and religious groups which had implications on mental health and drinking practices. Regarding mental health, there was a focus on education, career and providing for the family among participants from a Black background while a career and maintaining a good family image to the community among Asian groups. Not meeting these expectations and the implications this may have on the family were detrimental to participants which is consistent with previous research within Asian communities (Wynaden et al., 2005). However, across ethnic groups, women were expected to uphold a united family image but for men, and particularly those from a Black background, showing indications of poor mental health were discouraged. Some of these differences may be exacerbated by cultural beliefs held within religious ethnic groups where mental health problems were believed to stem from bad spirits among those from a religious Asian background, therefore experiencing mental health problems was perceived as out of the individual's control. Previous quantitative evidence has highlighted the use of intersectionality in identifying level of engagement and treatment for mental health problems (Rhead et al., 2022) and mental health inequalities (Moreno-Agostino et al., 2023). The use of intersectionality in this qualitative research has highlighted how gender, ethnicity and religious statuses intersect with acknowledgement of types of mental health problems, and potentially exacerbate such problems.

Regarding alcohol use and drinking practices, alcohol was more acceptable, and therefore drinking practices were known to others, particularly among participants from a Black Mixed or White Other backgrounds, or among non-religious groups. The extent to which alcohol use was known to others, and particularly the mother, could at times be hidden while discussing one's alcohol use may be deemed as inappropriate according to the individual's cultural background. While women were discouraged from drinking in excess (or at all) and experienced social isolation due to their drinking habits. Previous research has shown how some minority ethnic groups seek to fit in with cultural norms (Robinson et al., 2011), while we have also shown this, this was particularly notable among participants from a religious and Asian background who relocated and socialized within a multicultural group.

Further, it has been previously shown that beliefs and perceptions of alcohol use were strong predictors of drinking (Sudhinaraset et al., 2016), while the acceptability of drinking was gendered (Agic et al., 2011). A recent qualitative systematic review of stigma around alcohol and other substance use among migrant and minority ethnic groups highlighted how women were particularly stigmatised for engaging in these behaviours, while race/ethnicity resulted in individuals experiencing double stigma in treatment settings (Douglass et al., 2023). Our findings are somewhat similar with regards to women being discouraged from drinking alcohol and being ostracized for doing so. Our findings also indicate that ethnicity and religion played a role while the extent of drinking were hidden from key figures. Further, considering alcohol use and mental health together, our findings suggest how alcohol may be used as a means to manage mental health problems (and symptoms) because of how people with certain characteristics may be treated and, therefore, have little means of accessing support. This has implications on the way in which healthcare professionals and potential interventions approach sensitive topics, such as alcohol use and mental health, and the appropriateness of including the wider community in an individual's care.

Across participants, there was a limited understanding of mental health problems (and associated symptoms) within their family and community, and particularly for men from a Black background. The recognition of symptoms and the beliefs held within minority ethnic communities around the causes of mental health problems seemed to influence whether and how participants sought help. This has been consistently shown in previous research where a lack of recognition of mental health problems and symptoms have been key barriers to help-seeking (Memon et al., 2016). However, we also highlighted difficulties in the recognition of symptoms depending on the type of mental health problem, gender, ethnic and religious background of the individual, indicating a need to improve the awareness and understanding of the range of mental health problems with minority ethnic groups. Psychoeducational workshops have been found to show improvements in awareness and reductions in stigma among minority ethnic communities (Knifton et al., 2010) and it may be that a similar approach could be tailored to different ethnic groups.

We found that participants drank to i) cope with problems, ii) seek the effect of alcohol, and iii) fit in. This partially supports existing psychological theories such as the self-medication hypothesis (Khantzian, 1997) and drinking motives model (Cooper et al., 1995). However, we also found that some of the reasons for drinking to cope were situated in the context of the cultural norms and expectations of participants, which was particularly notable among women, religious participants. This suggests that when addressing alcohol use with minority ethnic groups, there is a need to establish how supported a minority ethnic service user is, the service users' gender, their (and their families) religious affiliation, and how alcohol is perceived within their community as this may identify whether additional support is required.

Prior to seeking formal mental health support, the majority of participants were unaware of the level at which they were drinking, and how this may affect their mental health. Self-reported reductions and the decision and act of stopping drinking seemed to occur after seeking formal support where alcohol was assessed, regardless of the ethnicity of the professional. This provides support for current recommendations in the United Kingdom around the need for people with possible co-occurring alcohol and mental health problems to access support from a range of different services (Public Health England, 2017) and guidelines around screening for alcohol use (National Institute for Health and Care Excellence, 2011; National Institute for Health and Care Excellence, 2023). This is particularly important given that the majority of participants did not initially seek support for their drinking, and were more open about their alcohol use when they felt comfortable and trusted the professional which is consistent with previous research (Robinson et al., 2011). However, men seemed to receive wider support from their family and community, therefore, women from a minority ethnic and religious background may require additional non-clinical support when receiving help for their mental health and/or alcohol use.

4.1. Strengths and limitations

This study is one of the first to explore the experiences of alcohol among minority ethnic current and former drinkers who have a mental health problem. Taking an intersectional approach and recruiting participants from a range of ethnic, religious and demographic backgrounds has highlighted the importance of how such characteristics interact and influence mental health and drinking practices (Alliende et al., 2023), and seeking and engaging with support. Exploring at changes in alcohol use over time and in relation to seeking support has identified ways in which minority ethnic groups can be better supported by mental healthcare professionals in identifying and changing drinking habits, particularly if their drinking has become a problem.

Our study also has some limitations. We attempted to recruit participants from a range of ethnic and demographic backgrounds, however, we had several issues recruiting women and participants from different Asian backgrounds to the study. Informal feedback from community mental health organisations indicated that many of their service users did not meet our hazardous and above drinking criteria, we attempted to overcome this through advertising the study online but continued to struggle to recruit these groups. Another limitation of the study is that, because we recruited participants from a range of minority ethnic backgrounds, it is difficult to draw firm conclusions on the experiences with alcohol among specific minority ethnic groups or delve deeper into potential relationships between and within different statuses. Nonetheless, our study has provided an initial insight into the ways in which alcohol is perceived, consumed and managed among minority ethnic groups and the importance of cultural expectations, ethnicity, religion and gender on both alcohol use and mental health.

5. Conclusions

This study highlights the importance of identifying mental health symptoms and problem drinking on seeking support. The application of intersectionality has provided insight into the way in which statuses, such as gender, ethnicity, religion and migration, interact and exacerbate mental health and alcohol use among individuals from a minority ethnic background, and how they seek and engage with support. Further, we have identified specific reasons why minority ethnic groups may drink and how this is closely linked with perceptions of mental health, cultural expectations, and acculturation. Finally, we provide insight into the role of healthcare professionals on identifying alcohol use and initiating changes in drinking behaviour among minority ethnic groups experiencing poor mental health.

Statement of contribution

What is already known on this subject?

- •Research has established that some minority ethnic groups are more likely to experience mental health problems, are less likely to seek formal support, and experience poorer treatment outcomes, compared to White British groups.
- •Psychological theories, such as the self-medication hypothesis, indicate that alcohol may be used to cope with poor mental health, specifically to alleviate symptoms and modulate affect, and this may be exacerbated among minority ethnic groups due to additional stressors they experience, and the known stigma associated with mental health problems.
- •Among minority ethnic groups, other statuses such as gender and religion, are understood play a role in drinking practices, mental health problems, and seeking support, respectively.

What does this study add?

- •An intersectional lens which highlighted intersections within and between gender, ethnicity, and religion on i) expectations of the individual, ii) drinking practices, iii) declines in mental health, and iv) a reluctance to seek formal support.
- •Explores how the wider family and community can be both detrimental and facilitate mental health and drinking practices.
- •Identifies the potential role of healthcare professionals and initiating conversations around drinking on changes in drinking behaviour but in a culturally sensitive way.

CRediT authorship contribution statement

Jo-Anne Puddephatt: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Validation, Writing – original draft, Writing – review & editing. **Millissa Booth:** Formal analysis, Validation, Writing – original draft, Writing – review & editing. **Juliana Onwumere:** Conceptualization, Funding acquisition, Methodology, Supervision, Validation, Writing – review & editing. **Jayati Das-Munshi:** Conceptualization, Funding acquisition, Methodology, Supervision, Validation, Writing – review & editing. **Ross Coomber:** Conceptualization, Funding acquisition, Methodology, Supervision, Validation, Writing – review & editing. **Laura Goodwin:** Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Validation, Writing – original draft, Writing – review & editing.

Declaration of competing interest

None to declare.

Data availability

In accordance with the guidelines from the ethics committee, we cannot share our anonymised transcripts. We provide our interview schedules, examples of the analytical framework and direct quotations.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.socscimed.2024.116803.

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