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Non-opiate and cannabis drug use in minority ethnic groups

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Contents

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Glossary and abbreviations

Abbreviations

APMS	Adult Psychiatric Morbidity Survey
CI	Confidence Interval
CSEW	Crime Survey for England and Wales
IMD	Index of Multiple Deprivation
TDF	Theoretical Domains Framework

Glossary

Table 0.1: Definitions used in this report

Term	Definition
Adjusted odds ratio	In logistic regression models, how many times more or less likely someone with a specific explanatory characteristic is to experience the outcome variable, after adjusting for additional predictor variables such as age or gender.
Base size	The population size, the desired statistical confidence level, and the assumed population variability within the research determine the base size.
Confidence interval	The mean of your estimate plus and minus the variation in that estimate.
Culturally appropriate	This means being alert and responsive to beliefs or conventions that might be determined by cultural heritage.
Drug use/ substance use	Used interchangeably to describe use of illicit drugs within the scope of this research.
Framework Approach	A qualitative technique developed by NatCen, used for social research to ensure quality standards in qualitative evaluation methods. It involves using a matrix output that enables researchers to systematically analyse data by participants and themes.
Intersecting Identities	The concept that an individual's identity consists of multiple, intersecting factors, including but not limited to gender identity, gender expression, race, ethnicity, class (past and present), religious beliefs, sexual identity and sexual expression.
Intersectionality	Intersectionality refers to experiences where multiple forms of inequality or disadvantage compound themselves and create obstacles.
Minority Ethnic groups/ communities/ populations	Refers to racial and ethnic groups that are in a minority in the (UK) population.

Non-opiate dugs	Non-opiates is a term used to describe all drugs other than opiate based drugs like heroin or codeine. For example, cannabis, amphetamines, steroids, cocaine and crack cocaine, new psychoactive substances (or 'legal highs').
Odds ratio	These are a key output from logistic regression models. Odds ratios reflect how many times more or less likely someone with a specific explanatory characteristic is to experience the outcome variable.
Professional stakeholders	Professionals involved in the design and delivery of treatment and support services. This report included academic subject specialists, community leaders, and treatment providers that lead on culturally specific services and provide targeted support.
Scoping review	A scoping review is a type of knowledge synthesis that uses a systematic and iterative approach to identify and synthesize an existing or emerging body of literature on a given topic.
The Index of Multiple Deprivation	The English indices of deprivation measure relative deprivation in small areas in England called lower-layer super output areas. The index of multiple deprivation is the most widely used of these indices.
Topic Guide	A topic guide is a tool used for interviews which sets out key discussion topics. This ensures a consistent approach across interviews while allowing the discussion to remain participant led.

Executive Summary

Overview of the research

The second volume of the Government commissioned independent review of drugs (published in 2021) highlighted a need for research into what works to diminish problems related to substance use across supply, and to improve prevention, treatment, and recovery.[1] Particular evidence gaps were highlighted around drug use in minority ethnic communities, including barriers and facilitators to treatment and prevention. More recently, the House of Commons Home Affairs Committee released a report which identified that people from minority ethnic communities face additional barriers in accessing treatment and support for drug use, while also being adversely impacted by drug-related legislation (e.g., stop and search policies).[2]

This research explores:

- Variations in the frequency and type of drug use across different ethnic groups;
- Drivers of drug use among minority ethnic communities; and
- Barriers and facilitators to support for drug use for minority ethnic groups.

The report draws on findings from:

- A review of pre-existing research, including academic papers and research published by organisations / groups working in the field (e.g., UK Drug Policy Commission);
- Analysis of data from the Adult Psychiatric Morbidity Survey (APMS) and the Crime Survey for England and Wales (CSEW); and
- In-depth interviews with:
  - professional stakeholders; and
  - people from minority ethnic communities with experience of drug use.

Key findings

Prevalence and drivers of drug use

- Our analysis of the APMS and CSEW showed that the numbers of people from minority ethnic groups who have used drugs vary when comparing minority ethnic groups to the White British population. There was also variation in the numbers of people who have experienced drug dependence, and the types of drugs that they use (although cannabis was the most used drug in the last year across the whole sample).

- In the analysis of APMS, **age** was the strongest predictor of past year drug use (with younger people being more likely to use drugs). Age explained some of the differences in likelihood of past year drug use between minority ethnic groups and the White British majority. **Deprivation or poverty** (as measured by IMD) also

[1] Black, 2021. Footnotes contain short form references (e.g. Smith, 2010), while full references can be found in Appendix A and D. We have used a slightly modified style of Harvard referencing in this report.
[2] House of Commons Home Affairs Committee, 2023.

explained some of the difference in likelihood of past year drug use when comparing the Black group with the White British group.

- Interviews with professional stakeholders and people with experience of drug use from minority ethnic communities allowed deeper exploration of the drivers of drug use behaviours. The findings highlight that experiences of drug use are driven by a range of intersecting factors, including culture, gender, mental health, and migration experiences. In particular:

  - People with experience of drug use felt that **normalisation or acceptance of drug use within their social group or community** influenced their behaviours. Some people with experience of drug use felt that spending time with people who used drugs as teenagers led them to first start using drugs themselves. Some spoke of their desire to fit in while others mentioned that their White British peers provided an opportunity for exploration of substances that were not accepted within their own communities or families. Cultural acceptance or non-acceptance of substances also factored into whether participants engaged in drug use, and which drugs they chose to use.

  - **Availability of resources** can drive drug use behaviours, however the relationship between wealth and drug use is complex and multi-factored. There are links between drug use and challenges such as poverty and unemployment which are experienced disproportionately by some minority ethnic communities.

  - People with experience of drug use also stressed the **convenience of accessing substances**, generally believing that drugs were easy to access. Personal experiences of the impact of the 2014 khat ban[3] demonstrated that restricting access to certain drugs (e.g., through legislative change) has the potential to alter the types of drugs used within a community.

  - People with experience of drug use discussed **using substances to manage mental health challenges**, including those influenced by trauma, isolation, discrimination, and social exclusion.

Barriers to accessing support and treatment services

- Minority ethnic groups face specific barriers to accessing and engaging with treatment and support services, including:

  - Stigma, shame, and fear of judgement;

  - Lack of awareness of available services;

  - Language barriers;

  - Lack of trust in services stemming from previous negative experiences, concerns over confidentiality and the appropriateness of the service offer;

[3] This refers to the Government's decision to reclassify miraa as a Class C drug. For more detail, please see: https://www.gov.uk/government/news/statement-on-the-uk-ban-on-khat

- Lack of culturally tailored and culturally competent (including gender specific) services;
- Limitations in knowledge around different drugs and the potential impacts of use; and
- Covering the cost of accessing and receiving treatment.

Facilitators to accessing support and treatment

- Professional stakeholders and people with experience of drug use felt that there were a number of ways in which barriers to treatment can be overcome or mitigated to enable more equitable access and support for people from minority ethnic communities. The recommendations from this research (see section 4.2) involve:
  - **Improving knowledge about, and trust in, services**, including through outreach work;
  - **Implementing culturally appropriate service delivery.** This would involve ensuring diversity among staff/volunteers working for support providers and recognising and supporting diversity of needs and preferences;
  - **Ensuring person-centred, personalised approaches that recognise and support all aspects of service users' lives** and address wider barriers to treatment success, including challenges with mental health, housing; and employment.
  - **Ensuring that services are accessible and responsive**, including consideration of opening hours and online vs in-person delivery.

1. Introduction and methods

1.1 Aims and objectives

The second volume of the Government commissioned independent review of drugs (published in 2021) highlighted a need for research into what works to diminish problems related to drug use and improve prevention, treatment, and recovery.[4] Particular evidence gaps were highlighted around drug use in minority ethnic communities, including barriers and facilitators to treatment and prevention. More recently, the House of Commons Home Affairs Committee released a report which identified that people from minority ethnic communities face additional barriers in accessing treatment and support for drug use, while also being adversely impacted by drug-related legislation (e.g., stop and search policies).[5]

Our research aimed to address some of the evidence gaps in this area, particularly focusing on the day-to-day experiences of minority ethnic groups that are related to subsequent harmful drug use, and are also linked to barriers to accessing treatment and support. The research questions were:

- How does **prevalence of drug dependence, or harmful drug use,** differ between different minority ethnic groups when compared to White British populations?
- If there is **a higher prevalence** of drug dependence, or use, in certain minority ethnic groups, what are the **drivers** for this prevalence?
- Are there differences between minority ethnic groups in the **type of drugs used** and **frequency of use**?
- What are the **perceived barriers** (particularly socio-cultural barriers and issues related to intersectionality[6]) experienced by the identified minority ethnic groups to **accessing**, **completing,** or **engaging** in appropriate **support and treatment**?
- What are the **effective strategies or methods** of engaging with these groups (this may include culturally appropriate approaches)?

This research focused on **non-opiate and cannabis** drug use (excluding alcohol, opiates, and crack cocaine).[7]

1.2 Brief overview of methodological approach

This research involved three work strands, which are each outlined below and explained in more detail in Appendices A-C. Findings have been integrated across the work strands and are presented thematically in Chapters 2-3.

Review of pre-existing literature

In order to map the existing evidence base, we conducted a scoping review of the pre-existing literature relevant to our research questions. This involved conducting searches on the academic database SCOPUS and other

[4] Black, 2021.
[5] House of Commons Home Affairs Committee, 2023.
[6] "Intersectionality refers to experiences where multiple forms of inequality or disadvantage compound themselves and create obstacles" Crenshaw, 2013.
[7] Steroids were also excluded from the secondary data analysis.

relevant grey literature websites,[8] screening results for relevance and then extracting and analysing findings. Websites searched included the National Institute for Health and Care Excellence (NIHR), Joseph Rowntree Foundation, UK Drug Policy Commission and NHS England.

Twenty-five relevant papers were included in the review. These included academic articles, grey literature reports and articles, and healthcare / treatment service best practice guidance documents. The volume of relevant papers found through our searches demonstrates the limited nature of up-to-date research on non-opiate and cannabis use among minority ethnic communities in the UK.[9] Our research findings go some way in filling this gap, and also address specific evidence gaps highlighted by the earlier papers reviewed (as discussed further below). References to literature identified through the scoping review ("pre-existing research") can be found throughout this report.

Secondary data analysis

To understand the national picture of drug-related behaviours across different ethnic groups, we analysed data from two surveys which are designed to be representative of the whole population:

- **The Adult Psychiatric Morbidity Survey (APMS) (2007/14 combined).** The APMS is a national survey of people aged 16+ which captures data on mental health and wellbeing in England. Our research builds on pre-existing analysis of APMS data on drug use and ethnicity[10] by drawing on a combined 2007 and 2014 dataset which has the benefit of larger sample sizes and enables more robust analysis.

- **The Crime Survey for England and Wales (CSEW) (2019/20).** The CSEW[11] is a national survey which asks members of the public about their experiences of crime over the last 12 months. Our analysis again builds on previous research[12] by exploring relationships between drug use and ethnicity in the most recent survey data captured prior to the COVID-19 pandemic.

We analysed this survey data to understand whether / how different drug-related behaviours (e.g., past year drug use) varied when comparing different minority ethnic groups to the White British population. We also used a statistical analysis tool (regression analysis) to examine which factors can predict drug-related behaviours (e.g., age, education level, employment status).

Qualitative in-depth interviews

Qualitative interviews were conducted to provide in-depth insights into drivers of drug use and barriers to support and treatment. We conducted interviews with two groups, as described below.

- Twenty-four interviews were conducted with **people from minority ethnic communities who self-identified as having experiences of drug use which had been problematic** ("people with experience of drug use"). This included people who had, and had not, sought treatment and support. Pre-existing research had stressed the diversity of experience within different ethnic groups, emphasising the need for future studies to take into account factors such as age, gender, sexual identity, migration history/generation, religion, and socioeconomic background. In particular, it was identified that there was little evidence

[8] We also asked professional stakeholders who worked in drug use treatment services and were being interviewed to suggest further literature and conducted forward and backward citation tracking of relevant papers.
[9] We found that most of the academic literature available was from outside the UK and/or focuses on alcohol or opiates.
[10] For example: Cabinet Office, 2017.
[11] Office for National Statistics, *ONS SRS Metadata Catalogue, dataset, Crime Survey for England and Wales*. Released 26 October 2021, DOI: 10.57906/bs66-9627
[12] For example: Home Office, 2014.

capturing experiences of drug use among women from minority ethnic communities and people with intersecting identities.[13] To reflect learnings from earlier research, our approach was to seek as much diversity among participants as possible (specifically in relation to gender, ethnic background, and the types of drugs experienced). Key information on the composition of the sample and range of responses can be found below in Table 1.1.

- Pre-existing studies also identified that there was little research about experiences of minority ethnic groups which drew on the knowledge and expertise of providers of treatment and support, particularly with regard to non-opiate drugs.[14] Therefore, interviews were conducted with fourteen **professionals involved in the design and delivery of treatment and support services** ("professional stakeholders").[15] This included academic subject specialists, community leaders, and treatment providers who lead on culturally specific services and provide targeted support. Information on this sample can be found in Table 1.2.

Five interviews were carried out in-person[16] and others by phone, using semi-structured topic guides between February and June 2023. A topic guide is a tool used for interviews which sets out key discussion topics. This ensures a consistent approach across interviews while allowing the discussion to remain participant-led. Topic guides were informed by our review of pre-existing literature. The same barriers to accessing drug treatment services were consistently mentioned in the existing literature but rarely explored in-depth, and so were included in the topic guides. These included: stigma and shame; migration status; language barriers; cultural barriers; concerns over confidentiality; lack of information about, and awareness of, the available services; and waiting times for assessment. There was also an important evidence gap around what a "culturally appropriate" approach to drug treatment service provision consists of, with a lack of examples of good practice. This topic was made a key focus of interviews with both professional stakeholders and people with experience of drug use. Interviews were transcribed and analysed using the Framework approach,[17] whereby each row represented one interview and each column represented a topic of relevance. Relevant information from each interview was written into the corresponding cell. This grouped information around each research question, enabling the research team to assess the relevant evidence.

In order to seek further stakeholder contributions, test and refine recommendations (see Chapter 4), feedback was sought in a workshop conducted with professional stakeholders involved in treatment and support for drug use.

[13] Demant et al., 2018 and Williams et al., 2016.
[14] Fernandez, 2015.
[15] A total of thirteen stakeholder interviews were conducted with fourteen professionals – one of the interviews was a dyad interview with two members of staff from the same organisation.
[16] All in-person interviews were with participants with experience of drug use.
[17] Ritchie et al., 2013.

Table 1.1: Participants with problematic experiences of drug use

Attribute	Number of participants
Drug used[18]	
Cannabis / Cannabinoids	20
Cocaine	8
MDMA[19] / Ecstasy	8
Crystal meth	2
Ketamine	2
Khat	2
GHB[20]	1
LSD	1
Psilocybe mushrooms / Magic mushrooms	1
Age	
18 to 35	8
36 to 45	10
46 to 55	4
55+	2
Gender	
Male	17
Female	7
Ethnicity[21]	
Black British / Black British and Black Caribbean / Black British and Somali	7
British Asian (British Sri Lankan, British Pakistani, British Indian and British Bangladeshi)	5
Black Caribbean / Black Caribbean and Indian	3
Chinese / Chinese and Burmese	2

[18] Most participants reported having experienced the use of more than one drug (during the same period of their life or at different times). Some participants also reported using opiates, alcohol and crack cocaine but they were not included in the table since these substances were not in the scope of this project.
[19] MDMA is the shortened chemical name for the synthetic psychoactive drug 3,4-methylenedioxy-methamphetamine.
[20] GHB (gamma hydroxybutyrate) is a central nervous system depressant drug. For more detail, please see: https://www.dea.gov/sites/default/files/2020-06/GHB-2020_0.pdf
[21] Researchers recorded ethnic identity the way it was self-reported by participants. Among participants, there were experiences of those who were, and were not, born in the UK. There was also a mix of English and non-English native speakers. While this information was not routinely recorded at the recruitment stage (and therefore is not included in the table), language and country of birth were discussed during the interviews. Where relevant, this information has been included in the findings in the report.

Somali	2
White Irish and Jamaican / White British and Jamaican	2
White Non-British (Polish; Spanish)	2
Asian	1

Table 1.2: Professional stakeholder participants

Attribute	Number of participants
Type of organisation	
Charity	8
NHS	3
Social enterprise	2
University	1
Role of the stakeholder	
Management/strategic role in an organisation providing treatment/support services	8
Healthcare professional	3
Service delivery role in an organisation providing treatment/support services	2
Professional involved in research but not delivery	1

1.3 Research ethics

This study was approved by NatCen's Research Ethics Committee. The interviews with people with experience of drug use had the potential to be sensitive due to the subject matter involving both drug-related experiences and experiences of culture/ethnicity. Therefore, we took careful steps to reduce any risk of harm for those taking part. All participants received an information sheet which set out the purpose of the research and explained what would happen to participant data. Participants were reminded of their freedom to refuse to answer questions, withdraw, and take a break before and during the interview. Participants were also signposted to a list of relevant organisations that they could contact if the subject matter of the research prompted any upset or distress. To ensure as many people as possible could take part, further adjustments were made in some cases such as arranging in-person interviews and/or assistance from a support worker.

1.4 Structure of the report

The remainder of the report is divided into the following chapters:

- **Chapter 2** explores the prevalence and drivers of different drug-use behaviours, specifically exploring factors which impact people from minority ethnic communities;
- **Chapter 3** considers barriers and facilitators to support and treatment services;

- **Chapter 4** identifies key strengths and limitations of the research and makes recommendations for providers and future research.

2. Prevalence and drivers of drug use

2.1 Prevalence of drug use

This chapter explores how various drug use behaviours (e.g., past year drug use) compare between minority ethnic groups and the White British population. Sections 2.2 and 2.3 then discuss factors impacting drug use, and how these might explain differences between and within groups. The figures presented below should be viewed in the context of two key caveats:

- Throughout this report, there is discussion of how experiences of drug use vary across and within communities, noting that factors such as age, gender, and wider social experiences interact to create unique experiences.[22] Care should be taken not to stereotype experiences on the basis of ethnicity and these figures should be considered as part of the overall picture of drug use. In our analysis of the APMS and CSEW, it was also necessary to collapse ethnic groupings to ensure consistency and due to small case sizes. This enabled less detailed / nuanced analysis of differences between ethnic groups.

- Figures may also be affected by under-reporting. While most of the sample (81%) completed the module on drug use for the CSEW, all minority ethnic groups were significantly more likely to refuse to answer these questions compared to the White British population (see Appendix Table B1).

Past year drug use

Survey data shows mixed results when comparing past year drug use among ethnic groups. The ethnicities captured in each survey can be found in Appendix Figure B2. The majority of the sample in the APMS 2007/14 combined, as well as the CSEW 2019/20 were from the White British population (see Appendix Figure B1).

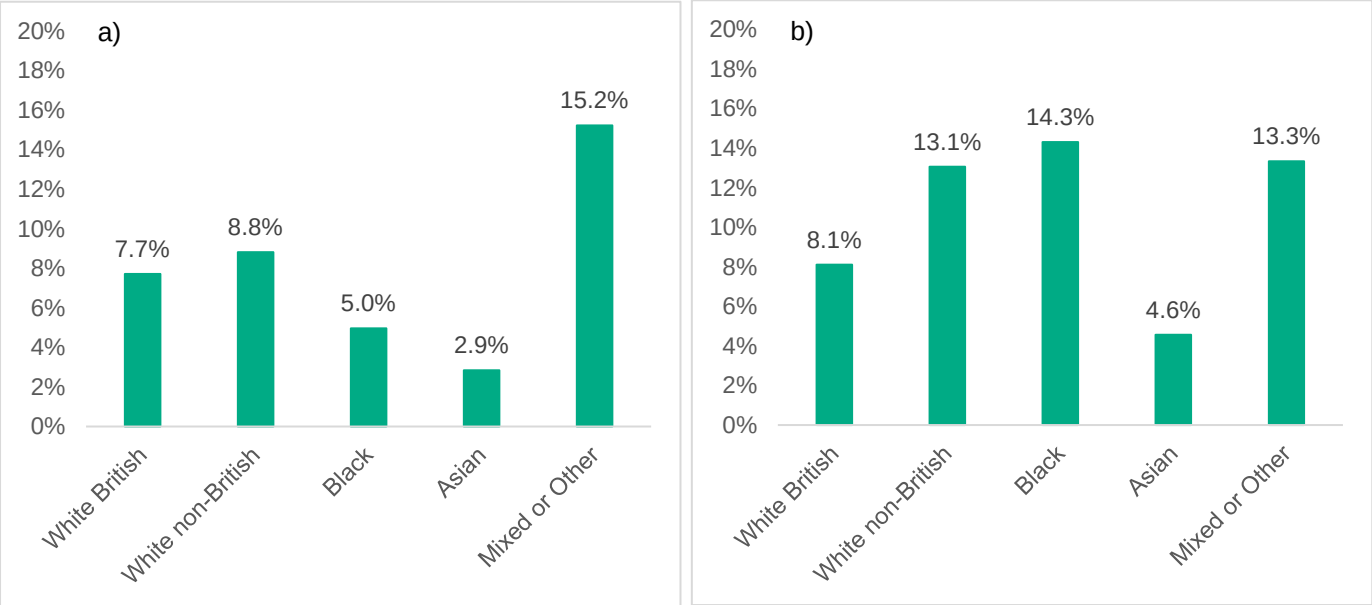
- In the 2019/20 CSEW, **prevalence of past year drug use[23] was highest among the Mixed/Other ethnic populations** (see Figure 2.1a).[24] Compared to White British respondents, individuals of Mixed or Other ethnic background were at a 2-fold increased odds of having used at least one drug in the past year (see Appendix Table B2). This finding is consistent with past research which analysed 2011-2014 CSEW data.[25]

- In the 2007/14 APMS, **prevalence of past year drug use was found to be highest among the Black ethnic populations** (see Figure 2.1b).[26],[27] When compared to the White British population, the White Non-British population, Black population, and Mixed/Other population were **all** at an approximately 2-fold increased odds of having used at least one drug in the past year (see Table 2.1). Conversely, **the CSEW showed that the Black ethnic population had an approximately 40% reduced odds of past year drug use** compared to the White British population (see Appendix Table B2).

[22] This has also been flagged in previous research. For example, European Monitoring Centre for Drugs and Drug Addiction, 2013.
[23] Of individuals who had used at least one drug in the past year, the majority reported using a drug once or twice (42%; see Appendix Table B3).
[24] The prevalence of past year drug use in the total CSEW sample was 7.5% (n=1,842).
[25] Home Office, 2014.
[26] 8.53% of the total APMS 2007/14 combined sample had used at least one drug in the past year prior to interview (n=1,208).
[27] Some differences in figures may be due to the nature/focus of the survey (i.e. crime vs health)

- In both the CSEW and the APMS, **prevalence of past year drug use was lowest among the Asian ethnic population**. Analysis of 2007/14 APMS data showed that the Asian population were less likely to have used at least one drug in the past year when compared to the White British population (0.5-fold decreased odds; approximately a 50% reduction in odds; see Table 2.1). In the CSEW, the Asian population had 65% reduced odds of having used at least one drug in the past year compared to the White British population (see Appendix Table B2). Earlier research has also found that drug use is lowest among Asian populations, although it should be noted that studies are not directly comparable, with some examining smaller population groups (e.g., young people of Indian ethnicity) and / or using different measures to understand drug use (e.g., 'regular' drug use rather than past year drug use).[28]

Figure 2.1: Prevalence of past year drug use



Source a) CSEW 2019/2020. Base: All respondents who responded to questions about drug use in the past year (n=24,728).
Source b) APMS survey 2007/14 combined. Base: All respondents who responded to questions about drug use in the past year (n=14,158).

Table 2.1. Odds of having used at least one drug in the past year prior to interview, by ethnicity (APMS)

Ethnicity	No drug use in past year n, (%)	Used at least one drug in the past year n, (%)	Odds ratio	95% CI
White British	10,826 (91.89)	955 (8.11)	Ref	Ref
White non-British	711 (86.94)	107 (13.06)	**1.70**	**(1.25-2.31)**
Black	373 (85.69)	62 (14.31)	**1.89**	**(1.29-2.78)**
Asian	716 (95.44)	34 (4.56)	**0.54**	**(0.32-0.92)**
Mixed or Other	325 (86.66)	50 (13.34)	**1.74**	**(1.14-2.66)**

Source: APMS 2007/14 combined. Base: n=14,158

[28] Dogra et al., 2013; Reid et al., 2018; Penney et al., 2016; Commission on Race and Ethnic Disparities, 2021; Home Office, 2014; UK Drug Policy Commission, 2012; Health and Social Care Information Centre, 2014.

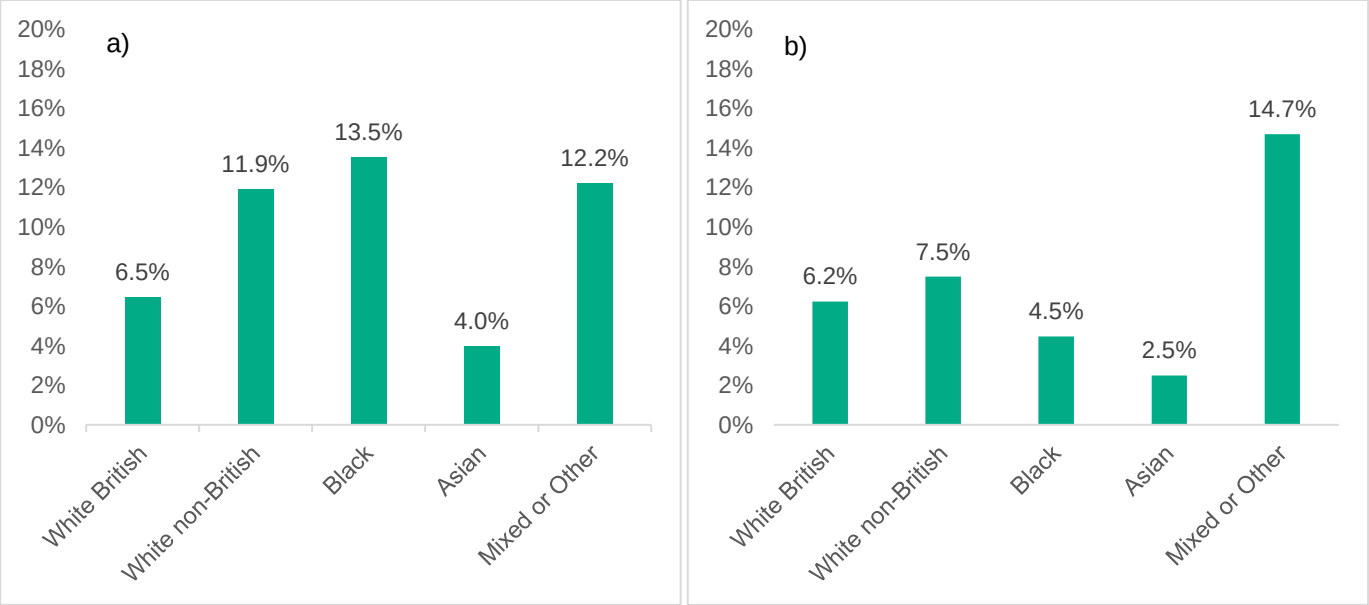
Differences in past year drug use between ethnic groups

- **The three drugs with the highest prevalence of use in the total APMS sample (i.e. across all ethnic groups) were cannabis** (7.02%), **cocaine** (2.06%) and **ecstasy** (1.27%). Prevalence of these drugs were similar in the CSEW 2019/20, with cannabis (6.2%), cocaine (2%) and ecstasy (1%) being the drugs with the highest prevalence of past year use. In both datasets, all other drugs had a prevalence of use <1%. Due to sample sizes, we were only able to reliably explore differences between ethnic groups in respect of cannabis use.[29]

- In the APMS, the **Black population had the highest prevalence of past year cannabis use** (13.5%) (see Figure 2.2a). The odds of using cannabis in the past year were approximately 2-fold greater in the Black population, the Mixed / Other population and White non-British population when compared to the White British population (see Appendix Table B6). In the CSEW 2019/20 data, **the Mixed / Other ethnic population had the highest prevalence of past year cannabis use** (14.7%) (See Figure 2.2b). The Mixed / Other ethnic population had an approximate 2.6-fold increased odds of having used cannabis in the past year compared to the White British population. In the CSEW, there was no significant difference in the odds of using cannabis in the past year for the White non-British, nor the Black population compared to the White British population (see Appendix Table B7).

- In both the APMS and the CSEW, **the Asian population had the lowest prevalence of past year cannabis use** (4% in the APMS as shown in Figure 2.2a and 2.5% in the CSEW as shown in Figure 2.2b). In the APMS, the Asian population did not significantly differ in their use of cannabis in the past year when compared to the White British population. In the CSEW, the Asian ethnic group were at an approximately 60% reduced odds of having used cannabis in the past year when compared to the White British population (see Appendix Table B7).

Figure 2.2: Prevalence of past year cannabis use, by ethnicity



Source: a) APMS 2007/14 combined. Base: All respondents who responded to questions about cannabis use in the past year (n=14,178). b) CSEW 2019/20. Base n=24,959

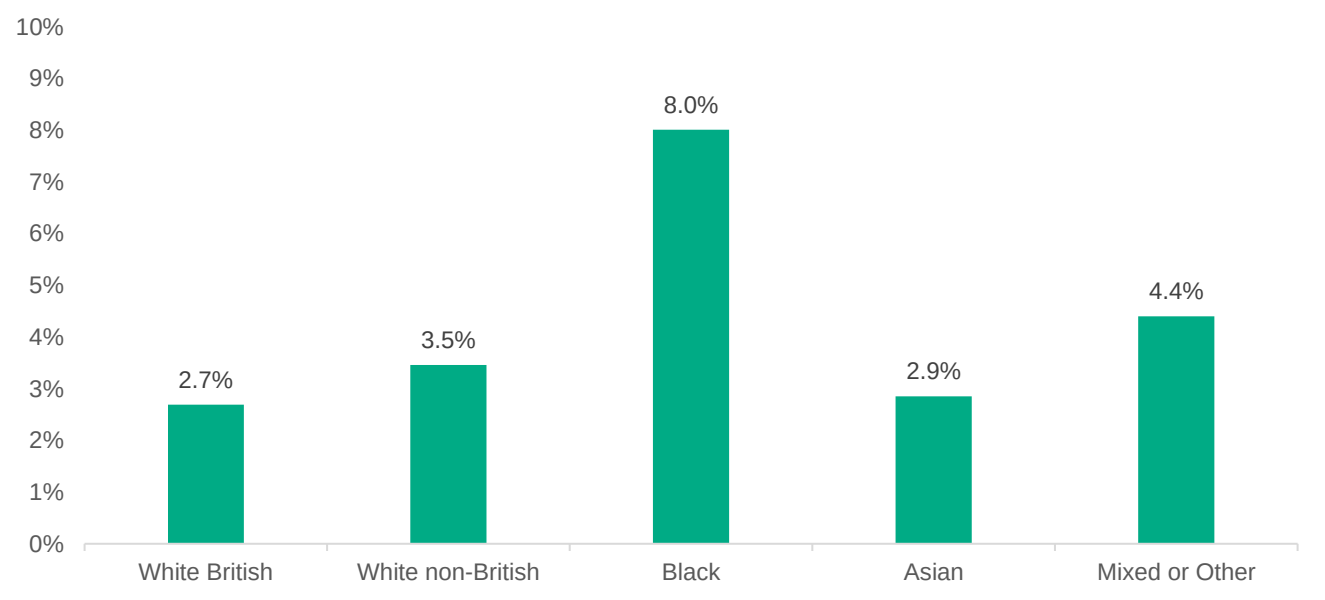
[29] In the APMS, there were no significant differences in the past year prevalence of cocaine use for any minority ethnic group when compared to the White British population. The White non-British population were at a 2-fold increased odds of having used MDMA/ecstasy in the past year compared to the White British population. Case sizes were too small in the CSEW to reliably look at ethnic differences in the prevalence of having used powder cocaine and/or MDMA/ecstasy in the past year. See Appendix Table B4 and Appendix Table B5.

Drug dependence

- In the APMS survey (2007/14 combined), **drug dependence was most prevalent among the Black population (8%) and least prevalent in the White British population** (2.7%; see Figure 2.3).[30] This aligns with findings from previous analysis of APMS survey data.[31] The odds of showing signs of drug dependence were approximately 3-fold higher in the Black population compared to the White British population (OR=3.16, 95% CI 1.87-5.33). All other minority ethnic groups were similar in terms of drug dependence compared to the White British population (see Appendix Table B8). This shows that although the Asian population are less likely to have used at least one drug in the past year, and the Mixed or Other population are more likely to have used at least one drug in the past year compared to the White British population, they do not significantly differ from the White British population in terms of drug dependence.

- **Across the total sample, most individuals with signs of drug dependence showed signs of cannabis dependence** (with or without signs of dependence on other drugs).[32] When cannabis dependence was excluded, less than 1% of the sample showed signs of dependence on other drugs.

Figure 2.3: Prevalence of drug dependence in the APMS, by ethnicity



Source: APMS survey 2007/14 combined
Base: All respondents who responded to questions about drug dependence (n=14,164).

2.2 Predictors of past year drug use

This section looks at why prevalence of past year drug use may vary across different ethnic groups, drawing on the analysis of APMS survey data. We conducted multiple logistic regression models to explore which aspects of someone's identity might predict their past year drug use. In our first model discussed in section 2.1 (which did not consider any factors except ethnicity) all minority ethnic groups were significantly different from the White British population in terms of their odds of drug use in the past year (see Table 2.1).[33] **However, from a theoretical standpoint, ethnicity itself does not *cause* an increased/decreased prevalence of drug use**.

[30] Just under 3% of the APMS sample (2.95%) showed signs of any drug dependence in the past year (n=418).
[31] Cabinet Office, 2017.
[32] Among all respondents, 2.3% showed signs of cannabis dependence in the CSEW 2019/20 (n=327).
[33] Due to the low prevalence of drug dependence, we were unable to explore this reliably by ethnicity using logistic regression models.

Some professional stakeholders and people with experience of drug use were resistant to generalising on the basis of ethnicity, highlighting that drug use is driven by a range of psychosocial and societal factors that will vary within any community. We therefore controlled for the following factors to explore whether they explain the significant differences in the likelihood of past year drug use by ethnicity: age, education level, employment status, having English as a first language, household income, the presence of at least one mental disorder, index of multiple deprivation (IMD), and sex.[34]

When we controlled for all above factors (see Table 2.2),[35] the Black and Mixed or Other ethnic groups were no longer significantly different from the White British group in terms of past year drug use. This means that initial increased likelihood of drug use can be explained by factors in our analysis other than ethnicity. When we controlled for all above factors, the Asian ethnic group remained significantly less likely and the White non-British group significantly more likely to have used drugs in the past year compared to the White British group. This shows there are other socio-cultural, societal, and/or economic factors accounting for these differences in these groups which we have not been able to examine in our quantitative analysis.

Table 2.2. Final Model: Odds of having used at least one drug in the past year prior to interview, by ethnicity (APMS)

Ethnicity	Adjusted odds ratio	95% CI
White British	Ref	Ref
White non-British	**1.71**	**1.16-2.52**
Black	1.49	0.92-2.43
Asian	**0.39**	**0.19-0.81**
Mixed or Other	1.46	0.88-2.43

Model controls for age, sex, education level, employment status, having English as a first language, household income, the presence of at least one mental disorder and index of multiple deprivation. Source: APMS 2007/14 combined. Base: n= 11,171.

We added each variable (age, sex, education level, employment status, having English as a first language, household income, the presence of at least one mental disorder and index of multiple deprivation) to the model in turn, once already controlling for each of the other factors. This identified two characteristics which were important in explaining the relationship between ethnicity and increased likelihood of drug use:

- **Age:** Before age was added to the model (but controlling for all the other factors) the Mixed or Other group was found to have an increased odds of past year drug use. Once age was controlled for in the model this relationship was no longer statistically significant.

[34] To do this appropriately, we excluded individuals who had missing data on any of the above variables. This left a sample size of n=11,171. Income had the highest proportion of missing data; 21% of the sample had missing data for at least one of the questions used to create the 'income' measure. It is important to note that missing data may be disproportionately spread across ethnicity and thus this analysis is no longer representative of England's general population; for example, the Asian population had the highest proportion of missing data on Income (31.2%; see Appendix Table B9 for missing data on income by ethnicity). 'Population' is used where findings are representative of the population, and 'group' is used for results in the final model, which is no longer representative of the general population.

[35] See Appendix Table B10 with coefficients for all variables.

  - This is in keeping with the descriptive analysis which showed that 37% of the Mixed or Other ethnic population[36] were aged 16-29, compared to 20% of the White British population, and that younger people were more likely to use drugs (see Figure 2.4).

- The other finding which emerged from this analysis was that controlling for **age** also affected the relationship identified between belonging to the Asian ethnic group and past year drug use:

  - Before controlling for age, the Asian population were not significantly different from the White British population in terms of past year drug use.

  - However, once age is controlled for, the Asian group were found to be at a reduced odds of past year drug use compared to the White British group (as can be seen in Table 2.2 above).

  - Similar to the Mixed or Other ethnic group the Asian population were, on average, younger than the White British population (for example, 38% vs 20% are in the 16-29 age group).[34] Therefore, it might be expected that the Asian population would be more likely to have used drugs in the past year compared to the British population when age is not controlled for. However, when controlling for all factors except age (i.e., when not taking age into account), the Asian group were not significantly different from the White British group in terms of past year drug use. **This suggests there are wider protective factors (not accounted for in our model) that reduce likelihood of drug use within the Asian group** – reflected in the lower odds of drug use shown in the final model once age and all the other characteristics in the model are controlled for.

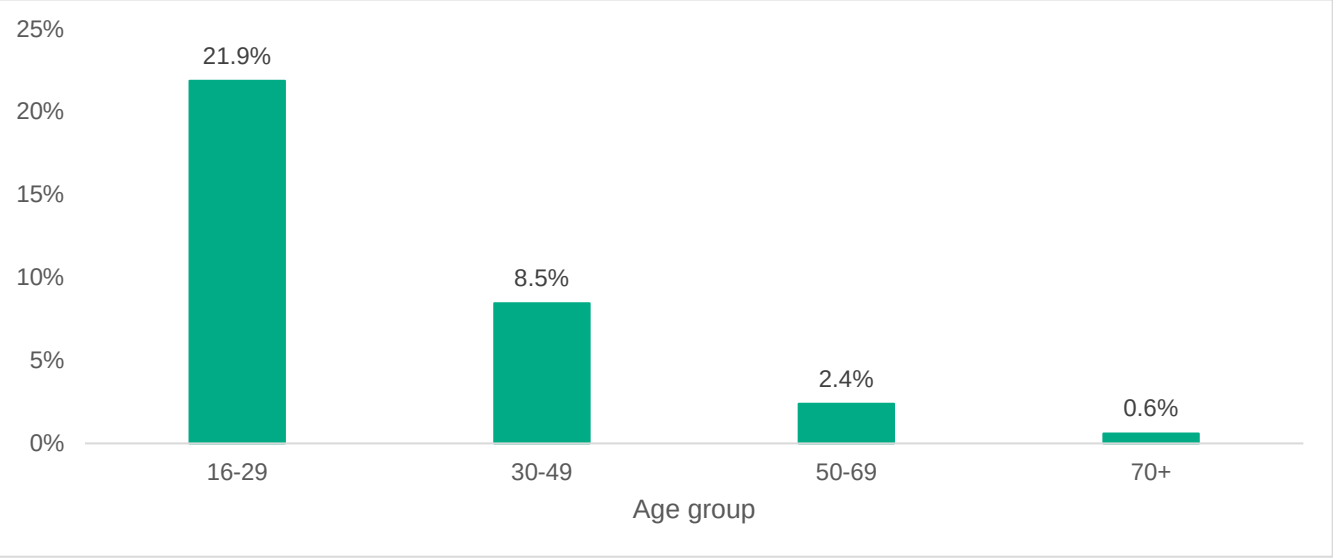
- **IMD:** When not controlling for the IMD of a person's area the Black ethnic population had an increased odds of past year drug use compared to the white British population, which in the final model (controlling for IMD) is no longer statistically significant between the two groups.

  - This also fits with the findings of the descriptive analysis, which showed that a higher proportion of the Black population are in the 'Most Deprived' IMD category (45% vs 17% of the White British population).

It should be noted that this does not demonstrate a causal link between these factors and increased past year drug use. As discussed at section 2.3, there are very likely to be other factors which are important as well (e.g. social norms, mental health, accessibility of drugs).

[36] Age figures refer to the total Mixed, Other and Asian populations in the survey.

Figure 2.4: prevalence of past year drug use, by age group



Source: APMS 2007/14 combined. Base: All respondents who responded to questions about drug use in the past year (n=14,158)

2.3 Wider factors driving drug use

As highlighted above, drug-related behaviours are influenced by a wide range of psychosocial and / or societal factors. This section primarily draws on interviews with professional stakeholders and people with experience of drug use to discuss some of the key factors which can drive different drug-related behaviours, and how these may relate to ethnicity and / or influence prevalence of drug use across and within different groups. Altogether, these findings highlight that drug-use behaviours are driven by a range of intersecting factors, including culture, gender, mental health status, and migration experiences.

Social factors, gender and cultural norms, and identity

People with experience of drug use reiterated that **normalisation or acceptance of drug use** within their friendship or social group influenced their behaviours. It was common for participants to have been introduced to drug use by friends or in social situations such as parties. Where drug use was common among the group, participants discussed using substances out of curiosity, to fit in / not feel left out, or simply because drugs were "around" and easy to access. For some males with experience of drug use, links were made between drugs and an overt display of masculinity or "looking hard". Previous research has often found that prevalence of drug use tends to be higher among men in all ethnic groups.[37]

> *"It's not so much peer pressure but when you're hanging around the lads who are doing it, you're going to do it because you're hanging around with them. It's as simple as that, you're going to. If you're hanging around with people who take drugs, you will take drugs."* – Person with experience of drug use (White Irish / Black Jamaican)

Past research has highlighted examples of young people from minority ethnic communities using cannabis to fit in with perceived Western culture and trends.[38] While people with experience of drug use did not discuss being pressured to use substances, some spoke of their desire to fit in while others mentioned that their White British peers provided an opportunity for exploration of substances that were not accepted within their own communities or families.

[37] For example: Cabinet Office, 2017
[38] Fountain, 2009.

Some participants with experience of drug use felt that their substance use was more influenced by social / peer groups than ethnic or cultural communities. However, participants also expressed that cultural acceptance or non-acceptance of substances can factor into whether people engage in drug use in a number of ways:

- Some participants discussed **normalisation of specific drugs in their community, cultural community, or family as a factor which influenced substance use**. Past research has identified that religious and cultural traditions are likely to guide which drugs are used in different communities. For example, one qualitative study found that among a Pakistani community in Glasgow, cannabis was more acceptable than alcohol (due to Islamic teachings which discourage use of alcohol).[39]

- Some participants with experience of drug use from the Somali community described how using khat was an **integral part of their cultural identity** and something they had been exposed to from a young age. As highlighted in earlier research,[40] this was felt to be particularly true for Somali men, with khat being commonly used at gatherings of male friends/family to aid socialising and relaxing. Similarly, some participants with experience of drug use from a Black Jamaican background grew up perceiving cannabis use to be a part of their Jamaican heritage because this was the narrative told and accepted by the members of their community around them. However, participants started to question this association as they grew older, and they were less likely to continue to associate cannabis with their culture if family members did not use the drug.

- While past research has suggested that **Black African and Black Caribbean populations regarded the use of cannabis as more socially acceptable than other ethnic groups**,[41] professional stakeholders did also point out that cannabis is also more normalised among the wider British population. Past research has also suggested that within some gypsy and traveller communities, positive links are made between cocaine use and affluence (with people using cocaine being held in high regard on that basis).[42]

  "If you go back to Jamaican roots music and Bob Marley, cannabis has always been a huge part of that culture… and it is a huge part of that society, normalised and not seen as particularly harmful, it also isn't amongst the White community either." – Professional stakeholder

- Some participants felt that their **curiosity around drugs was partly driven by a lack of exposure during childhood / adolescence**. Some experiences were linked to religious upbringing, others to growing up in ethnic groups that have a particularly negative view of drug use, but not necessarily for religious reasons. In general, the experiences of participants highlighted that parental views and practices regarding drugs and alcohol vary somewhat across all communities and cultures.

  "My parents, they're a Muslim household, so they don't drink, they don't do anything. If anything, maybe because I was so sheltered in my life, it kind of pushed me towards doing it as often as I did." – Person with experience of drug use (British Bangladeshi)

[39] De Andrade, 2014.
[40] Beddoes et al., 2010.
[41] Beddoes et al., 2010.
[42] Beddoes et al., 2010.

- **Cultural perceptions around certain drugs** could also guide behaviours. One participant explained that cocaine was seen as being a rich White person's drug which made them averse to using it.

Professional stakeholders also felt that normalisation of drug use in popular culture and the media can drive substance use among young people.

Peer group and social influences can also be a driver for reducing drug use. Some people with experience of drug use described reducing their usage (frequency and quantity) after moving away from a particular environment. When participants moved away from the environment where they had first been introduced to drugs, or where drugs were more accessible, a reduction in drug use could follow. For example, one participant recounted that they started smoking cannabis with friends at university, but reduced their usage once they moved away because there were less people around them smoking cannabis on a regular basis. Some people with experience of drug use had cut down or stopped using after starting a romantic relationship or having a family. This was often linked to broader changes in lifestyle which encouraged participants to prioritise other aspects of their life such as family, career, mental health or saving money. One participant recalled reducing their use of drugs (such as cocaine and MDMA/ecstasy) when they stopped going to as many parties on the weekends, and then completely stopped smoking cannabis altogether due to lifestyle changes / health reasons once their first child was born.

"Yes, I'm not completely abstaining now, but I'm a bit more sensible, I guess I would say, when it comes to just thinking about what you're taking and how it can impact your mental health and those types of things." – Person with experience of drug use (British Asian)

Environmental context and resources

Availability of resources can drive drug-use behaviours, however the link between wealth and drug use is complex and multi-factored. Some participants described how, once they had started taking drugs, gaining employment, or more lucrative employment, enabled them to spend more money on drugs. They felt this led to an increase in their drug use as they could buy and use drugs when they wanted, rather than relying on friends to share them. Others felt that the high cost of drugs and living (noting the cost-of-living crisis) had caused them to reduce their usage. For some of these participants, spending money on drugs had left them with limited budget for everyday necessities such as food and toiletries. A common experience of cutting down involved only using drugs in social settings.

"So, it got to a point where it was pretty much every day, like in the evening, and then I realised I was spending quite a lot of money on it, so then I started to cut it down to just weekends, or if I was with someone that had it, then I'd smoke it with them." – Person with experience of drug use (Black British)

However, the relationship between drug use and wealth is complex. As shown in section 2.2, we believe that deprivation (based on IMD) is a key predictor of drug use. Previous qualitative evidence has suggested that drugs can be used as a coping mechanism to deal with poor living conditions.[43] Some professional stakeholders had observed that their service users from minority ethnic communities were often facing issues relating to poverty and poor housing that had influenced their drug use. People with experience of drug use also highlighted how substance use (particularly cannabis) was used to relieve stress, and could be seen as a cheaper way to relax when compared to more expensive holistic services (e.g. massage or acupuncture).

[43] European Monitoring Centre for Drugs and Drug Addiction, 2013.

Interviewees also highlighted the links between drug use and unemployment. For example, one person with experience of drug use felt that unemployment had led to their drug use becoming more frequent because they used substances as a way to pass the time. Professional stakeholders also flagged that lack of meaningful employment opportunities, and the resulting boredom and isolation, was a particular driver for drug use among younger people.

"There are lots of factors… particularly with the amount of young people that we're seeing getting in trouble with criminal justice, it's lack of opportunities. There is not a lot for them to do." – Professional stakeholder

People with experience of drug use also stressed the convenience of accessing substances. While it was generally believed that drugs were quite easy to access, some participants felt that substances were particularly available in their social group or local area. One participant described the area they grew up in as being more deprived and "rough", which they felt was linked to the constant presence of drugs.

"It was so much easier than Deliveroo and Uber. Deliveroo and Uber have a timescale. When it came to drugs, there wasn't. As long as you had money, that's it really. So, money and a phone. You just call someone." - Person with experience of drug use (British Bangladeshi)

Legislative and policy drivers

Some people with experience of drug use from a Somali background discussed how the use of khat within their communities had been impacted since the ban in 2014. Some people who had used khat felt that since it had been made illegal, it had reduced in popularity. Others explained that the quality of khat available had decreased since the ban. Participants felt that these effects had led them and others from their community to try other more accessible substances instead such as nitrous oxide and alcohol.

Managing mental health and difficult experiences or emotions

- **APMS data suggests an association between past year drug use and mental ill-health**. In the total APMS sample (2007/14 combined) individuals who had used drugs in the past year were at a 2-fold increased odds of having at least one mental disorder compared to individuals who had not used drugs in the past year (OR 2.22, 95%CI 1.88-2.62). 28% of people who had used at least one drug in the past year had at least one mental disorder, compared to 15% of people who had not used drugs in the past year.

- **This association between past year drug use and mental ill-health remained true across White British and Black ethnic groups.** When stratified by ethnic group, White British individuals who used at least one drug in the past year were significantly more likely to report at least one mental disorder compared to White British individuals who had not used drugs in the past year (OR 2.28, 95%CI 1.90-2.74). Similarly, Black individuals who used drugs in the past year were over 4-times more likely to report at least one mental disorder compared to individuals of the same ethnic group but who did not use drugs in the past year (OR 4.14, 95%CI 1.90-9.00; see Appendix Table B11). See Figure 2.5 for the prevalence of mental disorder in individuals who have, compared to individuals who have not, used at least one drug in the past year by ethnicity.

- **Prevalence of mental disorders varied when comparing White British and Black groups who reported past year drug-use**. Almost 50% of Black individuals who had used drugs in the past year reported at least one mental disorder, compared to 28% of White British individuals who had used drugs in the past year (a 2-fold increased odds of reporting a mental disorder (OR 2.39, 95%CI 1.15-4.97; See Table 2.3)).

However, these findings should be considered in the context of two key caveats:

- These are overall patterns between *any drug use* and *at least one mental disorder* which may differ for specific drugs and for specific mental disorders. The drug with the highest prevalence of use was cannabis, the full list can be seen in Appendix B.

- The findings do not show causality or indicate the nature of the potential relationship(s) between mental health and drug use. Professional stakeholders and people with experience of drug use felt that that there could be two relationships between drug use and mental health. Firstly, some professional stakeholders and people with experience of drug use perceived that, in certain cases, drug use may contribute to the development of mental health issues (e.g., paranoia, depression, and anxiety) or the worsening of pre-existing conditions. Secondly, it was also suggested that drugs can be used by people with mental health challenges to help manage symptoms. However, it should be noted that the links between drug use and mental health were discussed in general terms, and based on observations (rather than clinical diagnoses and research[44]). It is outside the scope of this research to further comment on the intricacies of the relationships between mental health and drug use, and wider academic research should be consulted to better understand the interactions between specific drugs and mental health symptoms. Instead, the detail in the paragraphs below focuses on drivers of drug use among minority ethnic communities.

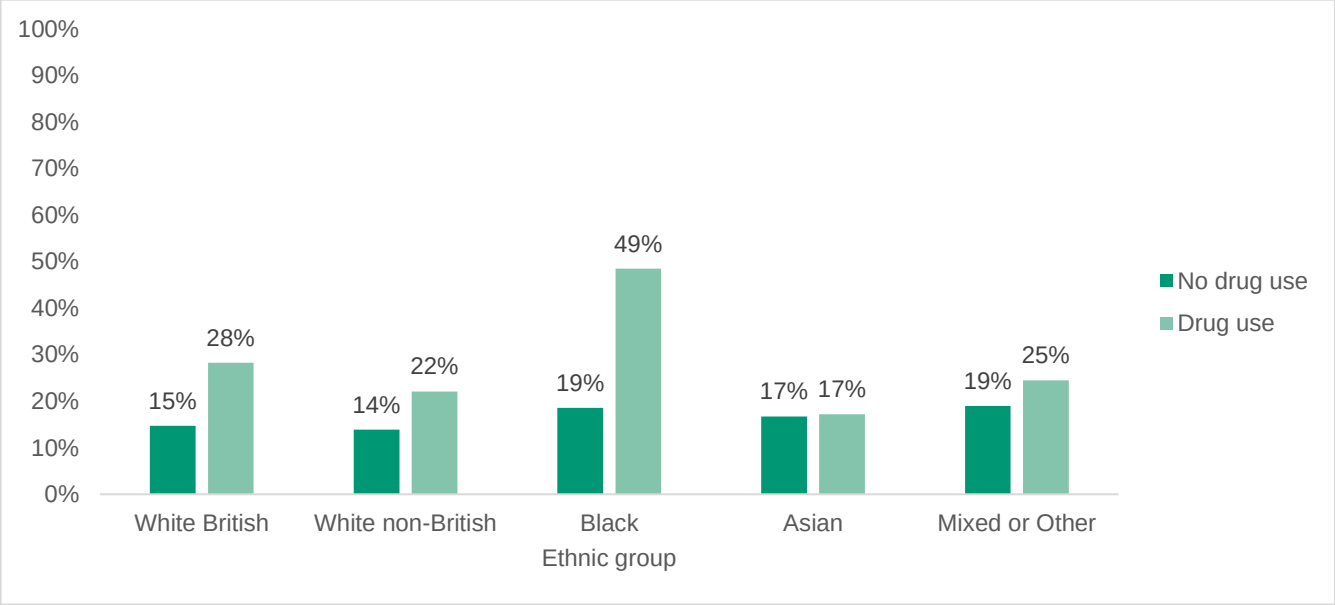
Table 2.3: Prevalence of mental disorder in individuals with past year drug use, by ethnicity

Ethnicity	No mental health condition n (%)	Any mental health condition n (%)	Odds ratio	95% CI
White British	536 (71.75)	211 (28.25)	Reference	Reference
White non-British	65 (77.90)	[18] (22.10)	0.72	(0.38-1.38)
Black	25 (51.47)	[24] (48.53)	**2.39**	**(1.15-4.97)**
Asian	22 (82.76)	[5] (17.24)	0.53	(0.13-2.08)
Mixed or Other	30 (75.53)	[10] (24.47)	0.82	(0.36-1.89)

Source: APMS 2007/14 combined. Base: individuals who have used at least one drug in the past year, and have data on mental health variables, n = 945. Note: [X] indicates caution due to small numbers.

[44] Most of the professional stakeholders did not hold clinical roles.

Figure 2.5: Prevalence of at least one mental disorder, by drug use and ethnicity



Source: APMS survey 2007 and 2014 combined. Base sizes differ; 'no drug use' n=13,213, 'drug use' n = 945.

It was a common experience among people with experience of drug use to have used substances (at some point in the life course) to cover up, escape, or numb negative or painful feelings, and to aid relaxation and sleep. For some participants, this related to physical pain, such as joint and/or back pain. Participants also discussed using drugs to combat stress, anxiety, and trauma caused by changes in their life conditions or past experiences (e.g., financial issues, family problems, unemployment, work-related stress, bereavement, and child sexual abuse). Others mentioned the COVID-19 pandemic and the first lockdowns as the main cause of feelings of uncertainty, entrapment, boredom, and isolation which contributed to the worsening of their wellbeing, and sometimes mental health, and the consequent increased use of drugs.

"I think it was triggered by the environmental factors of how tough the lockdown was, in terms of no physical contact." - Person with experience of drug use (British/Sri Lankan)

"I think I started taking drugs because it covers my pain for me, because I was sexually abused at a young age... It's really sad to say, it's like the weed and the alcohol was my support." - Person with experience of drug use (Black Caribbean)

Isolation, discrimination, and social exclusion are also key drivers of drug use for people from minority ethnic communities. Some participants with experience of drug use described their experience with discrimination and racism as one of the main causes of their mental health problems for which (they felt) using drugs became a coping mechanism. This aligns with findings from earlier research with people from minority ethnic groups.[45] As described by these participants, being from a minority ethnic group, especially if their family had recently moved to the UK, meant experiencing a higher degree of isolation compared to their peers, linguistic barriers and consequent educational problems, episodes of racism and discrimination, and confusion about their own identity. One participant felt that being unable to integrate into their school community due to language barriers influenced a spiral of negative impacts including isolation, low academic performance and mental health challenges which culminated in drugs being used as a coping mechanism. In particular,

[45] Burton et al., 2017.

professional stakeholders highlighted experiences of individuals with refugee or asylum seeker status who are coping with a lack of belonging in their communities, lack of employment opportunities and trauma related to conflict and displacement.

"We have a big Somali community. They are from groups, lots of them are displaced or they are housed as part of displacement. When you look at some of the causative factors [of drug use], some of that was also related to sense of belonging in their communities, lack of employment opportunities, still recovering from trauma." – Professional stakeholder

Other participants explained how feelings of exclusion during their formative years (due to ethnicity, sexuality, or disability) influenced identity struggles that drove drug use. One person with experience of drug use described a period when they felt more comfortable with their sexual identity whilst using certain drugs (including GHB and crystal meth), describing these substances as helping them feel more relaxed in social situations.

"I really struggled actually as a teenager. Not necessarily just about drugs, but I struggled in other ways, finding my own identity in a Western country with first-generation migrant parents, and… there was times when I was really rebellious. I look back on the way I behaved, and I think the drug taking was one of those things to be rebellious." – Person with experience of drug use (Chinese)

Others described feelings of guilt and shame as emerging from their experience of not behaving according to their family's religious and cultural traditions. Some participants felt the pressure to make certain life decisions, including getting married and having children. These feelings were described as particularly intense by gay participants who explained that using drugs was their way to cope with feelings of guilt and shame and with the trauma and anxiety derived from their need to hide their sexual orientation from their families. The use of drugs, however, also needed to be hidden from their families. This compounded the feelings of guilt and shame, and made it more difficult for them to look for help.

"*[I was in an environment where] everything was a sin, everything was bad, everything was given either good or bad value, everything was either permissible or non-permissible. […] I was building up more and more shame and guilt, [and] I didn't know what to do. I didn't know how to ask for help from my family, because I thought that I would be disowned, and I thought I was going to be disowned anyway for being gay, which is why I kept it a secret, and I do think that that had a role to play in fuelling my addiction and keeping it going for as long as it has.*" – Person with experience of drug use (British Pakistani)

There may also be **barriers to mental health treatment and support** for minority ethnic communities, which exacerbate mental health challenges. In individuals who had not used drugs in the past year, the White non-British and Black population were significantly less likely to have received any mental health care in the past year when compared to the White British population (see Appendix Table B12). Among individuals who reported using at least one drug in the past year in the APMS, there were no significant differences in the likelihood of having received mental health care in the past year between minority ethnic groups and the White British population. However, it is important to note that case numbers are small and confidence intervals are wide, and this adversely impacts the extent to which we are able to make inferences about differences between groups on mental health (see Appendix Table B13). When compared to individuals in the same ethnic group who did not use drugs in the past year, White British individuals and Black individuals who had used at least one drug in the past year were significantly more likely to report receiving mental health care in the past year (OR 2.18 and 2.98 respectively). While not discussed in detail, people with experience of drug use did mention barriers to receiving mental health care, including a stigma around discussing or seeking help for mental health challenges. Gender

norms were felt to influence this stigma for both men and women. Some participants highlighted challenges that men might face in talking about their mental health (due to fears of seeming “weak” or similar) while women were seen to face additional caregiving pressures that did not allow them to express or seek support for mental health issues. Participants also highlighted wider barriers to seeking treatment and support, which are discussed in Chapter 3.

Knowledge and reinforcement

Knowledge around different substances and the impacts of drug use can drive behaviours. People with experience of drug use discussed how their beliefs about the consequences of using drugs influenced them to use or not use drugs. Some spoke about how they had heard about positive benefits of drugs, particularly cannabis, which they believed had no severe negative effects unlike other drugs such as cocaine and MDMA/ecstasy. Those who felt that cannabis use was normalised in their childhood/adolescence explained that drug use was only seen as a problem in the case of “hard” drugs like cocaine. This was the rationale some participants – particularly those from Black ethnic backgrounds – gave for only using cannabis and avoiding other drugs. Other participants felt that their cannabis use had led them to use other substances (for example, because they were exposed to drug dealers who introduced them to other substances). Professional stakeholders felt that in some cases, the marketing of certain substances had influenced perceptions of, and knowledge around, drug use. In particular, it was felt that the rise in “cannabis shops”[46] (which advertise drugs as helping with stress and anxiety) and links between health and substances such as CBD,[47] may normalise use or portray drugs in a more positive light.

"I feel like I haven't heard of any deaths from weed personally, or I haven't seen anyone I know smoke weed and really become violent or completely change as a person." – Person with experience of drug use (Black British)

People with experience of drug use also spoke about their **understanding and experience of the effects of drugs and how this influenced their use**. It was common for participants to take particular drugs due to their own positive experiences of those substances.

“I enjoyed taking it though, this is the thing. I don't care what anyone says, I had the time of my life getting stoned at 15. I'm not going to deny it.” – Person with experience of drug use (White Irish / Black British)

However, some participants reduced their use of drugs or stopped altogether when they realised that they were relying too much on a drug to feel better or when they felt the need to better look after their mental health. Some participants were supported by mental health services or drug use support services in doing this, while others did not access any services when trying to prioritise their mental health by reducing their drug use.

"I was like, oh God, I'm becoming too reliant on cannabis to relax. I just felt like I would look forward to it, and I felt like I needed it to relax...I kind of said to myself, I was like, okay, I have to stop. I had to just stop using it for a while because it was becoming too habitual." – Person with experience of drug use (Chinese)

[46] Referring to shops that sell the cannabis-derived supplement cannabidiol (CBD).
[47] The cannabis-derived supplement cannabidiol.

3. Support and treatment services

3.1 Experiences of treatment and support

Reasons for seeking treatment and support

Participants with experience of drug use accessed support with the aim of ceasing all drug use; ceasing use of one type of drug but not all drugs or alcohol use; or minimizing or managing drug use rather than aiming for abstinence. Aims were influenced by the financial situation and health of the individual.

Pathways to treatment and support

It was common for participants to **first discuss drug use with their GP**[48] in conjunction with other health concerns, primarily mental health or problems sleeping. GPs gave advice to people about issues that were driving drug use (e.g. sleeping problems) or referred them on to other services, including mental health or drug treatment services. Overall, participants found the advice of their GP helpful. **Other healthcare professionals also played a role in signposting to drug use services**. For example, one participant had been hospitalised due to drug use and mental health and the mental health team they were working with referred them to a local drug treatment centre.

Participants also learnt about drug treatment and support services through researching support available or word of mouth (for example, through friends who had accessed the service or who worked at the service). Other participants had seen information or advertisements about help services (e.g., on the noticeboard of the housing association where they lived or seeing an advertisement on social media).

Types of treatment and support accessed

People with experience of drug use had varying experiences of treatment and support services (including those who had not attended these services). Some people engaged with one service and found that their goals were met, while others have worked with many different organisations and are still struggling with their drug use. There was also variety in terms of the types of treatment accessed.

- Some individuals **attended rehabilitation services in the UK while others attended services abroad in their home nation** – for some this was residential, while others attended daily or every few days.
- Some participants attended **in-person services at local drug treatment centres** – this included attending group sessions, being assigned a caseworker, or enrolling in a multi-step treatment programme. Another experience was accessing support delivered by drug use services **over the phone or online** – in some instances this was due to in-person services not being available during the COVID-19 pandemic.
- Some participants accessed services not specially designed to address substance use. For example, telephone support through organisations such as Samaritans who **signpost to other providers**. Some

[48] Referring to General Practitioners (Find a GP - NHS)

participants also had experience of **accessing mental health support** which helped improve their overall health (including drug use).

- Interviews with professional stakeholders also demonstrated the different forms of support. Stakeholders offered a range of services including addiction psychiatry and other NHS services and community-based drug and alcohol support services targeted at specific groups (e.g., young people)

Participants who did not access support fell into two groups: those who felt that they would benefit from accessing support but faced barriers to doing so, and those who felt that their drug use was sufficiently "controlled" that they did not need and would not benefit from formal support. Some of the steps taken by both groups to manage or reduce their drug use included seeking informal support from friends and family and looking up advice online, including educational videos and support forums. For some, these steps were sufficient and they did not have the need or desire to access other formal sources of support, while others felt they would benefit from accessing further support but reported experiencing barriers that made doing so difficult – these barriers are discussed below in section 3.2.

3.2 Barriers to accessing and engaging in treatment and support

While there are cross-cutting barriers to treatment experienced by all ethnic groups, minority ethnic groups face specific barriers to accessing and engaging with treatment and support services.[49] This section explores these barriers, drawing on earlier research and interviews with professional stakeholders and people with experience of drug use.[50]

Stigma, shame, and fear of judgement

It has already been shown that the stigma attached to substance use and addiction can cause people who struggle with drug use to conceal their experience from those around them and refrain from seeking out or accepting support.[51] Stigma was commonly highlighted as a barrier to accessing treatment and support in interviews with people with experience of drug use. **While participants acknowledged that experiences vary between and within ethnic groups, some felt that that there was a particularly significant stigma around drug use in their own ethnic, cultural, or religious community.**

A number of factors were thought to drive stigma around drug use for people from different communities, including religious teachings, attitudes / norms around gender, and community size and values. Some participants with experience of drug use explained that their faith or the prominent faith in their community prohibited all / certain substance use, which could be a driver of community members feeling shame if they did engage in drug use. Professional stakeholders and people with experience of drug use also described how experiences of stigma were gendered, with women potentially facing additional repercussions if their community found out about their drug use. For example, young Muslim women were reportedly concerned that if people in their community found out about their drug use, this may affect their likelihood of getting married. Earlier evidence suggests that women can face a greater degree of stigma around drug use, relating to perceived failings in their roles as mothers or caregivers.[52] Arguably, these stereotypes may apply to all women with experience of drug use. However, one view was that this type of gendered stigma may be more pertinent for women who feel that their community expects them to take on more traditional 'female' roles. People with experience of drug use also discussed situations where men might be more reluctant to talk about struggles with

[49] https://publications.parliament.uk/pa/cm5803/cmselect/cmhaff/198/report.html
[50] This chapter does not provide an exhaustive account of barriers to treatment and services and focuses on factors which have been specifically linked to the experience of people from minority ethnic groups.
[51] Burton, et al., 2017., Fountain, 2009. & The UK Drug Policy Commission, 2010.
[52] With You, 2021.

substance use due to gendered notions of pride and wanting to avoid appearing "weak". While talking about personal issues was felt to be difficult for men generally, some male participants experienced this perception of masculinity as being particularly strong in their ethnic or religious community, especially among older generations.

Professional stakeholders also suggested that stigma can be particularly challenging for people within small, tight-knit communities and highlighted that some people were particularly reluctant to access services within / close to their own community for fear that someone will see them, and their community will become aware of their drug use. Professional stakeholders also echoed findings from earlier research, which highlight that some communities may be more likely than others to view behaviours as the responsibility of the family rather than the individual. This can result in stigma around drug use negatively affecting the person using substances and their family or increase the likelihood that people will hide their drug use from those close to them.[53]

People with experience of drug use described how this stigma led them to hide struggles with substance use for fear of embarrassment, judgement, and isolation. This caused some participants to delay seeking help for their drug use, or to not access support at all. People with experience of drug use believed that the stigma around drug use in some minority ethnic communities means that families are less likely to support a drug using member to get help than in White families, which were perceived by participants as being comparatively more "relaxed" about drug use.

> *"I was scared of what everyone would say from my background, family and community."* – Person with experience of drug use (British Pakistani)

Stigma and shame can also act as a barrier to successful treatment outcomes once services are being accessed. Professional stakeholders provided examples of service users receiving treatment without the knowledge of those close to them. In these cases, the risk is that someone's drug use is discovered while treatment is ongoing, leading to strain on personal relationships and the service user disengaging with support.

Lack of awareness of available services

Information about drug treatment and support services is less likely to reach minority ethnic communities than the White majority, preventing these groups from accessing help when they need it. People with experience of drug use described the lack of visibility of services and spoke of situations where they wanted to seek help but did not know where to look for it.[54] It was felt that this challenge was particularly pertinent for first generation immigrants who may be less familiar with support options and navigating healthcare services. Professional stakeholders highlighted that they face challenges publicising their services generally due to high demand and limited resources. They also reported that strain on resources can prevent targeted approaches to reach specific groups, such as working with groups and organisations already active in these communities. Professional stakeholders and people with experience of drug use emphasised the key role of GPs in the referral process, with many interviewees first contacting their GP over concerns about their drug use.[55] People with experience of drug use also felt that there were **few examples of successful recovery stories** within their communities, making the idea of seeking help more daunting.

[53] European Monitoring Centre for Drugs and Drug Addiction, 2013. & Fountain, 2009.
[54] This supports findings from previous research, including Fountain, 2009.
[55] Previous research further supports this, finding that minority ethnic groups were more likely to hear about help from GPs, religious organisations and their friends and family rather than from drug use services directly (Beddoes et al., 2010).

Language barriers

Language barriers play a role in limiting knowledge of, and access to, available services. Participants with experience of drug use explained how they had not felt able to access services and communicate complex medical issues (like drug use) before they spoke English fluently. Other participants commented that while they personally were unaffected by language barriers, others in their community would be.[56] For example, participants explained how members of their family seek out medical professionals who speak the same language as them, and so their access to services is constrained by what is available in their own language. Others explained how they had never seen materials about services in their native language or distributed at places where people from their community typically gather.

Professional stakeholders stressed that even if an organisation is well equipped to deliver services in a variety of languages, anticipation of a language barrier can still deter potential service users. Furthermore, when service providers have the resources to provide interpreters, they will unlikely be able to cover every language spoken in the local area. Service users can also feel uncomfortable about the use of interpreters when discussing sensitive issues. Professional stakeholders and earlier research[57] suggest that there can be a power imbalance when translators are used, with stakeholders explaining that the translator is the one responsible for accurately conveying the meaning of the service user who is unable to gauge whether they have been understood as intended.

Certain groups may be particularly impacted by language barriers. For example, professional stakeholders believed that asylum seekers might be disproportionately impacted because they are more likely to speak a language less commonly spoken in the UK (that is less likely to be accommodated for in healthcare services). Earlier research also suggests that older people and women in some communities can be more affected by language barriers as they might have less contact with English speakers.[58]

Lack of trust in services

Previous research suggests that there is a **low level of confidence in mainstream drug services in minority ethnic communities**.[59] This barrier was commonly noted among people with experience of drug use, and related to the following factors:

- **Previous negative experiences***.* Past research has shown a lack of trust in healthcare services due to previous experiences of racism or discrimination.[60] Professional stakeholders and people with experience of drug use also highlighted how broader experiences of receiving poor treatment (in England and other countries) made people wary about having similar experiences at drug use treatment services. Lack of trust was not solely based on an individual's own prior experiences, but those of family or community members. Professional stakeholders suggested that negative views can be inherited, influencing communities to avoid services even where there have been improvements. Furthermore, a general awareness of poorer medical

[56] Interviews with people with experience of drug use were conducted in English only. As a result, our sample was unlikely to report having personal experience of language barriers.
[57] De Andrade, 2014.
[58] Fountain, 2009.
[59] BAC-IN, 2021 & Ismail, 2012.
[60] BAC-IN, 2021.

treatment or outcomes for people from minority ethnic groups is enough to deter them from engaging with services.[61]

"Being an ethnic minority is a barrier for me to want to access these services because I feel, within the regional services, there's a lot of racism." – Person with experience of drug use (White British / Black Caribbean)

- **Concerns over confidentiality.** People with experience of drug use reported concerns about police or social services being informed of their drug use by staff delivering treatment services. Others were concerned that their employer would be notified and they would lose their job. Participants expressed concern that staff members from their community might tell those close to them about their drug use. While no interviewees experienced breaches in confidentiality, the fear that it might happen influenced their decision about whether to seek treatment. Previous research suggests that the extent to which service users from minority ethnic groups are concerned about confidentiality can be impacted by their migration history. For example, people who have recently moved to the UK might have concerns over their drug use impacting their visa or asylum status, affecting their ability to get a house or preventing them from being able to claim certain welfare benefits.[62] This was also highlighted by a stakeholder as a barrier he had seen when generating awareness about the abstinence programme he was delivering. Earlier research suggests that some minority ethnic women with experience of drug use fear having their children removed from their care.[63]

"Someone may know who I am, or my parents, and just spread the word." – Person with experience of drug use (British Bangladeshi)

- **Concerns over appropriateness of the service offer.** Previous research has identified that concerns or negative perceptions about the cultural competence of drug treatment services can prevent people from seeking treatment.[64] Professional stakeholders and people with experience of drug use highlighted concerns that healthcare professionals from different ethnic communities would not be understanding of cultural needs and may be perceived as unable to help. Some people felt that only someone of the same ethnic background would be understanding of their needs, while others felt that staff members of any minority ethnic group would be adequately understanding, and they would only be deterred by an exclusively White staff. One participant explained that when they moved to a more rural, predominately White part of the UK they did not access services out of fear of receiving discrimination due to their ethnicity and previous geographic location (an area in the UK usually associated with negative stereotypes).

"I know quite a lot of people from the Black and ethnic minority community, they feel like maybe certain doctors and nurses, because there's not as many of them from their community, can't relate to them, or don't take them seriously. Like there'd be an unconscious bias in how they'd deal with them, and I guess in general, people are more comfortable, especially when it comes to personal things, talking and dealing with people from similar backgrounds to them." – Person with experience of drug use (Black British/African).

[61] For example, people with experience of drug use cited statistics relating to how Black men are more likely to be sectioned, Black women more likely to die in childbirth and that minority ethnic people were disproportionately impacted by COVID-19 to explain a distrust in health services by Black people.
[62] European Monitoring Centre for Drugs and Drug Addiction, 2013., Ismail, 2012. & Burton et al., 2017.
[63] With You, 2021.
[64] European Monitoring Centre for Drugs and Drug Addiction, 2013.

Lack of appropriate services available

Further to the concerns above (which prevent people engaging with services), this research has highlighted that for some people, local culturally appropriate services do not exist. These challenges are two-fold:

- **Lack of culturally competent services.** Professional stakeholders explained that cultural competence (understanding that different communities may prefer different forms of communication, treatment and support) is key to successful treatment outcomes. Previous research has highlighted that service users from minority ethnic groups feel there is a lack of treatment and support for people who use drugs that is sensitive to different cultures and religions.[65] Criticisms include services not recognising specific cultural challenges (e.g. familial pressures)[66] and not being flexible to different cultural, faith-based and spiritual perspectives to recovery and rehabilitation.[67] Culturally competent support should be flexible to respond to different needs and preferences. For example, professional stakeholders suggested that some people will want to speak to a staff member from a similar ethnic background who understands their specific cultural experience and how this links to drug use. However (as highlighted above) some people with experience of drug use would be less likely to fear judgment or breaches of confidentiality if their support provider was not from their community.

"If you're using substances to deal with a lot of your personal issues, you're dealing with racism and if you're dealing with the threat of forced marriage and whatever it is, you might not want to come into a service and talk to someone who doesn't understand it. I think that can be a big barrier into why you use substances and why you might not want to talk about it, because you don't feel like someone understands." – Stakeholder

- **Lack of gender-specific services**. People with experience of drug use explained how within some minority ethnic or religious communities, it is considered inappropriate for men and women to mix in public places. As a result, members of these communities may only be comfortable being supported by someone of the same gender. Professional stakeholders explained that women who have experienced trauma or domestic violence can find it particularly difficult to open up in spaces that are male dominated (as many drug use treatment services often are, since the majority of people accessing drug use treatment in the UK are men).[68] They felt that this was a particularly significant issue given links between experiences of domestic violence and drug use. People with experience of drug use also highlighted that it is especially difficult for women to access services where they are the primary caregivers and cannot leave their dependents to attend treatment.

Not recognising drug use as problematic

Professional stakeholders highlighted that people will only attend support services where they identify their drug use as problematic. It was felt by professional stakeholders and people with experience of drug use that **cannabis use is more socially acceptable and normalised than other drugs, particularly among certain communities**. For example, some Black Caribbean participants explained that smoking cannabis was viewed as a normal part of their culture, and they had grown up in environments where cannabis use was viewed as commonplace and / or beneficial. Some participants felt this made it harder for them, and other members of their community, to recognise when their use was having a negative impact and consider seeking treatment. It should

[65] European Monitoring Centre for Drugs and Drug Addiction, 2013., & Fountain, 2009.
[66] Fernandez, 2015.
[67] BAC-IN, 2021.
[68] Stakeholder views are supported by findings from earlier research such as Beddoes et al., 2010 and With You., 2021.

be noted that although this particular experience emerged from participants in our research, there are likely to be many similar experiences in other communities where particular substances are normalised (including alcohol).

"Maybe in a community where people feel like it's not a problem to smoke it at all, then they wouldn't think that they need to access help to stop. I guess the mindset behind it, because some people see it almost the same as maybe British culture of going to the pub for a drink after work." – Person with experience of drug use (Black British/Caribbean)

More broadly, there is evidence (including from interview participants) that people who use cannabis may refrain from accessing, or engaging in, support due to a perception that treatment is only necessary for "hard drugs".[69] This can result in help only being sought when a crisis point is reached (such as severe health issues or arrest).[70]

Financial/resourcing barriers

Some people with experience of drug use mentioned **financial barriers which prevented them from accessing private services to help with their drug use**. While participants were generally aware of free drug use services available, some had concerns over the quality of the care they would receive from such services, particularly those operated by the NHS (citing a lack of funding and understaffing). As a result, some participants felt that to receive high quality support they may need to access private services.

People with experience of drug use also highlighted that some minority ethnic communities might have less disposable income than White British people to spend on private services, highlighting inequitable access to high quality drug treatment which is likely to become more pronounced as a result of the cost-of-living crisis. One participant felt that young people in particular would need financial help from their families to access private treatment but would feel unable to ask for this support due to concerns arising from stigma.

"In my cultural world, going private costs a fortune, and generally, you might need your parents to pay for that, but then you're too scared or whatever to ask your parents about it." – Person with experience of drug use (White British / Sri Lankan)

Professional stakeholders echoed concerns around resourcing for free-to-access support services, highlighting that shortages of staff and funding can limit the extent to which services are able to deliver a culturally competent service to service users from minority ethnic groups.

3.3 Facilitators to accessing and engaging in treatment and support

This section discusses ways in which barriers to treatment can be overcome to enable more equitable access for people from minority ethnic communities.

Improving knowledge about and trust in services

Professional stakeholders and people with experience of drug use stressed the need to **ensure that support / treatment offers are clearly communicated to minority ethnic groups, emphasising that services are confidential and free of charge**. Participants with experience of drug use also spoke about the need to improve broader education about the risks of drug use and opportunities for support, to enable informed decisions about

[69] Fernandez, 2015. & The UK Drug Policy Commission, 2010.
[70] Fountain, 2009.

substance use and seeking help. It was also felt that more information could help tackle misconceptions and stigma outlined in section 3.1. It was considered to be important for information to reach both younger and older people, to ensure that families are in a better position to support their loved ones regardless of their own feelings about drug use.

Professional stakeholders described efforts that had been taken to raise awareness of services. **Outreach work with minority ethnic communities was felt to be particularly successful in promoting services and building trust between communities and service providers.**[71] Successful approaches involved meeting people in community spaces rather than operating from one central hub. Spreading messages about drug safety and support **through organisations and groups integrated into communities** was highlighted as an important way of reaching people. This can also help ensure that approaches acknowledge preferences and needs of different groups within communities. For example, one participant with experience of drug use highlighted the importance of youth leaders / centres in engaging young people in conversations about drugs and supporting them to seek help where appropriate. Another professional stakeholder had successfully worked with a local South Asian women's group to promote their services and provide informed support. In some cases, it will be important to think carefully about who is involved in outreach work. For example, some female participants with experience of drug use felt that having female staff promoting services could help raise awareness among women who would feel less comfortable communicating with a man.

"The principles are really about going to where people are, not expecting them to come to us. They are about growing trust. They are about representing that community, not going in as somebody who doesn't particularly look like them, talk like them, know them." – Stakeholder

Both professional stakeholders and people with experience of drug use stressed the role that religious leaders could play in raising awareness of substance use issues and signposting people to support. One treatment provider we spoke to is supported by religious leaders to attend places of worship and highlight their service offer, making them more visible to the local religious community. People with experience of drug use also suggested that religious leaders could more actively promote people seeking support for drug use problems to help tackle stigma and attend treatment services to help reassure service users about their choice to get help.

"These things should be talked about in a productive and healthy way in mosques and in community centres… there needs to be healthy dialogue that someone in your family might be ill – that doesn't make them a bad person, and they need support, and this is where you can access support." – Person with experience of drug use (British Pakistani)

Past research has recommended that educational and promotional materials about drug use and treatment services need to be available where different communities are likely to access them, such as libraries, colleges, schools, and religious spaces.[72] Participants with experience of drug use stressed the importance of these materials being available at GP surgeries due to their key role in facilitating access to support and treatment. Professional stakeholders and people with experience of drug use also stressed the importance of translating these materials into different languages. One professional stakeholder found it helpful to work with local community organisations to ensure that translations are correct and appropriate. Services can also adjust their messaging to ensure relevance for different communities. One professional stakeholder explained how their

[71] This approach is supported by earlier research, which demonstrates that importance of word-of-mouth in promoting services among some minority ethnic groups (de Andrade, 2014; Fernandez, 2015; and Fountain, 2009).
[72] Burton et al., 2017.

service is trying to do this by adjusting the messaging on their website and newsletter to engage the Caribbean community in their area. People with experience of drug use suggested that images of diverse practitioners and service users should be featured on promotional information so that everyone can see themselves represented.

"They'd be just very simple things: if it's going to be a billboard or an ad in a magazine, to make sure that it features diverse practitioners so that it would engage a wider audience looking at it, reading it and thinking, yes, this is something that could work for me." – Person with experience of drug use (Black Caribbean)

Culturally appropriate approaches

The following factors were felt to be important to ensure that drug treatment and support services can meet different cultural needs and preferences.

- **The importance of lived experience and diversity among staff and volunteers**. Professional stakeholders explained how having staff from similar backgrounds to service users can dispel myths about the treatment offer (e.g. that the service is not suitable or appropriate) and can help service users feel more at ease and more likely to engage.[73] Some people with experience of drug use felt better understood by staff with similar life experiences – this included staff who had struggled with drug use in the past, or with similar experiences relating to ethnic background and / or sexuality. This was felt to reduce the burden of treatment, because staff members would better understand the background and context of their drug use. This emphasises the importance of encouraging and supporting diversity across staff working in drug treatment and support. Professional stakeholders and people with experience of drug use also highlighted the importance of having positive role models to help people feel confident about the likely success of treatment. As well as employing staff with experience of drug use, people with experience of drug use suggested that this could involve facilitating peer mentoring programmes whereby service users are supported by people with similar cultural experiences.

"They'll understand straightaway, so it seems like you're not having to double your workload by saying who you are, and what you follow, and what you've been around. It's more direct, isn't it, and you know that it's going to be less time-consuming and more tailored to you in a way." – Person with experience of drug use (British Bangladeshi)

"A peer mentoring programme where people are paired with someone from similar backgrounds who have gone through the same thing - I think that would be really handy because it's easier to tell someone who understands your situation than potentially the people closest to you or someone you've never met before." – Person with experience of drug use (White British/Sri Lankan)

- **Person-centred, personalised approaches.** While some people with experience of drug use felt there was significant value in staff having similar cultural experiences, others would feel more comfortable seeking support outside their community (see section 3.2). In some cases, people with experience of drug use also felt that shared experience was less important than staff being empathetic, non-judgemental, and having the skills to build strong relationships. This range of views demonstrates that enabling service users to have choice and flexibility around their support could help ensure that different needs and preferences are met. People with experience of drug use also stressed that needs vary across and within different minority ethnic

[73] These findings are also supported by earlier research which found that some people from minority ethnic groups felt that people with similar lived experience to them were better able to understand and respond to their needs (With You, 2021).

communities, and this diversity needs to be understood by service providers. Professional stakeholders emphasised the importance of truly understanding the needs of the population the service is hoping to help and recognising that the demographics and needs of different areas will vary – they recommend looking at local data to inform a culturally appropriate approach. Both professional stakeholders and people with experience of drug use stressed that staff need to be given adequate training to understand the needs of different local communities and deliver support that is culturally appropriate. It was felt to be important that services engage people from minority ethnic groups from the point of set up – through co-production – to enhance understanding of local needs and inform how services are designed and delivered.

"I guess one of the ways to make them more culturally appropriate is to understand the many variations of ethnically diverse communities… as a starting point, like having an understanding of the diversity of people within these communities is really important, and then how that affects the way they use the service." – Person with experience of drug use (Chinese).

- **Providing targeted services where appropriate.** While no participants suggested targeting services at specific minority ethnic groups, recognising wider elements of lived experiences may help some people engage with support. Professional stakeholders and people with experience of drug use emphasised that family support was especially important for younger people from minority ethnic groups living with their family. In these cases, it was suggested that staff members from the same community may be best placed to help families support their loved one through the treatment process. Professional stakeholders also highlighted the important role of partnership working in taking a culturally appropriate approach; organisations already exist that successfully work with people from minority ethnic groups, and more focus should be placed on working with these organisations to enhance service provision, rather than creating new services that might be less successful at engaging people from minority ethnic communities. As mentioned above, it was also suggested that treatment providers offering gender-specific groups or programmes could help some people engage with treatment. Professional stakeholders described specific services they offered in responding to the needs of their service users to boost engagement, for example offering childcare at a service that was frequently attended by single mothers.

"Instead of creating our own space within our service for [minority ethnic] service users, it's maybe just thinking about the work that's already going on in our local communities and building those up. They are the specialist services, and I think it's kind of working together instead of trying to say that we know everything and we know how to tailor to everyone." – Professional stakeholder

"*Maybe they should try to push out services just for women, where women can feel secure to talk behind the door with women."* – Person with experience of drug use (Black Caribbean).

Professional stakeholders working in drug treatment delivery highlighted that the above recommendations that ensure different cultural needs are met all require an investment of time and money to be implemented effectively. Some recommended that there needs to be "ring-fenced" funding to provide this culturally appropriate support.

Taking a holistic approach

As this research has shown, drivers and experiences of drug use will vary across and within communities depending on environmental context, social identity and individual challenges. There is no one-size-fits all approach to supporting people from minority ethnic groups, and increasing access to drug use services alone is

not sufficient in helping people address substance use issues. Professional stakeholders and people with experience of drug use stressed the importance of **providing holistic support services that recognise and support all aspects of service users' lives and address wider barriers to treatment success, including challenges with mental health, housing and employment.**[74] Interviews with professional stakeholders and people with experience of drug use highlighted the role of systemic issues (such as deprivation, unemployment, racism, and discrimination) which contribute to mental ill health and the use of drugs as a coping mechanism among people from minority ethnic communities. Professional stakeholders stressed that this particular challenge specifically requires a more holistic treatment and support approach. Such an approach needs to examine different aspects of someone's life that may have contributed to a worsening of mental health and provide a more comprehensive type of support that considers these aspects when defining their treatment journey. Professional stakeholders explained that partnership working (e.g. with mental health services and the Jobcentre) is key to providing this wraparound care.

"All of that other stuff: you need somewhere to live, you need enough to eat, you need mates, you need people who love you. You need to have a reason to change." – Professional stakeholder

Accessibility and responsiveness

People with experience of drug use and professional stakeholders stressed that services need to be as simple to access as possible. This was felt to be particularly important for people from minority ethnic groups who might already face a number of barriers to treatment – since they might face difficulty accessing services, it is important that once they do make contact the process is simple, quick and appropriate. This can be enabled in the following ways:

- **Opening hours.** This involves enabling flexible appointment times and a wide range of opening hours. People with experience of drug use spoke about working night shifts and needing services that were available outside of traditional working hours.[75] One participant with experience of drug use explained that opening times could be a particular barrier for young people from minority ethnic groups, since they might be more likely than young White British people to live with their families for longer. Where young people do not want to tell their families about their experiences with drug use, they may need flexibility around appointment times to maintain confidentiality. Similarly, earlier research has found that it is important for service providers to reach young people through schools, as it provides them with a way to access the service without parents being aware.[76]

"It's quite a tradition to live with your parents until you're a bit older in the Asian culture, and as a consequence, your parents probably – if you're not around, they might be like, where are you? If someone was working from home and they had an opportunity to go to a drop-in session at a sort of untraditional time [that could be helpful] […] it would be a reason not to go to an appointment if you were worried about where people think you are. So, yes, flexibility of timing [is important]." – Person with experience of drug use (White/Sri Lankan).

- **Efficient and responsive services**. Previous research has found that services that were successful in engaging and retaining service users from minority ethnic groups in drug treatment did so in part due to

[74] This is also supported by earlier research (BAC-IN, 2019 and EMCDDA, 2013).
[75] Earlier research has found that opening times were often reported as barriers to treatment by minority ethnic respondents (BAC-IN, 2019). However, it was not clear from the existing evidence whether/why this impacted minority ethnic people more severely than the white majority.
[76] Gray & Ralphs, 2019.

offering rapid assessment within 24 hours.[77] This allows service users' goals to be accommodated quickly. Professional stakeholders commented that rapid access is particularly important to support more vulnerable people (e.g. those being seriously harmed by drug use) to engage and minimise ongoing harms. Professional stakeholders also stressed the importance of being responsive when someone drops out or misses an appointment to help that person re-engage and prevent relapse. Being responsive to the needs of service users can also involve enabling individuals to set their own goals in order to boost engagement and motivation.

"If I told you what your goals are, you'll be less successful because they're not yours, they're mine. I think these nuances, they're subtle and they're really important. Services are set up to tell people what they need to do." – Professional stakeholder

- **Online vs in-person delivery.** As highlighted above, services need to be responsive to different needs. Some people with experience of drug use found it beneficial to have online or over the phone services – they felt that it was easier to fit this around their schedule and was less daunting than attending face-to-face support. As discussed in section 3.2, some people are also worried about being seen by people they know when accessing physical services, and therefore would be more willing to access services online. However, others found that they did not engage as well with remote services, and that it was only by physically attending treatment services that they saw progress toward their goals. Some young people from minority ethnic groups who live with their family members might not want to have online or phone support that needs to be accessed from their home for fear that family members will hear/see them.

[77] Fernandez, 2015.

4. Reflections and recommendations

4.1 Strengths and limitations of the research

This research was commissioned with the purpose of better understanding the use of drugs (with the exclusion of opiates, crack cocaine and alcohol) among people from minority ethnic communities.[78] The methods used for this study were selected to allow for extensive exploration of such a multifaceted subject within a finite timeline and budget. These methods presented strengths and limitations that are described in this section.

Key strengths

- **Mixed-methods approach**. The methodological approach used for this study (comprising both quantitative and qualitative methodologies) allowed for in-depth exploration of drug use among minority ethnic groups and, to some extent, how these compare to the White British majority. Quantitative analysis of survey data allowed us to present an overall picture of drug use while qualitative interviews allowed for in-depth exploration of issues such as drivers of drug use and barriers to support. In particular, collecting data from different stakeholder groups enabled a deeper understanding of how barriers to treatment can manifest.

- **Use of behavioural theories and frameworks i.e., Theoretical Domains Framework (TDF) and intersectional lens**. We have used the TDF and an intersectional lens to explore the determinants of behaviours linked to drug use and to decision-making on support and treatment. This approach helped us identify factors that shape specific behaviours and what may contribute to behavioural changes at different levels (individual, family, friends and peers, ethnic group, and general social system) in a systematic way. The TDF contains a number of "domains" which can be used to identify and categorise influences on behaviours. The TDF was used to inform the interview topic guides, and to identify and structure the findings in this report. TDF is an effective tool in mapping these different factors, but given the importance of intersecting social and individual factors with structures of power (racism, sexism, deprivation, etc.), the addition of an intersectional lens supported the exploration of how individual decision-making and behaviour are influenced by larger systemic factors.[79] A number of TDF domains were particularly key to understanding drug use and decision-making on support and treatment among minority ethnic communities. For example:

    - **TDF domain: Environmental context and resources.** Drug use behaviours were influenced by factors such as living in an area of higher deprivation, unemployment, disposable income and availability of substances. Covering the cost of accessing and receiving treatment was also a barrier to seeking support.

    - **TDF domain: Social influences.** Culture (alongside wider factors such as gender) can play a role in the normalisation of certain drugs, and ethnicity can heighten experiences/feelings of peer influence.

[78] Steroids were also excluded from the secondary data analysis.
[79] Etherington et al., 2020.

- **TDF domain: Beliefs about consequences.** Fears of stigma which prevented treatment seeking could be influenced by experiences of culture, religion and gender. Concerns about confidentiality and appropriateness of service offer also prevented some people from minority ethnic communities from seeking support.

- **TDF domain: Knowledge.** Knowledge about/exposure to different drugs influenced decisions about usage, while lack of awareness about treatment options prevented people from seeking support.

Key limitations

- **Possible limitations of the sample for qualitative interviews**. Professional stakeholders were recruited by directly contacting relevant treatment and support services, while people with experience of drug use were recruited through gatekeepers (e.g., support services) and social media advertising. Every effort was made to recruit a group of individuals with varying experiences (considering factors such as ethnicity, age and type(s) of drugs used). However, it may be that potential participants who either did not see our adverts or declined to take part would have provided a different perspective. Additionally, we were unable to recruit individuals from some ethnic and religious groups and from other minority communities (e.g., people from the LGBTQ+ community other than gay men). All the interviews were conducted in English (although we offered interviews in other languages). This may have limited non-native speakers in conveying their full experience. Furthermore, non-English speakers may have offered a different perspective.

- **Sensitive topic**. The sensitive subjects covered during the qualitative interviews may have caused some participants to self-censor and give evasive responses. We attempted to lessen the impact of this constraint by having experienced researchers conduct the interviews, having participant-led interviews, and assuring the participants of the confidentiality of their participation and their right to withdraw at any time prior to, during, and after the interview.

- **Problematic drug use**. The interviews with professional stakeholders and people with experience of drug use presented a multifaceted picture, however their perspective is necessarily limited to their personal or professional experience. Given the centrality of support and treatment for the present research, we decided to focus our recruitment efforts on problematic drug use. Nonetheless, drug policy research may benefit from exploring the experiences and perspectives of those who do not experience problematic drug use (some participants, for example, reported how their initial use of drugs was non-problematic, but things changed when their life conditions changed).[80] This would allow for a wider understanding of the experience of drug use, which – as observed in our study – may fluctuate and change over time.

- **Limitations of the survey data.** As highlighted in relevant places throughout the report, small case numbers prevented us from providing some more detailed analysis of survey data (e.g., looking at more nuanced ethnic groups in the CSEW). Both surveys are cross-sectional in nature, meaning we are unable to show the direction of relationships (e.g., whether lower IMD leads to drug use, or drug use leads to lower IMD). The analysis explored a limited set of variables, meaning it was not able to completely explain the relationship

[80] Anna Ross (2020) explains how the *happy user* (a person with a non-problematic experience of drug use) is always excluded from drug policy studies and policymaking. This makes having a clear and complete picture of drug use impossible, which in turn makes effective policymaking less achievable.

between ethnicity and drug use. Future work using different factors would be able to add to this, if future research identifies other characteristics that are likely to explain the relationship.

4.2 Recommendations

Recommendations for research

1. Recognising and proactively seeking out a range of perspectives within minority ethnic groups, taking into account intersecting inequalities.

- This research has demonstrated how demographic and psychosocial factors intersect to impact experiences of drug use. In particular, it will be important to seek views from people within minority ethnic groups who face intersecting inequalities and challenges (such as the LGBTQ+ community, asylum seekers etc). As has been highlighted in previous studies, this research demonstrates the importance of not generalising on the basis of ethnicity or seeking to explore experiences of ethnicity in isolation.

- This research has not captured the perspectives of those affected by drug use of loved ones / family members. Future research could aim to understand the experiences of these individuals, their role in facilitating treatment and sustained recovery and the challenges and barriers which impact them taking on this role.

- In terms of service provision, this research focused on access to treatment and support. However, the qualitative interviews we conducted demonstrated that journeys with drug use are not linear and individual and contextual factors may impact people in a variety of ways. Further research could explore approaches for strengthening early intervention and aftercare. This could involve longitudinal studies which examine long-term journeys with drug use and take into account the experiences of stakeholders who are often excluded from research.[81]

Recommendations for practice

2. Improving knowledge about and trust in support and treatment services

- Outreach work which provides access to information about the risks of drug use and opportunities for support could help some people from minority ethnic communities to better manage drug use and seek support where required. This should involve existing organisations and representatives already integrated into communities (including those catering for specific sub-groups such as young people) and healthcare professionals such as GPs who may be the first point of contact for people struggling with drug use.

- There is also potential to further address misconceptions and stigma around drug use with the support of respected groups/organisations and community leaders (e.g., religious leaders).

3. Providing culturally appropriate approaches

- Services should consider the lived experience and diversity of staff and volunteers (including peer mentoring), acknowledging that some people will feel most comfortable or motivated by those with common experiences.

[81] Ross (2020).

- Enabling service users to have as much choice and flexibility around their support as possible could help ensure that different cultural needs and preferences are met. Cultural needs will vary both within and across groups, impacted by factors such as age and migration experience.

- Resources and guidance will be needed to help staff/services understand the needs of different local communities and how this affects service use. A key area of focus, which may require additional support, should be partnership working with service users and representative organisations to enhance service provision. This should also include the involvement of minority ethnic communities in planning, designing and co-managing support and treatment services.

4. Taking a holistic approach

- Holistic support services need to recognise and support all aspects of service users' lives and address wider barriers to treatment success, including challenges with mental health, housing and employment. Partnership working (e.g. with mental health services and the Jobcentre) is key to providing this wraparound care.

5. Accessibility and responsiveness

- Services need to be as simple to access as possible. This will include consideration of opening times, responsiveness and online vs in-person delivery.

6. Sharing and spreading learning

- There may be learning which can be drawn on from other areas of healthcare (e.g. mental health services), particularly with regards to building trust and ensuring culturally appropriate approaches.

- Consideration should be given to sharing learning at scale and, where appropriate, scaling up successful approaches.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