ACMD Drug use in ethnic minority groups – call for evidence: WithYou response

Please describe either the nature of your organisation or your personal expertise within this area.

WithYou is a charity that offers free, confidential support and treatment to people in England and Scotland who have issues with drugs, alcohol or mental health. We have around 1500 staff and 100 volunteers who help more than 100,000 people every year.

Insights for our response to this submission incorporated feedback provided by WithYou's Equality, Diversity and Inclusion working group, data analysts, policy team, and insights from our previous research.

What ethnic minority groups do you work with? What features of substance use have been noted in that/those group(s)?

We deliver services across the UK, with the majority of our services in the South West, North West, North East, and East of England. We also provide services across Scotland. Many of our services are located in smaller towns and cities, and many of our services are also based in more rural locations. The largest cities where we have significant footprints are Liverpool and Glasgow. The geographical spread of our services has an impact on the different ethnic minority groups we work with and the proportion of which people from these groups make up our caseload. It is likely that if we had a larger footprint of services in some of the UK's larger cities and urban areas, people from ethnic minority groups would make up a larger proportion of our caseload.

The majority of our caseload (where we have full ethnicity data for) identify as 'White British'. A snapshot of our caseload taken this summer showed that 77.8% of people identified as White British. If you include people who identified as 'Other White', this number increases to just over 95% of our total caseload.

The most common substance people from the 'Black' and 'Black British Caribbean' cohorts were getting support for was heroin followed by alcohol. Within these cohorts, there are some other relevant trends we have seen, such as proportionally higher

levels of cannabis use among people from the Jamaican community. For people whose ethnicity was 'African', alcohol was their main substance.

For people of 'Asian' ethnicity, heroin was the most common substance that people were getting support with, followed by alcohol. Our staff highlighted some specific trends related to this cohort, including that within the South Asian community, most notably the Pakistani community, we have observed lower levels of engagement with drug treatment and support compared to those from other South Asian communities. Along with heroin use, we also heard how steroid use among people from the Punjabi community was more common than in other communities

For 'Mixed' ethnicities of 'White and Black African', and 'White and Black Caribbean' heroin was the most common drug people were getting support for, followed by alcohol. While those whose ethnicities were 'Other', heroin was the most common.

What are the particular consequences of drug use in ethnic minority group(s)?

Stigma and marginalisation are significant issues for people who use drugs in ethnic minority communities. This can be experienced through being marginalised by their immediate family, however can also extend beyond the individuals and also result in families being ostracised from their community. This stigma and marginalisation isolates people from the relationships, communities and networks that we know can be so important in helping people in their recovery journey. This can result in people hiding their drug use and their mental health difficulties, creating a cycle of isolation which often further exacerbates the challenges they face. It makes people less likely to come forward and access services, or can lead to people delaying accessing services until they are experiencing greater drug-related harms, reducing the likelihood of positive outcomes. Staff highlighted examples where clients from Indian and Pakistani communities had been moved out of the family home and sent abroad to live with extended relatives in South Asia.

We also know health inequalities are more prevalent among people from ethnic minority groups and people who use drugs from ethnic minorities will often face multiple challenges on top of the health needs related to their drug use, such as structural racism, societal stigma and community marginalisation and isolation. Some ethnic minorities are also disproportionately targeted by law enforcement, and therefore at an increased risk of criminalisation. For example, Black people are many times more likely to be stopped and searched for drugs, compared to white people, despite proportionally using drugs at a lower rate. There are also significant

socio-economic factors that impact the consequences of drug use. Healthcare access and quality varies strongly according to race and income as shown by those areas of the greatest deprivation experiencing the highest level of drug-related deaths.

What treatment services are available for ethnic minority groups? How are they accessed? What is the current level of engagement?

WithYou provides treatment and recovery support for everyone, whether it's for advice, signposting, or clinical treatment, free of charge. We offer in-person and telephone services, and an online anonymous webchat platform. We also work closely with LEROs and other local community organisations to ensure we are able to access communities that may be underrepresented in treatment.

What are the barriers to treatment for ethnic minority groups?

Language barriers can prevent people from ethnic minority groups being aware of what support is available to them. Websites, leaflets, and posters advertising support are not always readily available in other languages. When a client is not able to communicate in English, an interpreter can be provided, however access for in-person interpreting depends on geographical location, can be very costly to the service provider, and individuals are only able to have up to three sessions. The presence of an interpreter can also hinder a client's willingness to speak openly, and there is a risk of miscommunication. We also know clients from ethnic minority groups can sometimes feel uncomfortable sharing experiences before an interpreter who may be from a similar ethnic background. We have noticed this issue particularly with clients from the South Asian community, and stems from fears of being negatively judged by an interpreter. This complicates these clients' ability to express their needs and to receive adequate support.

WithYou have previously conducted research with people who use drugs from the South Asian community in the Midlands.[1] We found many of these people carried an acute sense of shame about their drug and alcohol use. They had specific concerns about being misunderstood, particularly in relation to their cultural values and beliefs and were far more likely to seek support from their communities and/or faith

[1] WithYou (2021). A system designed for women? Available at: https://www.wearewithyou.org.uk/who-we-are/research/

communities, rather than specialist support services. We also heard how due to a sense of stigma and shame, clients from ethnic minority groups may conceal their issues with drugs and alcohol not just from relatives and friends, but from health practitioners from their ethnic community.

Issues around anonymity are particularly important to people who use drugs and alcohol from minority groups, and is a reason why we see lower ethnic minority representation in our services. We heard how some clients will travel to services outside their local authority area in order to receive support in order to avoid being recognised by people in their community attending a drug and alcohol service.

Limited knowledge and cultural awareness among front-line workers across the sector can mean clients from ethnic minorities receive inconsistent and mixed experiences when seeking treatment and support. This can result in people from ethnic minority communities having their needs misunderstood in mainstream services, and can leave them feeling unheard and without agency over their treatment journey.. These negative experiences mean they become much less willing to engage again in the future

Women from Black, Asian, and ethnic minority communities face additional challenges as a consequence of their gender, and as such make up a 'tiny fraction' of the treatment population. Gaps in services being both appropriately female-friendly and culturally-sensitive makes it difficult for women from ethnic minority backgrounds to access support. Our previous research has also shown that women from ethnic minority backgrounds prefer to be treated by health practitioners who are from the same sex, this may be due to cultural or religious beliefs around the appropriateness of being in close proximity to a member of the opposite sex, particularly in enclosed settings and/or without their husband present.

From our previous research, we have heard that people from minority ethnic backgrounds may often feel that their needs are best met by services delivered by, or in collaboration with, specialist and culturally-embedded organisations, led by-and-for members of their community who themselves will often have their own lived experience of treatment and recovery.

A barrier facing some people from ethnic minority communities can be understanding how the health system works. Clients from ethnic minority groups who have arrived in the UK relatively recently may be unaware of referral procedures for specialist treatment, how to access appointments, and/or how prescription systems operate. These systems can appear complex, and so it is vital that they are made navigable for everyone.

How could engagement with clients from ethnic minority groups be improved by service providers? How could treatment be made more accessible?

Service providers could review how they work with ethnic minority groups to enable individuals to receive support from staff who understand their needs, experiences and culture. This may involve working with local services led by people from ethnic minority groups for training, consultancy and advice.

Services should continue to offer and expand their range of online and in-person support services to increase accessibility and inclusivity. For example, providing culturally sensitive services led by, or involving people with lived experience, offering peer-led services, offering women-only services, increasing out-of-hours services.

Commissioning frameworks should review the funding structure for the provision of interpreters and ensure that this offer is readily available to anyone who needs it. Sessions involving an interpreter can sometimes take twice as long to carry out due to the need to translate material and having a three way conversation. Removing barriers to accessing this offer, increasing funding and availability of translators and translated materials (websites, leaflets, apps) and facilitating certain cohorts of individuals to receive support in neighbouring counties will all help contribute to increased engagement of these individuals with drug treatment support.

For particular groups or communities, including people from ethnic minority groups who are not engaged with support services, partnership working with community organisations plays a fundamental role. Our sector can learn from other sectors such as the VAWG sector, where very small hyper-local community organisations are fundamental in helping women understand the options available to them, and making connections to larger organisations who can offer structured support. In depth partnership work takes time to build relationships, and this can be difficult in the short term contract environment.

Trauma-informed, non-stigmatising language should be adopted throughout services, as well as throughout government reports and media communications.

Ring-fenced funding and specific national grants could be provided for the provision of specialist services for ethnic minority groups, as-separate-from the current structure of locally commissioned services.

We are not aware of any national best practice guidelines for developing or providing services for minority ethnic communities. Guidance for commissioners could be created, co-produced with organisations led by-and-for individuals from ethnic

minority groups, to support the provision of effective and culturally sensitive treatment options appropriate for those living within their commissioning area.

Lastly, one of organisational objectives over the coming year is to reduce inequalities in treatment and recovery for marginalised people, and those underrepresented in treatment. This will focus on improving access to treatment including by reducing stigma and normalising drug, alcohol and mental health support in society, listening and learning from our clients, better understanding the barriers to treatment for underrepresented groups, and developing more targeted support for underrepresented groups.