



Multi-Ethnic Recovery Equality Project Aberdeen (MEREP)

Final Report

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Claire Miller

On behalf of Drugs Action, Aberdeen

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Executive Summary

The Multi Ethnic Recovery Equality Project (MEREP), funded by the Scottish Government's Drugs Policy Unit in 2009 - 2010, examined the needs of Black and Minority Ethnic (BME) communities in Aberdeen City in relation to drug services. Aberdeen City Alcohol & Drug Partnership (ADP) supported Drugs Action as the lead organisation to work in partnership with Multi Ethnic Aberdeen Ltd (MEAL) to carry out this work, resulting in the following outcomes:

1. Increased knowledge and understanding of drug use and related issues in BME communities in Aberdeen and surrounding area.
2. Improved knowledge in BME communities of drugs, their effects and how to seek help.
3. Make recommendations to inform the ADP and other relevant strategic groups regarding the development of services and approaches that are responsive to the needs of BME communities

Methodology

In order to achieve the project aims, a mixed methods approach to data collection was adopted;

- A literature review was undertaken in order to examine current patterns of drug use amongst BME community members in the UK and levels and patterns of presentation to drug services.
- Semi-structured, in-depth interviews were conducted with 75 individuals from BME communities. Six were engaged with drug services and 69 were not engaged with drug services. These interviews were conducted to assess the patterns and levels of drug use among BME communities in Aberdeen City and the service access barriers that might exist.
- Questionnaires were completed by 17 professionals within 6 different drug or alcohol services in Aberdeen city and Aberdeenshire. This allowed for analysis of the numbers of individuals from BME communities that are presenting to these services, how services currently work with these individuals, potential access barriers and how these might be overcome.

- Outcomes related to increasing knowledge and awareness within BME communities were achieved through training events, conferences and seminars specifically relating to issues that affect BME communities. Links were also established between Drugs Action and other local organisations that work directly with members of BME communities in Aberdeen City in order to foster reciprocal knowledge of drug services and the issues affecting BME communities.
- Drugs awareness training was delivered to BME community members in Aberdeen and information on local drug services was disseminated both at these training events and through BME society newsletters and websites.

Project Findings

1. Interviews with BME Community Members:

- **Culture and Drug Use:** Consistent with existing research, the vast majority of interview respondents considered drug use to be a heavily stigmatised activity amongst their ethnic group. Reasons for this included religion, links to crime and poverty, links to mental health problems, and family values. Many respondents also said that women would suffer a lot more stigma than men for using drugs.
- **Culture and Service Provision:** The majority of interview respondents stated that an individual would typically seek help from family members before approaching services for support. All respondents cited the reason for this as being related to the stigma and shame attached to drug use from within their culture. Of the 6 service users interviewed, 2 stated that they were initially anxious about presenting to services for help due to fears over confidentiality. All service users stated that they felt welcomed by services and have never felt discriminated against by staff. Most of the total 75 respondents stated they would rather access a mainstream service rather than a service specific to their culture / ethnicity, primarily due to concerns around issues of stigma and confidentiality.
- **Personal Experiences of Drug / Alcohol Use:** Levels of alcohol and drug use amongst the 70 interview respondents that answered this question was quite low overall, with only 19 respondents reporting to have ever tried drugs. This corresponds to existing research showing that levels of drugs and alcohol use amongst BME populations in the UK tend to be lower than that of the native

population. All 19 respondents that admitted to previous drug use reported that they were introduced to drugs by their peer group.

- **Knowledge of Drug Services in Aberdeen:** The vast majority of respondents said they did not know of any drug/alcohol services available in Aberdeen City. The majority of respondents (68%) reported they would look for information about drug services on the internet, should the need to do so ever arise.

Of the 6 service users that were interviewed, 5 found out about drugs services from friends and 1 individual was referred to a local alcohol service via his GP. All 6 interview respondents stated that they know of other problematic drug users from different BME communities that have never engaged with services in Aberdeen.

- **Improving Drugs Service Access:** The majority of respondents (59) felt that drugs services need to disseminate more information on services to BME communities in Aberdeen city, and 23 respondents stated that they felt that service leaflets should be available in different languages to encourage greater service uptake amongst BME communities. Other suggestions included sourcing interpreting services, ensuring that confidentiality policies are made explicit, ensuring 'cultural competence' amongst staff, and actively engaging with different BME communities in order to foster reciprocal knowledge and understanding. The possibility of utilising a peer – led approach was also suggested in order to promote service access amongst BME community members.

2. Questionnaire Analysis – Drug and Alcohol Professionals

- All 17 professionals (100%) that completed questionnaires working within 6 different drug / alcohol agencies reported that they **do not typically receive referrals from BME community members**.
- Responses suggested that drug and alcohol **services do not actively promote services to BME communities** in Aberdeen city.
- None of the 17 respondents reported that they **receive cultural competence training** to enable them to work most effectively with BME community members.
- Professionals considered the **primary access barriers** to be: language; lack of targeted service information; a lack of dedicated support for individuals from BME communities to engage with services; limited availability of translation services; high

levels of stigma from within BME communities, resulting in individuals being reluctant to admit they have a drug or alcohol related problem; and the social isolation of many BME community members from the native population.

- Respondents suggested the following to be pertinent in **improving drug/alcohol service access** to BME community members: increased availability of translation services; available and accessible service information in different languages; specific staff training; the development of stronger links between specialist services and BME communities to improve confidence to access services; and the need for more drug/alcohol workers from diverse ethnic backgrounds.

Project Conclusions and Recommendations

- More ethnic monitoring by drug services in Aberdeen is required in order to determine current use of services, identify gaps in service provision, achieve equal access to services, and to provide a baseline for planning.
- Providers of drugs services should actively promote services to BME communities by providing information that demonstrates sensitivity to their needs, and addresses common fears.
- Drug services should adopt a culturally sensitive approach. This requires an awareness of concerns that a service user might present with, understanding of commonly held fears and flexibility to delivery accordingly.
- Drug services should provide service information in different languages and through a variety of different media. This information should be easily accessed by BME community members, such as the internet, BME community newspapers and magazines, at local ethnic minority 'information points', community centres, and GP practices to ensure that information is widely disseminated and targeted.
- Information on services that provide support for family members and others affected by someone else's drug use should be made available to members of BME communities in Aberdeen.
- In order to increase service uptake, direct contact between drugs service agencies and BME communities in Aberdeen city should be fostered. This could be achieved

through greater multi-agency working with organisations in direct contact with BME communities in Aberdeen, and by implementation of peer-led approaches.

- Drugs awareness and education sessions should be provided to young people from BME communities. This could be done through schools and community groups.
- Drug services staff should receive regular cultural competence training as a matter of course in order to know how to meet the needs of diverse ethnic communities and incorporate this into a recovery approach.
- Drugs services should be able to access interpreting services for BME community members whenever this is required. Issues regarding confidentiality should be made explicit.

1.0 Project Background

The Multi Ethnic Recovery Equality Project (MEREP) was funded by the Scottish Government's Drugs Policy Unit between September 2009 and September 2010. A partnership approach was taken to the project by the Aberdeen City Alcohol & Drugs Partnership (ADP) supporting both Drugs Action and Multi Ethnic Aberdeen Ltd (MEAL) in order to identify and prioritise specific Black & Minority Ethnic (BME)* community needs.

The project specifically covered the geographic boundaries of Aberdeen City, although links were developed with other services and organisations across the Grampian area. Project activity consisted of street-level outreach work which was in part developed through access and integration with MEAL ethnic minority networks. Links were also established with ethnic minorities in Aberdeen city through community contacts already established with Drugs Action. New links were additionally made with other individuals and organisations affiliated with BME communities in Aberdeen as a direct result of this project.

In order to recruit interviewees to participate in this study, project flyers (see Appendix I) were produced and distributed to GP practices, various organisations that work directly with BME communities in Aberdeen and surrounding areas, local ethnic minority 'information points' (e.g. shops and community centres), local universities, religious organisations and via the internet (e.g. social networking sites, and organisations affiliated with different BME communities). The project flyers were produced in English and Polish. The author also attended local events aimed at BME communities in order to promote the project, and to inform these communities of drug services in Aberdeen.

*Note: The term Black and Minority Ethnic (BME) communities will be used to refer to the various diverse communities that are the focus of this report. It is a broad term that is used to describe groups in the population that share an ethnic origin, culture and/or nationality that is distinct from the majority population.

2.0 Project Aims and Outcomes

2.1 Project Aims:

1. To assess, understand and prioritise the specific needs of Black and Minority Ethnic (BME) groups within Aberdeen City utilising an evidence led approach that harnesses the specific knowledge and expertise of a range of agencies engaging and/or supporting equality and diversity.
2. To embed the outcomes and learning of the project within the ADP local recovery strategy. This could be seen to have a potentially significant impact on BME communities, because as the strategy develops, it will be multi-agency, multi-disciplinary and comprehensive (covering the full spectrum of interventions, from education and prevention through to rehabilitation). Furthermore, this is a city wide approach built upon recommendations taken from the Scottish Government publication “The Road to Recovery: a New Approach to Tackling Scotland’s Drug Problems” (2008).

2.2 Project Outcomes:

1. Increase in knowledge about how BME communities are affected by drugs, the nature of the problems they experience and the types of help they want to receive.
2. Increased awareness by members of BME communities of the nature of drugs, their effects and how to seek help for drug problems including the nature and existence of mainstream drug services.
3. Increase in knowledge about how to effect increased uptake by BME communities of mainstream drug services, including how to access help by family members in treatment.
4. Increased understanding of the possibility of recovery, and recovery ‘opportunities’ by those with a drug problem from within the BME community.
5. Recommendations made for the implementation of guidance to working with BME communities in Aberdeen City (including identifying key training needs across tiers of service provision) including representation by BME groups within the ADP to increase sustainability of long – term project findings.

3.0 Methodology

Outcome 1: Increased knowledge about how BME communities are affected by drugs, the nature of the problems they experience and the types of help they would like to receive.

- A literature review was undertaken on the following topics:
 - Ethnicity and patterns of drug use in the UK
 - The relationship between drug services and BME communities in the UK
 - How 'cultural competence' impacts on drug service delivery to BME communities
 - Levels and patterns of presentation to drug services by BME communities in the UK
- Semi-structured, in-depth interviews were conducted with 6 service users and with 69 members from different BME communities in Aberdeen that are not currently engaged with drug services in order to assess:
 - Patterns and levels of drug use among BME communities in Aberdeen City;
 - How drug use is viewed among different BME communities in Aberdeen City;
 - The barriers to accessing drug services to BME communities in Aberdeen City and how these might be overcome;
 - The cultural competence of staff working in drug and alcohol services in Aberdeen City and Aberdeenshire and how this might be improved.
- Questionnaires were completed by 17 drug service professionals in Aberdeen and Aberdeenshire in order to assess:
 - Numbers of individuals from BME communities that are presenting to drug services in Aberdeen City and Aberdeenshire;
 - What action, if any, services take to attract and retain individuals from BME communities;
 - How services work with individuals from BME communities;
 - Barriers to accessing drug services by BME communities and how these might be overcome.
- Training events, conferences and seminars specifically relating to issues that affect BME communities were attended in Aberdeen City, Manchester and London.
- Links were established between Drugs Action and other local services and organisations that work directly with members of BME communities in Aberdeen City in order to foster reciprocal knowledge of drug services and the issues affecting BME communities.

Outcome 2: Increased Awareness by members of BME communities of the nature of drugs, their effects and how to seek help for drug problems including the nature and existence of mainstream services.

- Drugs awareness training was delivered to BME community members in Aberdeen and information was disseminated on local drugs services.
- Information on Aberdeen drug services was disseminated through BME society newsletters and websites.

Outcome 3: Increase in knowledge about how to effect increased uptake by BME communities of mainstream drug services, including how to access help for family members and how to maintain support for family members in treatment.

- A literature review was undertaken on substance misuse issues amongst members of BME communities and the effects on family members. Issues of stigma and shame in relation to substance use within different cultures was explored in – depth.
- Interviews with BME community members and drug service professionals were conducted, exploring issues relating to stigma and shame within the family as a result of substance use within different cultures.
- Drugs service information was disseminated at training events to members from BME communities, specifically in relation to 1-1 counselling services and family support groups.

Outcome 4: Increased understanding of the possibility of recovery, and recovery ‘opportunities’ by those with a drug problem from within the BME community

- Drugs training and information was delivered to BME community members at several local events. Information on drugs services were explained so that BME community members can be better informed regarding how to access services and the kinds of support that drug services offer.

Outcome 5: Recommendations made for the implementation of guidance to working with BME communities in Aberdeen City (including identifying key training needs across tiers of service provision) including representation by BME groups within the ADP to increase sustainability of long - term

- This outcome will be taken forward through completion and the dissemination and discussion of this study within the ADP.

4.0 Background of the Partner Organisations

The Aberdeen City Alcohol & Drug Partnership (ADP) played a key role in co-ordinating a partnership approach to this project which ensured that there was a balance of knowledge and expertise both in relation to drug use and BME specific issues, which was informed by local knowledge. Whilst there were a number of organisations involved, the two primary organisations were Drugs Action (lead partner) and Multi Ethnic Aberdeen Ltd (MEAL), both of whom operate primarily in the Grampian area.



4.1 Drugs Action

Mission Statement

To improve the quality of life of individuals, families and communities by helping people reduce the harms associated with drug use, make positive changes and support recovery.

Vision

“To be recognised and valued as an effective and innovative organisation which works in partnership with others to provide a diverse range of high quality services responsive to the changing needs and local circumstances.”

The Organisation

Drugs action is a registered charity, number SC 013582 and a company limited by guarantee, company number 84162. Core funding is received from NHS Grampian and the Local Authorities, with other funding being provided by the Scottish Government *Violence against Women Fund*, Trust Funds and donations.

Services provided

Drugs Action provides a range of services to drug users, ex users, family members, professionals and communities affected by drug use. Services range from education & prevention, early intervention, information & advice, harm reduction including Blood Borne Virus Prevention, and recovery based programmes to build on recovery capital and promote positive life changes.

To achieve its objectives, the following services are delivered from a city centre base, outreach premises in Aberdeen City and Aberdeenshire and on the street.

- Specialist Injecting Equipment Provision
- Blood Borne Virus specialist services including Hepatitis A & B immunisation
- Telephone Helpline
- Counselling & support for drug users and family members
- One to one advice, information and crisis intervention
- Family Support Group
- Early intervention & drugs education
- “Quay Services” – targeted to women involved in prostitution
- “Families First” – in partnership with Aberlour Child Care Trust, for families affected by parental drug use (Aberdeen)
- Partners and specialist in Aberdeen City Integrated Drug Service: Community Rehabilitation
- “Incite Stimulant Users Service” (Aberdeenshire)
- “Community Alcohol Service Aberdeenshire” (CASA)
- “Compass” service for children & young people affected by parental alcohol and / or drug use (Aberdeenshire)
- Training & Consultancy (Local & National)

Drugs Action has developed credibility and is recognised locally and nationally for providing high quality, evidence based services that are forward thinking and innovative. Whilst working with individuals at all stages of drug use, particular strengths are as follows:

- Drugs Action’s ability to attract and engage with hard to reach groups
- Provision of a range of easy to access services for drug users, ex users, families and professionals involved with drug users
- Involvement in partnership working with a wide range of other service providers
- The organisation’s ability and commitment to provide flexible services to meet the needs of individuals at various stages of drug use at times and venues suitable to their needs.



4.2 Multi Ethnic Aberdeen Ltd. (MEAL)

Multi Ethnic Aberdeen Limited is a user led registered Scottish Charity and a non-profit company limited by guarantee.

MEAL is committed to promoting cultural diversity and raising awareness of the value of the ethnic individuals, business owners and organisations within Aberdeen, Aberdeenshire and North East Scotland.

We are working towards the social, educational, economic and cultural equality of all members of our community. We do this by working with the public, private and voluntary sectors to provide equal opportunities for the mutual benefit of everyone living in our area of Scotland.

As the need for the understanding of common values, respect, and equal opportunity arises, MEAL will be there to champion those without a voice, by supporting and assisting, by providing information, by opening doors of opportunity to employment or training, and by encouraging people to think and to care.

MEAL offer help and personal support:

- In timed of need
- To settle in the north east of Scotland
- To develop networks in local ethnic communities
- Arrange informal lunches/workshops and seminars to reduce isolation and facilitate interaction and networking
- Organise a 'buddy' system for visits, assistance and support to newly arrived and established local and people from diverse cultures
- Support to develop IT skills
- Promote training, education and employment opportunities through volunteering
- To tackle issues of personal development and employment

MEAL also offer a Multi Cultural Educational Outreach Programme (MCEOP) an activity based project involving various ethnic artists, promoting understanding of international cultures and celebration of diverse cultural heritage. The Cultural Diversity Awareness Training (CDAT) programme increases participant awareness of religious, cultural and ethnic diversity and the complex combination of beliefs, practices, and customs of other cultures.

Additionally, Me-FM is a unique multi ethnic community radio station, promoting cultural diversity, learning opportunities, volunteering, social inclusion and community development. The station is run by over 60 volunteers from all backgrounds living in Aberdeen and Aberdeenshire. Me-FM is there to educate, inform and entertain through a content of speech led programmes with news, current affairs focusing on local and international issues, discussions, poetry and drama with a wide variety of music and much more.

5.0 Context

The following section provides information on ethnic minority groups, and outlines the background against which this project has been based.

5.1 The Ethnic Minority Population in Aberdeen

According to the 1991 census, Aberdeen city had an ethnic minority population of around 3000 (1.5% of total city population). The largest ethnic groups were Chinese, Bangladeshi, Pakistani, Indian & African, almost 30% of whom were born in the UK.

Since this time, Aberdeen city has witnessed significant changes in terms of the ethnic minority population, as outlined in Aberdeen City Council Single Equality Scheme 2009–2012. For example, numbers of migrant workers have risen considerably since 2004. In particular, there has been a large influx of migrant workers and their families into Aberdeen from the Central and Eastern European countries who joined the European Union, primarily from Poland, Lithuania, Latvia, Bulgaria & Romania.

There has also been an increase in BME communities residing in Aberdeen on a temporary basis. These include students (16.6% of Aberdeen University and 21% of RGU students are from overseas, compared to 15% for all Scottish Universities (2005/2006), work permit holders, and job transferees.

According to the most recent 2001 census, Grampian's population included more than 18,000 people (2% of the total population) from BME communities. As of October 2007, the size of the local ethnic population appears likely to have nearly trebled from 18,000 to 54,000, thereby now constituting nearly 10% of the Grampian population of 554,000.

Between years 2002–2006 there were at least 84 different nationalities from the Grampian area registered for a NI number, with the majority of these being from:

- Poland – 1720 (28.8%)
- Lithuania – 520 (8.7%)
- India – 480 (8%)
- Latvia – 390 (6.5%)
- Nigeria – 260 (4.3%)

Aberdeen City Council Translation, Interpretation & Communication Support Services reported that these services were most in demand by the Polish, Lithuanian, Cantonese,

Russian & Bengali communities in 2008/09. The main users of this service were from social work, housing and education services. (*Aberdeen City Council Single Equality Scheme 2009-2012*).

Numbers of refugees and asylum seekers remain low in Aberdeen city. Grampian is not an area where asylum seekers have been officially relocated, but unofficial dispersal patterns estimate approximately 20 per month may have come between 2005 and 2007 (Ibid).

Additional information available from other sources should be examined by the ADP in taking forward the recommendations of this report.

5.2 Drug Use and BME communities

Statistics show that overall levels of drug use in BME communities in the United Kingdom is lower than that of whites. The most recent estimates on the extent and nature of drug use amongst BME communities are provided by the Home office in its analysis of combined 2006/7 & 2008/9 British Crime Survey data and findings indicate that Mixed race groups report the highest level of any drug use in the last year (17.6%), followed by Whites (10.5%), Black African and Afro–Caribbean groups (5.8%), Chinese /other groups (5.7%), and Asian groups (3%).

In terms of drugs used, cannabis is reported as the most commonly used drug across both ethnic and age groups. In relation to heroin use, prevalence data indicates that levels of use in Asian groups is low compared to other ethnic groups. Nonetheless however, heroin may still be problematic amongst some members of this community, although the tendency is to smoke or chase rather than inject (Beddoes et al, 2010).

There is a lack of national data regarding the prevalence of drug use amongst BME communities at both a Scottish and United Kingdom level. However, recent prevalence reports based on information gathered from across the UK suggest that although drug prevalence is lower among young people from BME backgrounds, there is under – reporting of the issue, with indications that drug use amongst these groups is in fact increasing (Scottish Government, 2008). A number of studies have examined the perceptions of BME communities on the prevalence of drug use and in some areas and within some communities, it is perceived to be increasing and as prevalent as within the white population (Fountain et al, 2003).

5.3 Why BME communities use drugs

A number of studies have explored BME communities' perceptions of why they and their communities use drugs.

Peer pressure & influence has been identified as one of the primary reasons why drugs are used amongst some members of BME communities. In a study conducted by Beddoes et al (2010) some communities, especially the south Asian community, highlighted the growing influence of western culture trends on young people who often try to 'distance' themselves from traditional values in order to fit in. Thus, young members of these communities will often partake in illicit substance use in order to "fit in" with their white counterparts.

Poverty has also been identified as another contributing factor to drug use amongst some members of BME communities in the UK. Bashford et al (2003) reported that the vast majority of the community organisations consulted with in their study felt the use of drugs by BME communities was related to the fact that many ethnic minorities tend to live in economically deprived areas. When coupled with high unemployment, isolation and social exclusion these social and economic circumstances can in turn lead to feelings of frustration, boredom and anxiety from which substance use might provide some form of albeit short – term, respite.

"Deprivation and chronic stress lead to a lack of resilience to cope with life events and circumstances, and to people feeling out of control and threatened [...] this is more likely to lead to problem drug use."

(Scottish Government, 2008 p.12)

Other reasons why young BME groups use drugs are believed to be the same as within the white population. These include curiosity, boredom, peer pressure and pleasure (Scottish Government, 2008).

5.4 Barriers to Service Access

The drugs misuse database for 2006 shows that in 2005, 99% of all new drug service users described their ethnicity as white. It is clear from this that service uptake of mainstream services by BME communities is very low (Scottish Government, 2008). Furthermore, consultation from drug services currently working with BME community members indicate

that families, carers and young people are still hesitant to acknowledge and discuss the issue and still very reluctant to approach mainstream drug services for assistance.

Fountain et al (2003) conducted a large scale study into drug use among BME communities in England and found that barriers to engagement by BME groups included:

- Lack of acknowledgement of drug use by BME communities themselves
- Ethnicity of staff (drug services staff being predominantly white)
- Lack of understanding of BME cultures amongst drug services staff
- Language barrier
- Lack of awareness of services and their functions by members of BME communities
- Fears over [perceived] breaches of confidentiality

Research has shown that BME opiate users are less likely to inject than whites (Sangster et al, 2001). As many drugs agencies are geared towards injecting drug users (e.g. the provision of needle exchanges) this could also account for low service uptake by BME community members. Particular issues have also been identified around harm reduction philosophies which have proved to be controversial with some BME community groups who consider that they condone drug use. However, it must be noted that although injecting drug use is generally reported to be less prevalent than amongst whites (largely due to BME community lack of presentation to Needle Exchanges), studies have shown that it does occur (Fountain et al, 2003).

“Denial” that drug use occurs in many BME communities is another significant barrier to overcome in increasing service uptake by members of BME communities. For example, Sangster et al (2001) found that denial of south Asian drug use by religious and community leaders has been identified as an important barrier to the development of appropriate services.

High levels of stigma surrounding drug use amongst many BME communities have also been consistently shown in research to be a primary factor in lack of service uptake. Issues of stigma and shame in relation to drug use are believed to be especially acute in Chinese and south Asian communities, whereby stigma is attached not only to drug users but also to their families. This can result in drug use remaining undisclosed and hidden, and as a consequence levels of use are likely to be underestimated (Beddoes et al, 2003).

Gooden (1999) also identified in his research that drug use is often heavily stigmatised and is a particular source of shame which constitutes an important barrier to use of services by

BME community members. This is often grounded in a range of religious and cultural influences.

The most common experience in Fleming's (2009) research was difficulty in engaging with BME communities for whom drug misuse was perceived as controversial and taboo.

Sangster et al (2001) found that the problematic nature of relationships between BME communities and drug services is a dominant theme in research due to issues such as:

- Racism and social exclusion
- The image of drug services and their isolation from the community
- An inability to respond to distinct patterns of drug use shown by BME communities
- A more general inability to respond to different needs

These issues were found to be especially evident in residential drug services.

Critics have further argued that drug services continue to be oriented to the needs of white users and where it does take place, specific work with BME drug users tends to be poorly thought out and inadequately implemented. Furthermore, drug services were not seen to be culturally neutral and it was frequently suggested that they presented a "white" image – this was seen to be reflected in their employees, clients & décor of the organisation. A lack of positive cultural symbols was seen to be a particular barrier to drug users from BME communities (Ibid, p.21).

5.5 Service Access amongst BME Communities in the UK

There is a wealth of evidence to show that BME communities do not have equality of access to a wide range of mainstream health, housing, social work and other support services, including those provided by the voluntary sector. Despite this, there are increasing demands being placed on service providers to develop and implement good practice in relation to equal opportunities generally and race equality more specifically (Williams, 2002).

The Scottish Executive's 2001 report, "Audit of Research on Minority Ethnic Issues in Scotland from a Race Perspective" found that:

"Substantial evidence in the areas of housing, social care & health indicates low levels of knowledge and use of services among minority ethnic people as compared to the majority population".

Reasons for this include:

1. Poor communication & consultation with BME communities
2. Little flexibility in the services offered to those communities including recognition of religious & cultural requirements
3. Inadequate interpreting services
4. The undermining of confidence and trust engendered by racial harassment

In relation to social care services it finds that the lack of culturally sensitive services leads to low uptake and levels of satisfaction and a reliance on informal support.

The audit adds that issues of gender, age & disability can compound the extent to which people from ethnic minority groups needs are met.

In a study of counselling provision in the voluntary sector and the perceptions & experiences of Asian people, Netto (2001) found uptake to be low and that few mainstream agencies had specifically targeted BME communities in publicising their services. Issues around lack of ethnic monitoring, small numbers of referrals by agencies and the inadequacy of training all emerged.

5.6 Service Access amongst BME Communities in Aberdeen

To date, there has been no research conducted which examines presentation to drug services specifically by BME communities in Aberdeen city. However, there have been studies, although relatively few, carried out to examine general service uptake by BME communities in Aberdeen. Two such studies that have been carried out are those by Lai (1999) and Williams (2002).

Lai's (1999) study for Pillar Aberdeen on voluntary sector mental health services in Aberdeen found very patchy access by and provision to BME communities. Barriers to access cited included language, lack of knowledge, stigma, & cultural barriers. This study also found that some voluntary organisations doubted the value of investment in practice measures given no firm evidence of need and small numbers of the ethnic minority population in Aberdeen.

Williams (2002) conducted a study of minority ethnic people and their access to the mainstream voluntary sector in Aberdeen. He found that almost 9 in 10 respondents in the mainstream sector described take up of their services by minority ethnic people as "poor" or "non – existent", a finding which applied to all sizes of organisation and all areas of activity.

One of the most significant findings of the study was the lack of training in relation to working with minority ethnic communities; three-quarters of staff reported they had no training or support in this respect.

As part of this study ten in-depth interviews were conducted with ethnic minority community members in Aberdeen. Williams (2002) found that all respondents had very little awareness of voluntary sector agencies; people did not know the services on offer in Aberdeen, as very little information was provided to ethnic minority community members.

6.0 Interview Analysis and Discussion - General BME Population in Aberdeen City

(Outcome 1: Increased knowledge about how BME communities are affected by drugs, the nature of the problems they experience and the types of help they would like to receive)

6.1 The Background of Interview Respondents

A total of 69 respondents were interviewed from the general BME population in Aberdeen City. All interviewees were anonymous in this study; the only details recorded were the respondent's age, gender and country of origin. This was done to alleviate any concerns that respondents might have regarding confidentiality, and to try to ensure that respondents felt comfortable enough to answer sensitive questions regarding drug use. The author transcribed all interviews conducted by hand, as it was felt that to use a recording device could also make some respondents anxious about issues of confidentiality.

Interview respondents originated from 27 different countries, and length of time resident in the UK ranged from 3 months to 35 years. Two respondents were born and raised in the UK, although their parents were from ethnic minority backgrounds.

A range of methods were used to source respondents for this study. The majority of interviewees (36) who were contacted via MEAL were either in paid employment or in a volunteering capacity. However, interviewees were also sources via personal contacts of the author (8), by attendance at local BME networking events (3), via community contacts made as a direct result of undertaking this study (15), ESOL classes (5), and a small minority of interviewees contacted the author directly after seeing the project advertised on the internet (2).

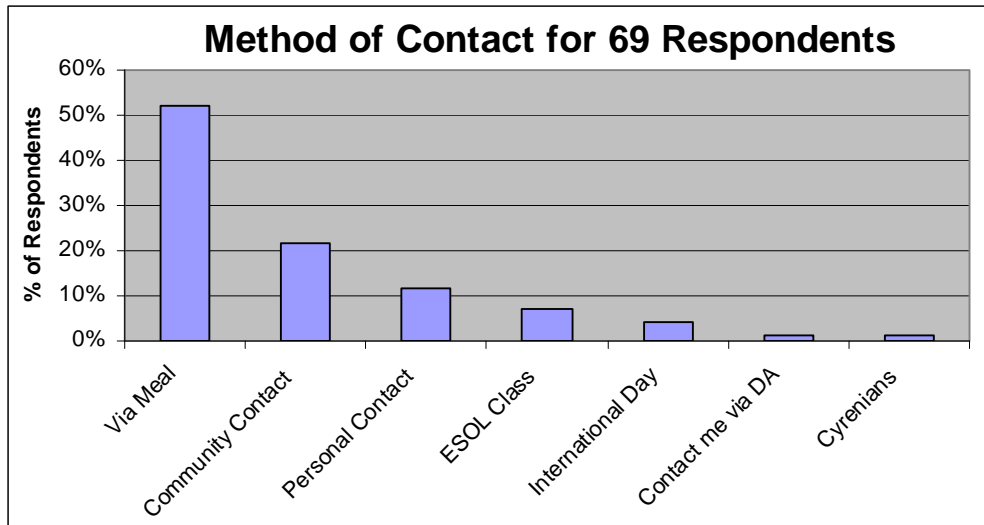
See Appendix II: General BME Respondents in Aberdeen city – Country of Origin, Method of Contact, Gender and Age.

6.1.1 Gender

More females (45) than males (24) were interviewed from the general BME population in Aberdeen City. This could be reflective of the fact that the majority of interview respondents

were volunteers working at MEAL, and traditionally, more women than men volunteer for organisations such as this. Graph 1 shows the method all contact for all 69 respondents.

Graph 1: The different methods used to contact all respondents



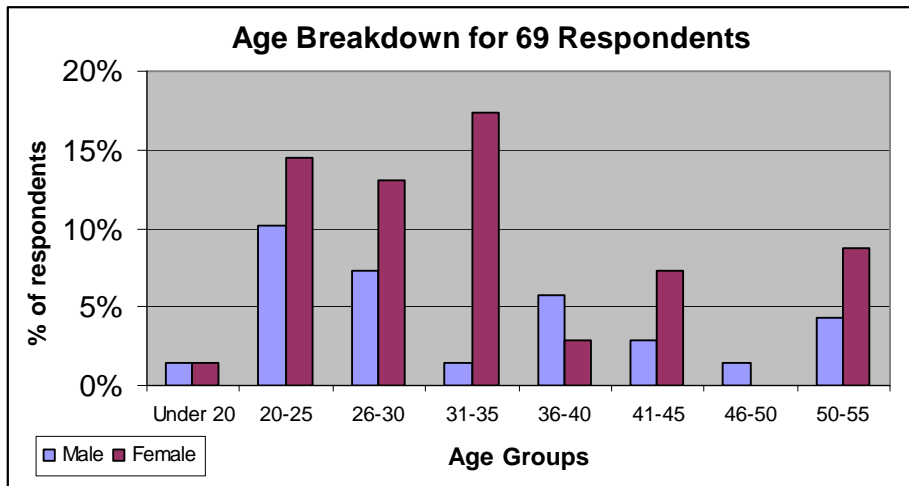
Also see Appendix V: Method of Contact by Gender.

6.1.2 Age

The interviewee respondents from the general BME population in Aberdeen City ranged in age from 19-55 years. The highest proportion of female respondents (26%), were in the 31-35 age group of total female respondents (45). The highest proportion of male respondents (29%), were in the 20-25 age group of total male respondents (24). The mean age of all respondents was 33 years.

The following graph 2 illustrates the age breakdown of all 69 respondents, by gender and age groupings.

Graph 2: Age Breakdown by Gender



See Appendix III for a breakdown of age of respondents based on gender and country of origin.

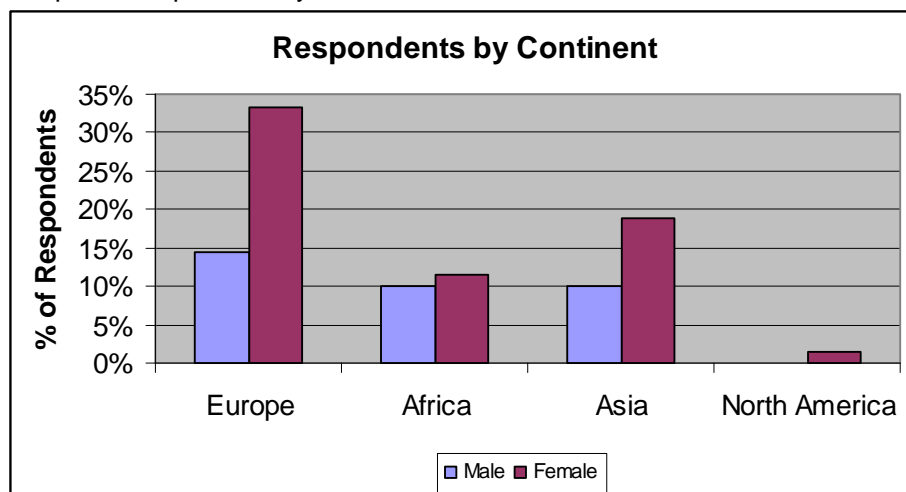
6.1.3 Country of Origin

Interview respondents originated from 27 different countries. Two interviewees were second – generation British citizens. The largest group of respondents interviewed were from Poland (15). There is a large Polish community in Aberdeen City and the author was able to access respondents from the Polish community through a contact already established with Drugs Action, who was herself a member of the Polish community and worked with other Polish individuals to help them into employment.

The second largest group of respondents were from Nigeria (8), followed by Bangladeshi respondents (7) and respondents from India (5). The majority of these respondents were MEAL volunteers.

All respondents were grouped into their respective continents and this is illustrated in graph 3, split by gender. This showed that the largest group within the study were European female, followed by Asian females.

Graph 3: Respondent by Continent



See Appendix 2: Country of Origin, Method of Contact, Gender and Age and Appendix IV: Age of Respondent by Continent of Origin.

6.1.4 Reasons for Moving to the UK

The majority of interviewees that participated in this study cited their reason for moving to the UK was to further their education (25 respondents). The majority of Nigerian respondents (7 out of 8) cited this reason.

- 18 respondents said they moved to the UK due to their husband's job transfer.
- 18 respondents said that they decided to move to the UK for the better employment prospects this country offered compared to their country of origin. 11 out of 15 Polish respondents cited this reason.
- 6 respondents moved to the UK to be closer to family members already resident here.
- 1 respondent said they moved to the UK for a 'better quality of life' overall.
- 1 respondent was born and raised in the UK.

6.2 Culture and Drug Use

Q: How is drug use viewed in your country? Do you think drug users suffer more stigma than in the UK? If so, then why?

Responses included:

- 57 respondents (76%) said that drugs users suffer more stigma in their country of origin than in the UK.
- 3 respondents (4%) said that drugs users suffer about the same level of stigma in their country of origin than in the UK.
- 10 respondents (13%) said that drugs users suffer more stigma in the UK than in their country of origin.
- 5 respondents (7%) were not sure.

Common reasons cited for drugs users suffering more stigma than in the UK included religion, links to crime and poverty, links to mental health problems, and stronger family values in country of origin. Many respondents also said that women would suffer a lot more stigma than men for using drugs.

6.2.1 Religion

The majority of respondents said that drug users suffer stigma more in their country of origin than in the UK. The majority of these respondents believed the reason for this is that in their country of origin, society is based more on religious beliefs and traditional family values. They believe that these factors can often mitigate against drug use, much more so than in 'westernised' countries such as the UK.

"Drug use would be seen as sinful" (Male, 22, from Ghana)

"Drug use is definitely more common in the UK - I think this is because the UK is not a very religious country like Nigeria. In Nigeria, religion is even more important than the law. The culture in Nigeria is also very family-orientated. A whole family would be stigmatised if even just one member used drugs" (Female, 31, from Nigeria).

"In Nigeria, if someone had an addiction problem, they would bring shame on the whole family. For example, sisters would have a hard time finding a husband, and the whole family would be stigmatised - this has a lot to do with religion (Christianity) - people would think that the family would be "Unchristian" (Female, 26, from Nigeria).

"Drug users are more stigmatised in Poland than in the UK. I think this is because the people in Poland still adhere to more traditional values, and I also think that religion (Catholicism) does also play a part" (Male, 23, from Poland).

The above quotes illustrate the centrality of religion in the lives of the respondents, and how drug use would be viewed in direct contrast to their religious values. Using illicit substances would not only cause the individual to feel guilt and shame, their families would also be stigmatised within their religious community.

Religion as a mitigating factor against the use of illicit substances has been explored in previous. Young people who are religious consistently report lower levels of drug use than young people who are less religious (Gorsuch 1995; Johnson, Tomkins, & Webb, 2002). Likewise, many studies have shown religion to be an important correlate of substance use in that lack of religious affiliation has been seen as a risk factor for increased illicit substance use (Bry, McKeon, & Pandina, 1982; Hawkins, Catalano, & Miller, 1992).

6.2.2 Gender Roles

It was also reported by many respondents that women would be much less likely to use drugs than men. In many BME cultures women are still expected to adhere to traditional gender roles and therefore women drug users would suffer even more stigma than men.

“Women would be looked down upon and considered “wild” (Female, 26, from Nigeria).

“Women should be “good” and “pure”. Women are socialised to not be interested in such things as drugs and are also never given the opportunity to try them, as they are rarely alone - women live with the extended family until they are married, therefore, women are never exposed to things like drugs” (Female, 23, from India).

“Women are expected to be “pure” - so there would be a real moral problem if a woman were to use drugs” (Female, 52, from Bangladesh).

Research has shown that men are more likely than women to use any illicit drugs in many ethnic groups, particularly among Asian, White and Chinese/other groups. Black and mixed race men and women are believed to have similar levels of use (UKDPC, 2010).

Hoare’s (2010) analysis of British Crime Survey data shows that respondents from a White or Asian background reported that men were more likely to use drugs than women, although no difference in overall drug use were detected from the other ethnic groups. However, records of service users in treatment indicate that the proportion of females is higher in White and mixed race groups compared with Asian and black service users.

However, despite existing evidence that shows that men are more likely than women to use drugs in many BME groups, by Fountain et al (2003) showed that whilst there are clear indications that drug use may be more concentrated amongst BME men, it is increasingly being reported amongst young BME women.

6.2.3 Traditional Values

The importance of adhering to 'traditional' values has implications for the younger generation, many of whom reject such values in favour of a more 'westernised' way of life, which may include the use of drugs and alcohol.

"Younger individuals are less aligned with religious and cultural beliefs and more influenced by western culture, therefore drug use may be seen as more acceptable" (Female, 24, from India).

Respondents reported that if the younger members of a family were to use drugs or alcohol, due to the level of stigma and shame associated with this, they would be very likely to keep such behaviour hidden and unlikely to tell family members.

"Family values are very important in Nigeria, and the view is that good and responsible parents wouldn't have children that use drugs. So, if kids were using drugs, they would not tell their family" (Male, 28, from Nigeria).

"The community may blame the family for a person's drug use and question his upbringing. There would definitely be some shame attached to the family" (Female, 24, from India).

Other respondents considered drug use to be more popular and accepted in the UK due to the high value placed on notions of 'individualism' over community:

"The UK has a more individualised society, whereas Nigeria has a more community based culture. A drug user would bring more stigma to the family and community (in Nigeria)" (Male, 27, from Nigeria).

"Drugs are absolutely more popular in the UK... success is hard to attain in the UK, even if one works hard. So I think people will use drugs as a means of attaining happiness in the UK. In India people gain happiness through things such as family and friends" (Male, 25, from India).

The responses highlighted above correlate to the findings of Fountain et al (2003) who found in their research that poor knowledge about drugs by older generations of BME groups and their unwillingness to discuss the issue both within and outside the family / community means that drug use among some BME communities remains hidden. This results in individuals from BME communities being reluctant to access services, and therefore levels of drug use among these communities remain very difficult to accurately determine.

6.2.4 Class and Poverty

Respondents also reported that drug use was linked to crime and poverty, and less associated with the 'respectable' middle classes.

"Drug users are much stigmatised in India and are classed as "untouchables". You are deemed to have failed in life and this is a very serious issue in India" (Female, 23 from India).

"The common view is that only "down and outs" use drugs, unlike in the UK where there is an acceptable social scene amongst young people" (Female, 33, from Thailand).

However, respondents from developing countries in Asia and Africa also reported that wealth can serve as a kind of "buffer" against the stigma of using drugs. These respondents reported that in their country of origin, there is no free national health service, unemployment is high and many citizens receive little or no financial assistance from the government. As a consequence, the majority of the population cannot afford to buy drugs, spending what little money they do have to feed and clothe their families. Thus, only those who are reasonably well-off financially can afford to indulge in 'luxuries' such as drugs and alcohol. For these individuals, their financial security means that they can afford to use drugs and their socio-economic position means that this behaviour is not associated with the stigma of poverty.

"I think that being rich would "buffer" one more from the stigma of using drugs - these are the ones that would be more in touch with the west...Only rich people could afford to buy drugs" (Male, 52, from Bangladesh).

"People talk openly about drug use here. There also seems to be more money in the UK and drugs are easily accessible. In Ghana it is spoken of, but only behind the scenes and this would only be with certain people in the 'know' " (Male, 22, from Ghana).

I think that there is more drugs use in the UK, as people have more disposable income. Drugs are cheap in Lithuania, however people are more likely to prioritise family, house, clothes etc” (Female, 23 from Lithuania).

The risk factors for problematic drug use are primarily linked to social exclusion and deprivation. There is evidence to show that BME communities are particularly at risk, despite general population and school surveys reporting that BME respondents are less likely than whites to use illicit substances (Fountain, et al, 2003).

6.2.5 Links to Mental Health

Nigerian respondents also reported that drug use is linked to mental health problems, and that treatment for drug addiction is often carried out in ‘mental hospitals’. Thus, drug users may suffer the ‘double stigma’ of not only using drugs, but of being viewed as ‘mentally unstable’. This would serve as an additional barrier to disclosure of drug use and service access.

“People that use drugs are seen as crazy...this may be because of lack of education (of drugs) and fear” (Male, 27, from Nigeria).

“Drug use is very much stigmatised and is believed to be linked to mental health problems – that if you use drugs you will "go mad" (Female, 35, from Nigeria).

6.3 Culture and Service Provision

Q: In your culture what are the typical attitudes towards seeking help from drug services?

This question was asked in order to determine cultural views regarding seeking help from services. From this, information can be gathered as to what some of the barriers to accessing support might be from different BME community groups.

17 respondents (24%) stated they were ‘unsure’ regarding typical cultural attitudes towards seeking help from services regarding drug problems.

38 respondents (41%) stated that an individual would typically seek help from family members first before approaching services for support. Highest proportion of respondents

stating this: Polish (67%) and Nigerian respondents (50%). All respondents cited the reason for this as being related to the stigma and shame attached to drug use from within their culture.

“There is a degree of stigma around going to outside services for help - problems are generally kept to oneself or are shared with family members - there is a particular stigma for men presenting to services for help as they would be seen as ‘weak’ ” (Male, 35, from Poland).

“Everything is dealt with in the family.... there is a lot of shame and stigma in going to services for support” (Female, 32, South Africa).

This finding reinforces the point that more drugs education should be aimed at parents within BME communities, so in the instance their children do disclose a drug problem they would be better informed and equipped regarding how best to help and how to access services.

10 respondents (14%) replied that it would be acceptable within their culture to seek help from drug services (respondents originated from Bangladesh, Romania, Lithuania, Libya, India, Latvia and Portugal).

1 Nigerian respondent said that people would be more likely to turn to their church for help.

2 respondents reported that individuals would be unlikely to divulge information regarding their drug problem to anyone, due to the stigma involved and lack of trust in services:

“In Romania, the general public are not very well informed as to what steps to take (in accessing drug services). People are usually reluctant because they don’t trust the service providers” (Female, 25, from Romania).

“It is ok to seek help from agencies in general, but I do not think that one would widely discuss it if they were going for addiction counselling, due to the stigma involved” (Male, 23, from Poland).

It must be noted that many cultures do not have a tradition of seeking ‘counselling support’ as is common in the west (Netto et al, 2001).

These cultural differences may serve as a barrier to accessing this type of support. It is therefore important that design of services and interventions to support recovery are informed by cultural differences and tailored accordingly to different target groups.

Q: If there was a specific drug service exclusively for people from your ethnic background would you prefer to use that service instead of a mainstream generic service? Why / why not?

There is ongoing debate regarding how service provision can best meet needs of individuals from different BME communities. In larger cities in England where BME populations are more prevalent, some drug agencies provide services exclusively to ethnic minorities. This question was therefore included in this order to gather information regarding how drug services in Aberdeen City might best meet the needs of BME drug users.

32 respondents (46%) stated they would rather access a mainstream generic service rather than a service specific to their culture / ethnicity. 17 of these respondents (53%) stated they would rather approach a mainstream service as they would feel more stigmatised by service providers from their own ethnic background. They also stated that they believe confidentiality would be more adhered to in a mainstream service, as BME communities in Aberdeen tend to be quite tight – knit and small.

“I would prefer to use a mainstream service because I would not want anyone else from my community to know that I had a problem, in case it got back to my family” (Female, 25, Romania).

“I would rather access a Scottish service, due to the stigma and shame that is directed at people with addiction problems within the Polish community” (Male, 25, from Poland).

“I would prefer to attend a mainstream service, as I would be afraid that I would be judged by others from my own country” (Female, 32, from Bangladesh).

18 (26%) respondents stated that they would have no preference regarding service provision in terms of the culture or ethnicity of workers.

13 respondents (19%) reported that they would prefer a service specific to their culture / ethnicity. The reasons cited for this were difficulties overcoming the language barrier in

accessing a mainstream service, and the lack of cultural understanding that mainstream service staff would have in working with individuals from BME communities.

“I would prefer a Nigerian service, I could relate to them and they would understand me better” (Female, 28, from Nigeria).

“I would prefer to attend a Turkish service, only because I could talk to them in my own language” (Female, 32, from Turkey).

6 respondents (9%) stated that they were unsure which type of service provision they would prefer.

Some of the above quotes illustrate that it should not be assumed that all clients will want to work with a worker from their same ethnic background. Fleming (2009) argues that feelings of shame may be sharply felt by a drug user when confronted by a worker who shares their own cultural background, and concerns regarding confidentiality are also likely to be prominent.

Sangster et al (2001: 47) also points out that “recognition must be given to the way in which other sources of identity such as religion and gender cut across ethnicity”.

Nonetheless, the Scottish Government (2008) recognises the need for more qualified drug workers of both genders from BME backgrounds, as well as those who are able to connect with new migrant communities & those seeking asylum. In order to achieve this, drugs agencies could deliver drugs awareness and education sessions to staff working in organisations that have regular direct contact with BME communities so they have the knowledge to deal with disclosure of drug use and are able to direct individuals to drug services for further support.

6.4 Personal Experiences of Drug / Alcohol Use

Q: What drugs do you use / have you used in the past including alcohol?

During the interview, it was explained to respondents that they did not have to answer this question if they did not so wish. Given the information gathered regarding the stigma and shame attached to drug use (and to a lesser extent alcohol use) in many cultures, the author was sensitive to the fact that respondents may be reluctant to disclose such personal information regarding their own history of drug or alcohol use. However, 64 respondents did

answer this question after it was explained that the interview data and analysis would be anonymous. 5 respondents (7%) were not asked this question, as they were interviewed in a group setting (ESOL class) and the interviewer did not feel it would be appropriate to ask participants to divulge this information in front of others.

This question was included in the interview in an attempt to gather more information about the level of alcohol / drug use in Aberdeen City amongst BME populations. As is indicated in the responses outlined below, levels of alcohol and drug use amongst the 64 interview respondents was quite low overall, which corresponds to existing research showing that levels of drugs and alcohol use amongst BME populations in the UK tend to be lower than that of the native population.

A: "I have tried alcohol, but have never tried drugs":

32 respondents (46%) reported that they have tried alcohol at least once, but have never tried any illicit drugs. Of these respondents, 24 stated that they drink alcohol only occasionally and never to the point of intoxication.

1 respondent (female, 40, from Poland) stated that her alcohol use was currently problematic: *"I began to develop an alcohol problem when I was 25 years old. In Poland, I have been in a rehab centre 3 times. I have told my GP here in Aberdeen and I now get counselling with a psychiatrist once per month. This was the only help I was offered. I plan to attend the Polish AA meeting here in Aberdeen"*.

1 respondent (male, 45 from Poland) said that his alcohol use was problematic in the past: *"I had an alcohol problem for about 10 years, but I have not had alcohol for 13 years now. I stopped on my own, without help from anyone else"*.

A: "I have never tried alcohol or drugs":

19 respondents (28%) reported that they have never tried drugs or alcohol.

Reasons cited for this include 'personal choice' and substance use as being 'against religious beliefs'.

A: "I have tried both drugs and alcohol in the past":

13 respondents (19%) admitted to having tried both drugs and alcohol in the past.

8 of these respondents reported only trying cannabis, and said that they have never tried any other illicit substance in addition to cannabis.

Of the 4 respondents that did report previous use of Class A substances:

- 1 respondent (male, 21, from Poland) reported to have begun using amphetamine on a recreational basis when he was 17. His use then escalated and he began taking it on a daily basis for the period of one month. He then decided to stop using amphetamine, as he found that *“the secrecy and guilt became too much”*.
- 1 respondent (male, 25, from Poland) said that he tried amphetamine only once and did not like it.
- 1 respondent (female, 29, born in the UK, father from India) began using alcohol at 12, and then used drugs such as cannabis, MDMA, amphetamine, cocaine, magic mushrooms and LSD on a recreational basis until the age of 22.
- 1 respondent (female, age 33, moved to the UK from Thailand aged 10) reported to have used marijuana, ecstasy, LSD, and cocaine as a teenager, although only on an occasional basis.

The fact that more women than men were interviewed possible explanation for low numbers of interviewees reporting drug use, given that more men than women use drugs traditionally, but especially in some BME cultures where drugs use is particularly stigmatised amongst women, due to social and culture norms regarding gender roles.

Q: How were you introduced to drugs?

This question was asked in order to gather information about how individuals from BME communities are typically introduced to drugs. This information is important as it can help services to consider where and how to target drugs education and prevention activities to BME communities in Aberdeen City.

All 13 respondents that admitted to previous drug use reported that they were introduced to drugs by their peer group.

Interestingly, the respondents who were raised in the UK stated that they first tried drugs in order to “fit in” with their peers in their teenage years. Whilst it is important for most teenagers to have a sense of belonging and affiliation with their peer group, this may be especially so for young adults of an ethnic minority, due to the notions of “difference” that their culture, religion, and skin colour can encompass.

"I did it [drugs] because everyone else was doing it, and I wanted to "fit in". I did tell my mother later on, and she was shocked". (Female, 33, moved to the UK from Thailand aged 10).

"At 14 I started going to pubs and doing harder drugs to fit in with the party/social scene. I would be a 'good Indian girl' all week and then party with older crowd at weekends because it was fun". (Female, 29, born in the UK, father from India)

The above quotes demonstrate the tensions that can exist within second generation migrants to the UK from BME backgrounds. Anecdotal evidence gathered for the purposes of this study further illustrates this. Information gathered from key individuals working directly with BME youths in Aberdeen City indicates that children born in the UK from BME backgrounds often work very hard to be included and affiliated with the local population. Furthermore, many of these children consider themselves to be 'British' and do not want to be associated with "foreign" children (i.e. children who have recently moved to the UK from another country). Such youths tend to "lead two lives" – they have one "face" for their family and religious organisations, and another "face" for their British peer group. This also means that their parents do not have a good understanding of the issues that are affecting them on a daily basis.

In light of this, drugs awareness and education sessions should be targeted at these youths and their parents, perhaps at separate events to allow for the young people to ask questions and share experiences without having to divulge any information to their parents that they do not wish to.

Anecdotal evidence gained from meeting with these key individuals who work directly with BME communities also suggested that drugs prevention and awareness training targeted specifically to BME communities has not taken place in Aberdeen City for some time, perhaps as long as 15 years.

Furthermore, evidence suggests that many Muslim youths and youths from Eastern European backgrounds are living in areas characterised by deprivation and drugs use in Aberdeen city, which makes the need for drugs awareness and prevention training all the more imperative.

"I think that services should give drugs education and prevention. Due to the vulnerability of teenagers, I think they would benefit from having more guidance" (Male, 35, from Poland).

The above points are recognised in the Scottish Government (2008) policy document '*The Road to Recovery*', which states that more intervention is needed through school based information provision, as well as addressing the general lack of knowledge and awareness of drug related issues amongst parents from BME communities.

6.5 Knowledge of Drug Services in Aberdeen amongst BME Communities

This study sought to gather information regarding how many respondents from BME communities had knowledge of the different services that are available in Aberdeen City for individuals that wish to address their drug or alcohol use. This information is important in determining how effective services have been in disseminating this information to BME communities.

Q: Do you know of any drug or alcohol services in Aberdeen?

51 respondents (74%) said they did not know of any drug/alcohol services available in Aberdeen City. Of these respondents, 41 (80%) had been resident in Aberdeen for a period of one year or more.

18 respondents (26%) did know of existing drug/alcohol services in Aberdeen City. Of these respondents, only 4 knew of 2 or more services. These respondents had been resident in Aberdeen for periods of between 18 months to 35 years. The services that these respondents cited include:

- **AA Meetings:** 2 respondents knew of AA meetings, both of whom learned about this service from friends.
- **Polish AA Meetings:** 3 respondents from the Polish community knew of Polish AA meetings in Aberdeen. 2 respondents learned about this service from friends and one respondent was informed by their church.
- **Drugs Action:** 8 respondents knew of this service. 2 respondents work in the drugs field, 2 respondents learned of Drugs Action via the internet and 4 respondents learned of this service as a direct result of the MEREP project.
- **The Cyrenians:** (A voluntary sector organisation that works with individuals who are homeless or are at risk of becoming homeless). One respondent undertook a work placement at this organisation and therefore knew that they work with clients with substance problems.
- **Substance Misuse Service, Fulton Clinic:** 2 respondents knew of this service through their work in the drugs field.

It is evident from these responses that services are not disseminating enough information to inform BME communities in Aberdeen city of the services available. This corresponds to existing research which shows that this is a recurrent issue across the UK. For example, Netto et al (2001 b) in the “Audit of Research on Minority Ethnic Issues in Scotland from a Race Perspective” found that:

“Substantial evidence in the areas of housing, social care & health indicates low levels of knowledge and use of services among minority ethnic people as compared to the majority population”. (p.62)

Reasons for this include:

- Poor communication & consultation with ethnic minority communities
- Little flexibility in the services offered to those communities including recognition of religious & cultural requirements
- Inadequate interpreting services
- The undermining of confidence and trust engendered by racial harassment

In his study into access to voluntary organisations by BME communities in Aberdeen city, Williams (2002) found there to be minimal targeted awareness raising to BME communities by voluntary sector agencies, largely due to doubts regarding demand for services by BME communities. He argues that this “reflects an implicit view that sees service provision to ethnic minority communities as additional to core activity” (p. 22). He further argues that it is wrong of services to judge that there is low demand when ethnic minority communities have not been informed of what services are available, and that a lack of service uptake is not necessarily reflective of a lack of need.

“Equality of access to services depends on all sections of the community feeling confident that they will receive an appropriate service, even if some communities are only very occasional users”. (Williams, 2002 p. 26)

The findings of this study show that BME communities in Aberdeen City are not aware of services available and drugs education and prevention activities aimed at these communities are lacking. This is in direct contrast to the Scottish Government drug policy agenda as stipulated in “The Road to Recovery (2008):

"[...] it is our view that no one in Scotland today should take drugs in ignorance of the consequences. It is essential that there is a range of credible and accurate information available to allow people to make informed decisions". (p. 14)

Q: How would you find out about drug services?

This question was asked to gather information regarding how drug services could best promote their services to members of BME communities in Aberdeen City.

- 47 respondents (68%) said they would source this information from the internet.
- 10 respondents (14%) said they would talk to their GP.
- 5 respondents (7%) answered that they were not sure how they would find out about services.
- 2 respondents (3%) said they would look for this information in local newspapers.
- 1 Bangladeshi respondent said they would contact Aberdeen City Council for this information.
- 1 Polish respondent said they would enquire through their church.
- 1 respondent said they would ask a friend who is native to Aberdeen.
- 1 respondent said they would enquire at their local police station.
- 1 respondent said they would enquire through Citizen's Advice Bureau.

As can be seen from the above responses, the majority of individuals interviewed said the internet would be the first place they would look to find out about drug services in Aberdeen City. This has clear implications for how drug services should advertise their services in order to reach individuals from BME communities.

The internet is an effective way of advertising and promoting services, at a relatively low cost to organisations. A further advantage is that it ensures anonymity, which is vital to individuals from BME communities given the high levels of stigma and shame associated with drug use in many cultures.

Services should have their websites translated into a range of different languages, which can easily be done through 'Google Translate'. Services could also advertise on BME websites and through organisations that work directly with BME groups, such as MEAL.

However, other effective means of promoting services might include printing service leaflets in different languages and disseminating them to GP surgeries, organisations that work

directly with BME communities and local information points that are accessed by BME communities (e.g. local ethnic shops).

Of course, it should be noted that drug services must first be equipped to provide a service to individuals from BME communities. This means that staff must be culturally competent and aware of the particular issues surrounding drugs use in different cultures, and have knowledge of best practice service delivery in working with individuals from BME communities. Services must also be able to provide translation services when necessary.

6.6 Improving Service Access for BME Communities

Q: What do you think drug services could do to promote greater access for individuals from BME communities?

The following was found:

- 53 respondents (77%) stated that they believe that drugs services need to disseminate more information on services to BME communities in Aberdeen city.
- 3 respondents (4%) feel that services need to provide interpreting services in order to break down the language barrier which prevents non English speaking individuals from accessing services.
- 1 respondent stated that more multi-agency working is required between drug services and organisations that work directly with BME community members.
- 1 respondent believed that drug services staff would need to have a better knowledge and understanding of different cultures and religions in order to work effectively with BME clients.
- 11 respondents (16%) were not sure how to improve service access to BME community members.
- 23 respondents stated that they felt that service leaflets should be available in different languages to encourage greater service uptake amongst BME communities. Respondents suggested numerous means of effectively reaching BME communities in Aberdeen city in this way:

- I. Having leaflets available in organisations accessed by BME community members, such as MEAL.
- II. Advertising services on specific websites accessed by BME community member, in magazines, newspapers and information points, such as ethnic shops and associations.
- III. Advertising services on social networking sites such as Facebook.

- IV. Having leaflets available in churches, and for services to develop greater links with religious organisations.
- V. Services could hold regular drugs awareness campaigns for members of the BME community in Aberdeen – possibly in partnership with organisations such as MEAL.
- VI. Services could target promotional activities at the oil & gas industry, as many oil & gas employees in Aberdeen are from BME communities.
- VII. Education and prevention sessions to be available for children of a BME background at schools.
- VIII. Drug services could promote their services to BME communities at cultural festivals and events.
- IX. Services could establish better links with GP's, and ensure they are aware that drug services can provide services to members of BME communities.

“There should be leaflets available in Polish, detailing what help is available, where services are located, and how to access them” (Male, 23, from Poland).

“I think if drug services has pictures of ethnic minorities on their promotional posters and had leaflets in different languages than there would be an instant affinity for ethnic minorities to identify with, and they might be more willing to use the service” (Female, 27, from Nigeria).

The above responses illustrate the need to provide service information to individuals from BME communities in Aberdeen city. This is a common finding in research on lack of drug service uptake by members of BME communities across the UK.

BME community members have suggested a variety of ways that services could successfully convey both service information and drugs education to different diverse community groups, including a variety of written, oral and visual media. These include bi-lingual leaflets and posters, although drugs information should not be limited to written media as some ethnic minorities might have poor literacy, even in their own language. However information is provided, it should be precise and explicit, especially in regard to service information (Fountain, et al, 2003).

6.6.1 Interpreting Services

“I think that services should have Polish staff or at least interpreters. However, Polish staff would be better, as it can be embarrassing to have to talk about your personal problems with

an interpreter there, especially when they are not qualified in helping people with addiction problems or may not even be interested in your problems” (Female, 34, from Poland).

The above quote highlights one of the complexities of delivering drugs services to members of BME communities whose first language is not English and for whom interpretation services are required. Having to disclose a drug problem to someone of the same cultural background in which drug use is heavily stigmatised may conjure up feelings of shame and concerns regarding confidentiality by the service user. One way of dealing with this might be to provide training to interpreters specifically in relation to this, so that they might address these issues with the service user before intervention begins.

6.6.2 Confidentiality

“Confidentiality needs to be stressed, as in Egypt, when a 18/19yr old seeks help, his/her parents will be informed. This is a barrier towards people seeking help” (Female, 35, from Egypt).

I think it would be difficult to find out who is using drugs in BME communities, and thus it would be hard to engage with "problem" drug users", mainly due to concerns over confidentiality” (Male, 24, from Sri Lanka).

The above responses illustrate the need for services to make explicit their policies regarding confidentiality, and to clearly communicate this to members of BME communities in Aberdeen city. In order to try to ensure that confidentiality is maintained, intervention could be provided at locations out with a service user's community locale, for example at community centres and other places that would not readily identify someone as accessing a drug service.

6.6.3 Cultural Competence of Staff

“An open approach, knowing that we would be treated with respect, and not made fun of because of our culture or colour of skin” (Male, 25, from India)

As already discussed, some BME communities do not have a tradition of counselling outside of family structures and kinship networks. In light of this, Fleming (2009) emphasises the importance of approaches which focus on notions of culture and cultural difference, identity,

intergenerational working and religion when working with members of diverse cultural backgrounds.

‘Cultural competence’ may be defined as “familiarity with the distinct norms, history, codes of conduct, experiences, expectations and beliefs that exist within communities” (Sangster et al, 2001 p. 38). For drug services to be ‘culturally competent’ might mean that staff should have the knowledge and awareness of a range of issues in addition to drug use experienced by BME individuals presenting to services. These might include the importance of family and kinship ties, distinct cultural and religious perspectives and issues surrounding stigma and shame.

In order to promote cultural competence among staff teams, drug services in Aberdeen city could receive training from services such as MEAL and other local specialist agencies that work directly with BME community members and have a sound knowledge of the issues that affect them. Reciprocal training to these agencies from drug services would mean that they would be better equipped to deal with initial disclosure of drug use and would also be able to direct such individuals to appropriate services.

As a result of the partnership working approach to the MEREP project between Drugs Action and MEAL, both organisations now have a greater understanding about the services that each provide. The working relationship that has been developed means that mutual referrals can now be made between agencies.

6.6.4 Community Engagement

Several interview respondents commented on the importance of services developing relationships with BME community members in Aberdeen in order to encourage increased service uptake.

“I think that services should be advertised more and that services should approach BME communities to educate them about drugs and services available” (Female, 28, from China).

“Services could be more pro-active in engaging with the community” (Male, 27, from India).

“Services need to make links with the Bangladeshi community” (Female, 45, from Bangladesh).

The findings of this study gained from interview analysis and anecdotal information received from individuals working directly with BME community groups in Aberdeen indicate that building up personal contacts with the BME community remains the key to promoting increased service uptake. Whilst providing translated leaflets might provide members of BME communities with a background awareness of services, it is likely that relationships and a greater degree of trust will need to be facilitated before individuals from BME communities feel “safe” enough to actually access services. This is especially so with drug services, given the powerful influence that issues of stigma and shame surrounding drug use can have in deterring engagement with services.

The findings of this study echo that of previous. For example, Williams (2002) in his study of minority ethnic communities and their access to voluntary sector services in Aberdeen found that personal contact with the BME communities was the key to increasing service uptake. One way of ensuring this would be through services making links with established BME community organisations or through the provision of community education.

“Voluntary organisations have to do a lot more than put out translated leaflets and wait for people to turn up – they will have to go out to the various communities and explain what they do” (Williams, 2002 p.17).

Research by Sangster et al (2001) into drugs service provision to members of BME communities in England also concludes that there should be an emphasis on services building relationships with and delivering work through, the “community”, which might encompass outreach work and satellite services.

6.6.5 Peer-led Approaches

“Recovered addicts should be involved in the community in things like community and peer support” (Female, 55, from Estonia).

The development of peer-led approaches to service delivery might be another method of promoting increased engagement between drug services and BME communities in Aberdeen city. In their review of the literature on drug prevention among vulnerable young people, McGrath (et al 2006) report on the success of peer-led approaches. However, peer educators would first need to be trained in delivering this kind of service and would also need to be supported in delivering formal sessions and facilitating large groups. Nonetheless, this method might prove successful in engaging BME communities in

Aberdeen city on issues surrounding drug use which could potentially lead to increased service uptake.

7.0 Interview Analysis: Service Users from BME Communities (Aberdeen City)

A total of 6 individuals that are using drug / alcohol services in Aberdeen City completed interviews.

5 of these interviewees were sourced opportunistically through Drugs Action Needle Exchange service, and 1 respondent was resident in a local voluntary organisation hostel to address his alcohol problem.

Due to the lack of individuals from BME communities currently engaged with drug or alcohol services in Aberdeen city and across the Grampian region, gaining access to interviewees from BME communities that use drugs proved difficult.

7.1 Background of Respondents

There were 5 male and 1 female interview respondents that were current users of drug / alcohol services in Aberdeen city. The age of respondents ranged from 29-46yrs., and the mean age of all respondents was 32.

Two interview respondents originated from the Czech Republic, 1 from Croatia, 1 from South Africa, 1 from Poland, and 1 was from a Scottish Gypsy/Traveller background.

The respondent from a Gypsy/Traveller background is native to the Aberdeen area. The length of time in Aberdeen of the other five respondents ranged from 1 month to 9 years.

3 respondents came to Aberdeen for better employment prospects (all from Eastern European countries). 1 respondent came over to attend university and the other to be with family already resident in Aberdeen.

7.2 Length of Engagement with Services

- Male (35), from Poland: Resident in a rehabilitation hostel for 3 weeks to address his alcohol problem, referred via his G.P. and residing in Aberdeen for 4 years.

- Male (31), from South Africa: Resident in Aberdeen for 1 month, using Drugs Action Needle Exchange Service for 2 weeks, after learning of this service via friends at his local gym. Using steroids for 3 years.
- Male (30), from the Czech Republic: Resident in Aberdeen for 1 year, using DA Needle Exchange service for 1 year, after being told about this service from friends native to Scotland who are also injecting drug users. Had been using heroin for 12 years.
- Male (31), from the Czech Republic: Resident in Aberdeen for 4 years, using DA Needle Exchange service for 4 years, after learning about this service from Scottish friends. Has been using heroin for 11 years.
- Female (26), from Croatia: Has been resident in Aberdeen for 5 years, using DA Needle Exchange service for 3 years, after being told about this service from her dealer. Has been using Heroin for 15 years.
- Male (35), from a Gypsy/Traveller background, using Drugs Action Needle Exchange Service for 8 years, and used Drugs Action 1-1 counselling service to address his drug use in the past. He found out about Drug Action's services from a friend. Has been using heroin for 9 years.

7.3 Drug Use History

The 5 interview respondents that were sourced via Drugs Action needle exchange service were all poly – drug users. Four of the respondents were injecting heroin users and one respondent was a steroid user.

- “I began using hash when I was around 15, and then used crystal meth when I was 16 - both experimentally and then recreationally. When I was 18 I began using heroin, to "come down" from stimulant use, and I quickly became addicted to this. Other drugs I have used recreationally include LSD, ecstasy, cocaine, and magic mushrooms. I have also used methadone illicitly. I wouldn't want to get on a script as I would be scared that I would become addicted to this also, and would also not want this on my medical records - in case I wanted to work offshore” (Male, 30 from the Czech Republic).
- “I began smoking hash when I was 15 and then used crystal meth shortly after, as this drug is very prevalent in the Czech Republic. Other drugs used recreationally include LSD, ecstasy, and cocaine. I began using heroin when I was 18 years old and quickly became addicted” (Male, 31, from the Czech Republic).

- “I have used steroids for 3 years. I had a cocaine and cannabis dependency for 4 years, but I haven't used now for 13 months. Other drugs I have used recreationally include ecstasy and LSD” (Male, 31, from South Africa).
- “I was introduced to drugs through a friend. I began by taking cocaine and ecstasy, which do not have a lot of stigma attached to them in Croatia. I then began taking heroin to help with the comedown from these stimulant drugs. I quickly became addicted to heroin” (Female, 26, from Croatia).

All interview respondents were introduced to illicit drugs from friends, and one respondent who had an alcohol dependency stated that he began using alcohol to cope with stress.

7.4 Cultural Views of Drug Use

Q: How is drug use viewed in your country? Do you think drug users suffer more stigma than in the UK? If so, then why?

All six respondents felt that drug users suffered more stigma in their country of origin than in the UK.

- *“Heroin has a lot of stigma attached to it - you get labelled a "junkie". Most other drugs are stigmatised also, except pot as so many people smoke it and grow their own. It is not decriminalised, but is very accepted now due to the increase in "harder" drugs like heroin, cocaine and ecstasy. Before 1989, the Czech Republic was a communist country so the borders were closed, which prevented drugs from coming into the country. However, with the introduction of the "rave culture" in the early 1990's, more drugs became available (esp. cocaine, amphetamine, ecstasy and crystal meth), and these drugs and the whole rave culture became very stigmatised (Male, 30, from the Czech Republic).*
- *“There is a lack of tolerance regarding alcohol and drugs from the community. Cannabis use isn't considered to be as bad as 'harder' drugs such as heroin” (Male, 46, from Poland).*
- *“Travellers suffer a lot of stigma from the wider community anyway - people see us as being dishonest people. Within the travelling community, drug users are viewed as being weak, as you have allowed drugs to conquer you. Men are not viewed as being manly if they are addicted to drugs, and drug users would suffer a lot of shame because of this. So, drug users are given very little sympathy from the travelling community. However, alcohol is much more acceptable, but only for men - a woman's role is seen as being at home with the kids” (Male, 35, Gypsy/Traveller).*

- *“I know a lot of other travellers that use and sell drugs - a lot of traveller's sons have heroin habits. However, they are unlikely to seek help due to the stigma surrounding drug use and also the distrust of outsiders - it is a very secretive community anyway” (Male, 35, Gypsy/Traveller).*

7.5 Experiences of Service Provision in Aberdeen City

Q: Did you have any concerns about accessing service provision for your drug/alcohol use prior to engaging with services?

4 of the respondents said that they did not have any concerns about accessing services, whilst 2 respondents said they did initially have concerns regarding confidentiality:

- *“Yes, I was afraid that I would be seen coming into D.A., especially by my boss” (Male, 30, from the Czech Republic).*
- *“Yes, I was concerned about confidentiality” (Male, 35, Gypsy/Traveller).*

Q: Do you feel welcomed by staff?

All 6 respondents said they did feel welcomed by staff.

Q: Do you feel that you are or ever have been discriminated against by staff in any way?

All 6 respondents said they have never felt discriminated against by staff, although 1 respondent resident in a hostel to address his alcohol use said that some staff did not speak slowly enough at times.

Q: If there was a specific drug service exclusively for people from your ethnic background would you prefer to use that service instead of a mainstream generic service? Why or why not?

All 6 respondents stated that they would prefer to use a mainstream generic service, due to the shame and stigma associated with drug use by members of their own BME communities:

- *“Due to the stigma and shame associated with drug use from within the travelling community I prefer to use a service like Drugs Action” (Male, 35, Gypsy/Traveller).*
- *“If there was a service for people from Croatia, then I would have had less of a language barrier. However, some people might be reluctant to expose their drug problems to others from their own communities due to the stigma attached to drug use” (Female, 26, from Croatia).*

7.6 Improving Service Access for BME Communities

Q: What do you think drug services could do to promote greater access for individuals from BME communities?

5 of the 6 respondents stated that services need to advertise and promote their services more directly to individuals from BME communities, and that service information should be available in different languages.

1 respondent from a Gypsy/Traveller community felt that regardless of the steps that services could take to increase service access, many from a Gypsy/Traveller background would still seek help from within their own family and community first, due to the mistrust that exists from within the community in relation to ‘outside’ services.

Q: Do you know of any other drug / alcohol users from within the BME community and are they currently using services?

5 out of the 6 respondents stated that they did know of other drug/alcohol users from within the BME community that were not currently engaged with services. This demonstrates the need to try to engage such individuals with services in Aberdeen City.

Outcomes of Interviews with BME service users in Aberdeen City:

The MEREP project allowed the author to engage with Drugs Action Needle Exchange service users from BME communities on an in-depth 1-1 basis. In addition to gaining valuable information regarding their drug use and service expectations, this also afforded the author the opportunity to explain about the full range of services that Drugs Action offer.

After completing the interviews, 3 out of the 5 respondents who used DA Needle Exchange service engaged for 1-1 counselling to address their drug use. This demonstrates the value and necessity of engaging directly with members of the BME community in order to increase uptake of services.

8.0 Questionnaire Analysis: Drug and Alcohol Professionals

In addition to the services that participated in this, several other drug and alcohol services were contacted although declined to answer a questionnaire, stating that they typically do not receive referrals from individuals from BME communities, nor do they monitor uptake of services by different ethnic groups in any formal way. This is obviously cause for concern, as ethnic monitoring of service uptake is vital in order to determine current use of services, identify gaps in service provision, achieve equal access to services, and to provide a baseline for planning (Fountain et al, 2003).

In order to collect information regarding drug and alcohol services access and uptake by members of BME communities in Aberdeen City, a total of 17 professionals working in drug and alcohol services completed a questionnaire. These professionals worked in 6 different organisations, 4 of which were located in Aberdeen City and 2 were located in Aberdeenshire.

The Aberdeen City agencies included:

- A voluntary sector residential rehabilitation hostel for alcohol users (service A)
- A voluntary sector support service for young people aged 12-18yrs, whose drug and alcohol use is having an impact on their offending behaviour (service B)
- A voluntary sector service offering accommodation, advice, advocacy, and resettlement support. Many clients of this service have drug and/or alcohol problems. (service C)
- A statutory sector service offering clinical treatment for drug and alcohol use. (service D)

The Aberdeenshire agencies included:

- A voluntary sector community drugs project offering support for dependent drug use (service E)
- A private sector residential detoxification and rehabilitation service that also provides out patient services and 1:1 counselling. (service F)

8.1 Service Users from BME Communities

Q: What percentages of your client group are from BME Communities?

4 of the 6 services reported that they typically do not get referrals from individuals from BME communities (services B, C, D and E).

Service F reported that they have received 2 referrals from individuals from BME communities in the previous 12 years.

Service A reported that they have had 1 hostel resident from a BME community in the last 22 years. This service also operates a Designated Place facility, whereby approximately 2.5% of referrals (125 individuals) have been from a BME background.

These responses demonstrate that drug and alcohol service uptake by BME community members in Aberdeen City and Aberdeenshire is exceptionally low.

8.2 Promoting Services to BME Communities

Q: Does your organisation promote its services directly to individuals from BME communities?

Respondents from 4 of the services that completed a questionnaire replied that their organisation does not promote its services directly to individuals from BME communities.

Respondents from service C reported that their service can provide leaflets in other languages, and respondents from service D stated that "leaflets and interpreters are available, but not regularly used".

However, these two services do not distribute service leaflets specifically to BME communities.

These responses demonstrate that drug and alcohol services do not actively promote services to BME communities in Aberdeen city.

8.3 Cultural Competence of Staff

Q: Does your agency offer cultural competence training for working with BME communities?

None of the 6 services that completed questionnaires reported that they receive cultural competence training to enable them to work most effectively with BME community members.

However, service B stated that Equality & Diversity training is mandatory training for all staff.

Service D reported that training sessions were available to staff in the use of language line.

The above responses demonstrate drug and alcohol service staff are not currently receiving cultural competence training to enable more effective working with members of BME communities.

8.4 Service Access Barriers

Q: What do you consider to be the main barriers for engagement with drug/alcohol services from BME community members?

The responses from drugs and alcohol service professionals echo many of those of individuals from BME communities that participated in this. Professionals considered the primary access barriers to be:

- The language barrier for non- English speaking individuals.
- Lack of information available to BME community members regarding service availability and access.
- A lack of designated professionals to support individuals from BME communities to engage with services.
- A lack of available funding to provide translation services.
- High levels of stigma surrounding drug and alcohol use from within BME communities, resulting in individuals being reluctant to admit they have a substance dependency.
- The social isolation of many BME community members from the native population.

Q: How do you think these barriers might best be overcome?

The responses from professionals include:

- Having greater funds available to provide translation services and to translate service information materials in different languages.

- Having service information available in different languages and in places that are easy to access for members of BME communities.
- More staff training in how to work effectively with BME community members, including training in cultural competence and training for professionals on the diverse needs of BME communities.
- The development of stronger links between drug and alcohol service providers and under represented communities so people feel confident about accessing services.
- Having more drug / alcohol workers available from diverse ethnic backgrounds.

9.0 Drugs Awareness Training

In order to meet project outcome 2, (*Increased Awareness by members of BME communities of the nature of drugs, their effects and how to seek help for drug problems including the nature and existence of mainstream services*), drugs awareness training was delivered BME community members in Aberdeen and information was disseminated on local drugs services.

9.1 Training Event: MEAL networking event, October 17th, 2009

The author gave drugs training and awareness sessions at a networking event for members of BME communities in Aberdeen City, hosted by MEAL. A total of 5 networking events were originally scheduled with the aim of delivering further drugs awareness and training, although 3 were cancelled. Although the author attended a further networking event hosted by MEAL, most of the participants had already been present for the drugs awareness and training input.

Drugs awareness training at the MEAL networking events was delivered to 15 members of different BME communities from Indian, Bangladeshi, Romanian, Libyan, Turkish, Nigerian ethnic backgrounds. The format of the training was as follows:

1. Background to the MEREP project
2. Drugs Awareness training:
 - “Why do people use drugs?”
 - Different drug groups
 - Drug names, appearance, cost, method of use, legal status, desired effect, short and long – term risks;
 - Types of drug use (experimental, recreational, problematic and dependent)
3. Information on drug services in Aberdeen city, including access routes and how significant others can access help for someone else’s drug use.

A total of 15 individuals attended the event and 9 feedback forms were completed (See Appendix VI).

As can be seen from the feedback provided, the drugs awareness training was well received. Some participants stated that they would benefit from having more dedicated time in the session to discuss the content with others and share views and experiences. Others commented that they would have liked to have had more information about drug problems specific to the Aberdeen city area, and more information regarding support services

available for families of drug users, although this was provided in the training. These comments should be considered when delivering future drugs awareness training to BME community members.

9.2 Training Event: Libyan School Aberdeen Drugs Awareness Training January 9th, 2010

This training was facilitated by the author and another member of Drugs Action staff, who had experience of facilitating group work with children. The initial contact with the Libyan School Aberdeen was facilitated by a Meal volunteer who also works at the school.

The training was given in a child-centred way, and consideration was given to the age and cultural background of the children. Pupils were split into 2 groups, one of 20 children aged 6-11yrs, and another consisted of 15 young people, aged 12-17 years. Training was delivered over the course of one day (6-11 year olds in morning session / 12-17 year olds in afternoon session).

9.2.1 Ages 6-11yrs: Training format:

1. Flip – chart activity : “What is a drug”
2. Shopping Bag: Children divided contents of shopping bag into items that they thought were drugs and items that they didn’t think were drugs. (Items that were drugs included alcohol, cigarettes, solvents, caffeine (coffee, chocolate and coca-cola) and medications. Discussion was then had with children regarding particular drugs and which would have stimulant, depressant and hallucinogenic effects.

Training Feedback:

Feedback forms were constructed in a child-friendly and clear way in order to take account of the ages of participants and the fact that English is not their first language. Overall, feedback on the training was very positive (see Appendix VII).

9.2.2 Ages 12-17 years: Training format:

1. Flip – chart activity : “What is a drug”
2. “Why do people use drugs?”
3. “What drugs do you know of?” (Depressant, stimulant, hallucinogenic and “other” drugs categorized and discussed, placebo kit circulated).

4. "Drug Bodies": Picture of a body drawn on 3 different flip – chart sheets, labelled "Stimulant", "Depressant" and "Hallucinogen". Children were asked:
 - a. "What would the person feel like?"
 - b. "What would the person feel like?"
 - c. "What would be the short and long – term risks of using each type of drug?"
5. Drugs and the law in the UK were then explored.
6. Handouts were distributed on:
 - a. Different drugs, drug groups and effects.
 - b. Types of drug use (Experimental, Recreational, Dependant and problematic)
 - c. Potential harms of drug use (physical, legal, employment, relationships)

As is indicated from the feedback provided (see Appendix VII), the majority of the children in attendance felt the training to be enjoyable and beneficial. From a drug services point of view, training of this kind is vital in delivering drugs education and prevention to 'hard to reach groups', such as young people from a BME community.

Therefore it is recommended that more training of this kind is planned and delivered in the Aberdeen city area.

10.0 Dissemination of Information on Drug Services to BME Community Members

In order to meet project outcome 3; (*Increase in knowledge about how to increase take up by BME communities of mainstream drug services, including how to access help for family members and how to maintain support for family members in treatment*), the following action was taken.

In addition to the training sessions provided, the MEREP project allowed for information on drugs services to be disseminated to BME community members in Aberdeen city.

The author attended various events aimed at BME community members in Aberdeen City. These included:

- An open day at Grampian Racial Equality Council (GREC). The author spoke to members of the BME community in Aberdeen and had the opportunity to raise awareness of the MEREP project and drugs services in Aberdeen.
- The author and other members of Drugs Action staff attended an 'International Day' hosted by MEAL which was well attended by BME community members in Aberdeen city. A stall as set up detailing information about drug services in Aberdeen and about the MEREP project, and drugs information leaflets were distributed.
- The author attended a 'Polish Information' day at a local church. Drugs information leaflets were distributed, and information given to Polish community members about the MEREP project and drug services in Aberdeen.

These events provided a valuable opportunity to meet with members of the BME community in Aberdeen and to promote the MEREP project and raise awareness of drug services in Aberdeen city.

Drug and alcohol services in Aberdeen should be proactive in attending events such as these in efforts to make greater links with BME community members and to disseminate information on services provision and access.

10.1 Support for Significant Others

In order to increase knowledge amongst BME communities in Aberdeen regarding how family members and significant others can access support for help with dealing with someone else's drug use, this information was also included in the drugs awareness training given.

The author contacted several family support groups in Aberdeen City and Aberdeenshire to enquire about levels of service uptake by BME community members. All of the support groups reported that they do not presently have any members attending from BME communities, and previous uptake has also been very low.

This information, combined with that given by drug and alcohol service providers, clearly illustrates that more effort is needed to attract family members from BME communities into services and support groups.

The author attended a SFAD (Scottish Families Affected by Drugs) event in order to both gather information regarding uptake of services by BME family members, and to disseminate information on the MEREP project and drug services in Aberdeen. Unfortunately, attendance at the event was low and no members of BME communities were in attendance. On reflection, this is perhaps not surprising as there are many barriers to engagement with both of these groups.

There is a clear need to disseminate information on drug services to BME community members affected by someone else's drug use.

11.0 Conclusions and Recommendations

This has highlighted significant issues that need to be considered in order to increase uptake of drug services by members of BME community members in the Aberdeen area, and to retain service users in treatment.

11.1 Levels and Patterns of Drug Use in BME communities

National prevalence reports show levels of drug use among BME communities to be lower than that of indigenous population overall, although evidence suggests that drug use is increasing amongst members of BME populations. Patterns of drug use amongst BME communities in Aberdeen and surrounding areas are difficult to accurately determine due to ***the lack of ethnic monitoring by drug services***, and the low numbers of individuals from BME backgrounds presenting to services overall. Only 6 individuals that are drug users from BME communities participated in this – the other 69 interview respondents reported very low levels of drug use, and none reported problematic drug use. However, it should be highlighted that the lack of presentation to services does not necessarily indicate a lack of need.

Recommendation 1: More ethnic monitoring by drug services in Aberdeen is required in order to determine current use of services, identify gaps in service provision, achieve equal access to services, and to provide a baseline for planning.

11.2 Concerns of BME Communities Regarding Drug Service Access

The findings of both this study and of national studies show that members of BME communities are often reluctant to engage with drug services for a number of reasons. These include issues of stigma and shame associated with drug use (especially acute for women), fears over confidentiality and the perception that services will be unable to meet their needs. Drug services need to be aware of and sensitive to these concerns in their service provision to individuals from BME communities.

Recommendation 2: Providers of drugs services should actively promote services to BME communities, providing information that demonstrates sensitivity to their needs, and addresses common fears. An example of this would be to make explicit their policies regarding confidentiality.

Recommendation 3: Drugs agencies should endeavour to provide services in a culturally sensitive way. This would necessitate an awareness of concerns that a service user might present with, which could be fostered by asking direct questions during initial assessment and by providing services at discreet locations which may be out-with their own community in attempts to ensure that confidentiality is maintained.

11.3 Disseminating Service Information to BME Communities in Aberdeen

Interview respondents stated that there is a lack of drug service information available to members from BME communities in Aberdeen. Only very few respondents reported a knowledge of drug services in Aberdeen or the kinds of services on offer. Furthermore, drug services reported that they do not advertise or promote their services directly to members of BME community groups. It is vital that information on drug services in Aberdeen is available and accessible to members of the BME community if agencies are to offer fully inclusive services that can be easily accessed by all community members.

Recommendation 4: Drug agencies should provide service leaflets and drugs information in different languages and through a range of different media. This information should be available in places that can be easily accessed by BME community members, such as the internet, BME community newspapers and magazines, at local ethnic minority 'information points', community centres, and GP practices to ensure that information is widely disseminated to BME groups in Aberdeen. Information regarding service access should be explicit and concise.

Recommendation 5: More information on services that provide support for family members and significant others affected by someone else's drug use should be made available to members of BME communities in Aberdeen, and service uptake should be monitored and evaluated regularly.

11.4 Engaging with BME Communities

In light of the concerns over issues of stigma and shame that many BME community members have in accessing services coupled with the isolation that exists between some BME communities and the wider community, it is necessary for drug services to engage with BME communities more directly and meaningfully than through provision of service information alone. This would entail making contact with members of BME communities and

especially with groups potentially more at risk of using illicit substances, such as younger people and those residing in areas characterised by economic and social deprivation. This might be achieved by making links with key individuals within BME communities such as community and religious leaders, and organisations that work directly with BME community members. Drug services could also be more proactive in attending events aimed at BME community groups, in order to make contact with individuals and provide service information. Until drug agencies make efforts to directly engage with BME community members to inform them of available service provision, develop relationships and foster trust, it is unlikely that drugs agencies will witness any significant increase in service uptake by members of BME communities in Aberdeen.

Recommendation 6: In order to increase service uptake, direct contact between drugs service agencies and BME communities in Aberdeen city should be fostered. This could be achieved through greater multi-agency working with organisations in direct contact with BME communities in Aberdeen, and by implementation of peer-led approaches.

Recommendation 7: Drugs awareness and education sessions should be provided to young people from BME communities. This could be done through schools and community groups.

11.5 Service Provision to BME Communities

Although the six service users of drug and alcohol agencies in Aberdeen that participated in this were generally satisfied with the service they received, the drugs agency staff that completed questionnaires reported that they receive little or no training in how to best meet the needs of service users from BME communities or of the particular issues that they face in accessing services. It is vital that staff feel competent in meeting the needs of diverse community groups if services are to be fully inclusive and provide a high standard of service provision to all community members.

Recommendation 8: Drug services staff should receive regular cultural competence training as a matter of course in order to know how to meet the needs of diverse ethnic communities and incorporate this into a recovery approach. This would be necessary to ensure that recovery capital takes account of cultural differences and strengths. This could be done by greater multi-agency working with services that work directly with BME communities. Reciprocal training could be provided to staff in these organisations so that they are more aware of local drug services and referral

procedures. More direct referral routes between such agencies could also be established.

In order for drugs agencies to provide services to BME community members with limited command of the English language, interpretation services need to be available for this purpose. Issues surrounding confidentiality must be made explicit, in light of the concerns that some service users might have regarding disclosure of drug use to someone of their own community or cultural background.

Recommendation 9: Drugs services should be able to access interpretation services for BME community members whenever this is required. Issues regarding confidentiality should be made explicit.

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Appendix I - MEREP Information Flyers



Multi Ethnic Recovery Equality Project

This is a new partnership project between Drugs Action and Multi - Ethnic Aberdeen Ltd (MEAL). We have been given funding for this 1 year project from the Scottish Government's Drugs Policy Unit. The aims of the project are as follows:

- ❖ To increase our knowledge about how ethnic minority communities in Grampian are affected by drugs, the nature of the problems they experience and the types of help they would like to receive;
- ❖ To increase awareness amongst ethnic minority communities of the nature of drugs, their effects and how to seek help for drug problems, including the nature and existence of mainstream services.

In order to fulfil these aims, individuals from ethnic minority communities are needed to participate in a short interview, for which a £5 voucher can be given for their time. All interviews are confidential - the only personal details taken are age, gender and ethnicity.

Drugs Action are also keen to provide free drugs awareness training to individuals from ethnic minority communities and / or organisations that work with such individuals.

If you can help with this or would like to receive drugs awareness training, please contact:

Claire Miller (Multi - Cultural Worker, Drugs Action) on 01224 577120 or email claire@drugsaction.co.uk.

Any help would be most appreciated. Thank you.

(Polish Information Flyer)



Multi Ethnic Recovery Equality Project (Projekt odbudowy równości wielokulturowej)

- ❖ Poszukujemy osób chętnych do wzięcia udziału w krótkiej ankiecie na temat narkotyków i alkoholu. Prowadzimy badania nad możliwością udzielania informacji i pomocy osobom narodowości Polskiej, które zmagają się z problemem nadużywania alkoholu i narkotyków, jak również rodzinom i bliskim osób uzależnionych.
- ❖ Zapraszamy do udziału w badaniu wszystkich chętnych, również tych, których problem uzależnień bezpośrednio nie dotyczy.
- ❖ Każdy uczestnik badania otrzyma bon o wartości **£5** do zrealizowania w sieci drogerii Boots
- ❖ Ankiety przeprowadzane są anonimowo i poufnie - wymagane jest jedynie podanie wieku i płci.
- ❖ Zainteresowane osoby, które chciałyby wziąć udział w ankiecie, bądź uzyskać poradę lub informacje na temat używania narkotyków i alkoholu prosimy o kontakt z Claire z 'Drugs Action' (Tel. 01224577120/Claire@drugsaction.co.uk)
- ❖ Osoby nie mówiące po angielsku - prosimy o kontakt z Gosią (07871071516 gosia.tlumaczenia@gmail.com), która zapewni poufne tłumaczenie.

****Będziemy wdzięczni za wszelka pomoc. Dziękujemy!****

**Appendix II: General BME Respondents in Aberdeen city –
Country of Origin, Method of Contact, Gender and Age**

Algeria	ESOL class - Seaton Community Project 14/12/09	Female	24
Bangladesh	Meal worker	Female	42
Bangladesh	Meal workers husband	Male	52
Bangladesh	Meal volunteer	Female	53
Bangladesh	Meal volunteer	Male	37
Bangladesh	Meal contact	Male	46
Bangladesh	Meal contact	Female	32
Bangladesh	Meal volunteer	Female	32
Bulgaria	International Day event	Female	21
China	Meal volunteer 1	Female	28
Hong kong	Meal volunteer	Female	43
Egypt	Meal volunteer	Female	35
Estonia	Meal volunteer	Female	55
Finland	Meal volunteer	Female	27
Germany	Via internet	Female	30
Ghana	Meal volunteer	Male	22
India	Meal volunteer	Female	23
India	Meal volunteer	Female	24
India	Meal volunteer	Male	25
India	Community contact	Male	27
India	Community contact	Male	25
Iran	ESOL class	Female	45
Latvia	Meal volunteer	Female	24
Latvia	ESOL class	Female	23
Libya	Meal volunteer	Male	36
Lithuania	Meal volunteer	Male	19
Nigeria	personal contact	Female	35
Nigeria	personal contact	Female	26
Nigeria	International Day event	Female	31
Nigeria	personal contact	Female	26
Nigeria	Via internet	Male	28
Nigeria	Meal volunteer	Male	28
Nigeria	Meal volunteer	Male	28
Nigeria	Personal Contact	Male	27
Poland	ESOL class	Female	31
Poland	Meal volunteer	Female	28
Poland	Community contact	Male	45
Poland	Community contact	Female	40
Poland	personal contact	Male	23
Poland	Community contact	Female	34
Poland	Community contact	Male	35
Poland	Community contact	Female	53
Poland	Community contact	Female	31
Poland	Community contact	Female	29
Poland	Community contact	Female	51
Poland	Community contact	Female	19
Poland	Community contact	Female	21

Poland	Community contact	Male	25
Poland	Community contact	Male	52
Portugal	Meal volunteer	Female	39
Romania	Meal volunteer	Female	25
Romania	Meal event 1	Male	36
	Meal event		
Romania		Female	20
Romania	Meal event	Female	41
Romania	International Day event	Female	20
Romania	Meal volunteer	Male	41
Romania	Meal volunteer	Male	20
Russia	Meal volunteer	Female	43
South Africa	Meal Volunteer	Female	32
South Africa	Personal contact	Male	53
Spain	Personal contact	Male	37
Sri Lanka	Meal volunteer	Male	24
Sudan	ESOL class	Female	32
Thailand	Meal volunteer	Female	33
Turkey	Meal volunteer	Female	32
Turkey	Meal volunteer	Female	29
Born in England. Father born in India and moved to UK when he was 6 yrs old. Mother was born in the UK.	Personal contact	Female	29
Canadian citizen. Parents from Zimbabwe	Community contact shop	Female	51
English/Nigerian parents	Meal volunteer	Female	51

Appendix III: Age of Respondents by Gender

<u>Age Groups</u>	<u>Females (43)</u>	<u>Males (24)</u>
Under 20	1 (2%)	1 (4%)
20-25	10 (23%)	7 (30%)
26-30	8 (19%)	5 (21%)
31-35	11 (26%)	1 (4%)
36-40	2 (5%)	4 (17%)
41-45	5 (11%)	2 (8%)
46-50	0 (0%)	1 (4%)
50-55	6 (14%)	3 (13%)
MEAN	33	33
TOTAL	(100%)	(100%)

Appendix IV: Age of Respondents by Continent of Origin

<u>Continent</u> <u>(4)</u>	<u>Countries</u> <u>(29)</u>	<u>Females</u> <u>(45)</u>	<u>Males</u> <u>(24)</u>	<u>Total By</u> <u>Continent</u>
Europe	12 (41%)	23 (70%) Mean Age: 33	10 (30%) Mean Age: 22	33 (100%)
Africa	7 (24%)	8 (53%) Mean Age: 30	7 (47%) Mean Age: 32	15 (100%)
Asia	9 (31%)	13 (65%) Mean Age: 35	7 (35%) Mean Age: 34	20 (100%)
North America	1 (4%)	1 (100%) Mean Age: 51	None	1 (100%)

Appendix V: Method of Contact by Gender

<u>Contact Method</u>	<u>Total (69)</u>	<u>Female (45)</u>	<u>Male (24)</u>
Via Meal	36 (53%)	23 (64%)	13 (36%)
Community Contact	15 (22%)	9 (60%)	6 (40%)
Personal Contact	8 (12%)	4 (50%)	4 (50%)
ESOL Class	5 (7%)	5 (100%)	None
International Day	3 (4%)	3 (100%)	None
Contact me via DA	1 (1%)	None	1 (100%)
Cyrenians	1 (1%)	1 (100%)	None

Appendix VI: MEREP Training Evaluation



Multi Ethnic Recovery Equality Project

Training Evaluation Form – MEAL Networking Event 17/10/09

1. What did you like best about the training?

- "I gained more knowledge about drugs"
- "Very precise and exploratory – the trainer was lovely"
- "The range of information that was produced"
- "The way it was presented to us"
- "Was very informative"
- "I learned about different kinds of drugs and their effects"
- "I did not know there were so many different types of drugs"
- "Informal, community – style training"
- "It was clearly laid out and easy to follow, I liked how you could ask questions"

2. What did you like least about the training?

- "Less interaction with others and their views – it was individual conversation"
- "A bit long" (x2)
- "Nothing" (x6)

3. What were the most useful things you learned from the training?

- "The help that people can get if they are addicted to drugs and how they can come off drugs"
- "The services that Drugs Action offers" (x2)
- "The effects that different drugs have on people"
- "The bad effects of drugs"
- "Short – term and long – term effects of drugs"
- "Updated information"
- "It made clear something I was unsure/unclear about"

4. Is there anything else that you would like to learn that was not covered in the training?

- "I would have liked to know more about others (respondents) views"
- "Support groups for addicts and their families"
- "What we can do to help people stay away from drugs"
- "Drug problems in Aberdeen more specifically"

5. Would you like to make any other comments?

- "It would have been better to have discussions with others and exchange knowledge and experience."
- "Very good, could be really useful for young people to attend it."

Appendix VII: MEREP Training Evaluation for Children



Libyan School Drug Awareness Session

Facilitated by: Claire Miller and Catherine Goven, Drugs Action

I think today's session was







The part of today's session I enjoyed the most was

The part of today's session I enjoyed the least was

One thing that I learned today was

Training Feedback : 6-11 years:

- 19 children ticked the smiley face, indicated that they assessed the training to be good, and 1 child ticked the face that indicated they assessed the training to be average.

The part of the session I enjoyed the most was:

- "Putting the shopping items into groups" (x2)
- "That I learned what things are good for me and what things are bad for me" (x2)
- "Learning about the things that have caffeine in them"
- "All of it (x9)
- "Learning about which items were drugs"

The part of the session I enjoyed least was:

- "Medicine"
- "Sitting a long time"
- "Guessing the kinds of drugs"

Training Feedback 12-17 years

- All 15 participants ticked the smiley face to indicate that they assessed the training given as "good"

The part of the session I enjoyed most was:

- "When we looked at the drugs" (placebo kit)(x4)
- "When we looked at the drugs and the drawing exercise" (x5)
- "The effects of hallucinogens and risks"
- "Talking about the uppers"
- "When we were joined in a team to work and then draw. When we were looking at the kinds of drugs"
- "When I talked about our drawing and when I learned new things about drugs"
- "Practical training" (x2)

The above responses indicate that the majority of participants enjoyed the drawing exercise and the opportunity to look at the placebo kit to learn what different drugs look like.

The part of the session I enjoyed least was:

- "When we drew the man" (x3)
- "When we were just sitting down and had to listen"

One thing I learned today was:

- "I learned the risks and the dangers that I might get from using drugs" (x4)
- "That there are a lot of different kinds of drugs"
- "That drugs are not good for me" (x3)
- "Everything was very helpful" (x2)
- "How drugs can be really harmful and the bad effects that they have on the body"
- "The names of drugs"
- "That nicotine is a dangerous drug"
- "That you can get Hepatitis by sharing needles"

One thing I learned today was:

- "How people are affected by alcohol"
- "A lot of things have drugs in them"
- "Cigarettes can kill you"
- "Drugs are unhealthy"
- "That drugs can harm you"
- "That drugs are dangerous if you have too much of them"
- "Different kinds of drugs" (x3)
- "About caffeine"
- "That coca-cola has caffeine in it"