Practitioners contend it is becoming increasingly difficult to work with black and minority ethnic drug and alcohol users. They say that despite efforts to improve diversity, the current Class A focused, target-driven system is not conducive to accessing and engaging marginalised BME users in treatment.

Problems identified by practitioners working with BME users include:

- The blanket emphasis on getting and retaining large numbers of Class A dependent users in treatment. Many BME users are hazardous rather than dependent users, and are misusing substances like khat and cannabis.
- Not enough priority is attached to drug education and outreach work. This work is essential as BME communities have a low awareness of health services and may be reluctant to seek help for religious or cultural reasons.
- Minority ethnic clients often approach services with related problems - for example around housing - which provides services with an opportunity to work with marginalised groups. However services are not funded to do this work.
- There are few resources attached to alcohol treatment, something that impacts on all BME communities.

Lennox Drayton, manager of New Roots, a specialist BME project run by Rugby House, says it is now harder to work with diverse groups. "With a lot of our clients there is a lack of awareness around treatment and building up relationships with them takes time. There is also a stigma around drug and alcohol use which needs to be addressed sensitively in order to build up confidence in the community. But that's not recognised by the current system which is all about numbers."

Harrinder Dhillon, service director at DASL agrees. He says generic services have to do tier one and two work consistently if they are to increase the numbers of minority ethnic users in treatment, but if services are already oversubscribed this is unlikely to be a priority for commissioners, especially as many BME users are hazardous rather than dependent users.

He says when he started working at DASL as an Asian development worker in the early nineties, it was easier to do targeted work with marginalised groups. "It took me six months to get into some groups. Do people have the time to do that now? I'm not sure in the current climate they do, there is so much emphasis on results."

The National Treatment Agency says BME users are being successfully engaged and retained in treatment, but that improving diversity is a priority, and is one of the areas being examined by the Healthcare Commission in this year's improvement review. It says drug action teams are expected to cater for diverse needs as part of treatment plans.

But Abd Al-Rahman from the Federation is not convinced this is happening. "The NTA says the system is getting better... yet when you go down to street level in Brixton or Haringey, Waltham Forest or Tower Hamlets, what you hear is that there is an over concentration on Class A drugs. Skunk is ravaging some communities but treatment agencies are being told not to focus on it." See Debate Reigns Over Complexities of Improving BME Access p4
news update

BME REHAB PROJECTS UNDERWAY

Two residential drug treatment units are being specially designed to attract people from ethnic minorities after successfully winning bids for NTA cash. St George’s Hospital in Tooting, south London has been given £2.6m to remodel its current in-patient drug and alcohol unit. In order to attract more problem drug users - especially from the area’s large Asian community - the unit’s dormitory will be turned into single rooms with en suite bathrooms and there will be a multi-faith quiet space for prayer. The changes have been made following consultation with ex-service users of the unit.

“We serve a very mixed population and feel that Asian service users are under-represented at the current unit,” said a spokeswoman for south west London and St George’s Mental Health NHS Trust. "We are hoping that people who have felt deterred from coming here will feel more confident." The new unit will be completed by 2010.

EACH, a substance misuse agency working primarily with BME communities in west London, was given £2m to build and establish a therapeutic rehabilitation programme with temporary accommodation - specifically targeting members from BME communities.

According to EACH chief executive Sandra Machado, BME groups are put off attending rehab for a number of reasons. “Currently most mainstream residential treatment services are unable to provide an environment where members of the BME community feel their specific cultural, language and religious needs are catered for,” said Machado. “The evidence shows that people with drink and drug problems in these groups are failing to access tier four treatment, and the barriers are even bigger for first generation people.”

Machado said BME users did not feel comfortable living or being treated in a group setting. For example, a Sikh would find it hard to carry out daily rituals if they were sharing a room with another person, while a Muslim would be put off by a lack of prayer space or non-halal meat. In addition, said Machado, many users from BME communities are not aware of the long term benefits of residential rehab.

The proposed £2m 15-18 bed rehab, to be set up by EACH in conjunction with housing and social care agency Look Ahead, will specifically target members of the South Asian community which is under-represented in the west London boroughs of Brent, Hounslow and Hillingdon. It will be up and running by 2009.

The bids were part of a total of £50m handed out by the NTA for tier four capital investments last year.

BANGLADESHI DETOX SUCCESS

A residential detox unit targeted at heroin users from the Bangladeshi community is claiming success, with seven out of ten clients completing its programme. The eight-bed Harbour Recovery Centre in Tower Hamlets, east London was set up in August 2006 in response to a gap in services for non-injecting Bangladeshi heroin users in the area. Although an official study into service user feedback is yet to be published, clinical team leader David Morgan says a key element of its success is the provision of one-to-one sessions instead of group work. According to Morgan, service users have also responded well to the fact the unit, managed by the Salvation Army and Tower Hamlets DAAT, has individual bedrooms, is situated locally, is clean and flexible to their needs.
RESULTS OF FIVE YEAR RESEARCH PROJECT DUE

The NTA is gearing up to publish the findings of the most extensive research project to date into the needs of drug users from ethnic minorities.

The Black and Minority Ethnic Drugs Needs Assessment Project trained and supported 179 community groups in England to conduct needs assessments of their own areas between 2001 and 2006. The aim of the project, a joint Department of Health and University of Central Lancashire study, was to raise awareness among ethnic community groups, provide training for them, and to recommend how barriers faced by ethnic minority drugs users who want to get help can be broken down.

The study found the most common barriers to treatment were a lack of awareness of drug services and their functions, the ethnicity of staff, a perceived lack of cultural and religious competence by drug services and a mistrust of the confidentiality of services. It found patterns of drug use were no different from the general population.

The NTA, in partnership with the University of Central Lancashire, will publish a series of briefings in the next few months up to March 2008 looking at the needs of different BME groups.

NDTMS GETS NEW "NATIONALITY BOX"

The NTA is adding a 'nationality' box to improve the ethnic monitoring of people in drug treatment. From October people entering drug treatment will be asked to fill in their nationality as well as their ethnicity. The decision to change the National Drug Treatment Monitoring System (NDTMS) was made because the 'White - other' field was seen as too vague. The NTA said the 'White - other' field had not been able to distinguish between a growing variety of people arriving in the UK to live, especially from eastern Europe.

A national audit will also look at whether the data collection of providers and commissioners are meeting the requirements of the Race Relations Amendment Act. Organisations which fall short of national average performance will be asked to provide an action plan to improve during the course of treatment planning.

REFUGEES FACE TOUGH TIME IN LONDON - MAYOR

Refugees face an uneven playing field when it comes to accessing vital services, says a draft strategy report issued by London Mayor Ken Livingstone. On top of the disadvantage of ethnicity and inequality, London's estimated 500,000 refugees and asylum seekers receive patchy advice and guidance services, inadequate English teaching and poor chances of moving into stable housing. Access to health and related services such as drug treatment is also limited, especially because there is a poor knowledge of available services and entitlements among refugees and practitioners.

London Enriched, the Mayor's draft strategy is out for consultation until the end of October. The final report is due in Feb 2008.

A8 NATIONALS FACE TREATMENT LOTTERY

Migrants from the eight countries that joined the European Union three years ago face a 'postcode lottery' when it comes to drug treatment in the UK.

Beyond Boundaries, an NTA-commissioned report into the accessibility of drug services for people who have migrated from countries such as Poland and the Czech Republic (known as 'A8 nationals'), found that the interpretation of government guidance "varied dramatically" between areas.

The report, carried out by researchers at the University of Hertfordshire said: "On one hand interviewees described services offered to all with no restrictions, while on the other an arrest referral worker described a case where two individuals in treatment, guidance emerged from the PCT and their involvement with services was ended."

It said while most A8 clients were able to access harm reduction advice, needle exchange, prescribing services and open access counselling, service managers were often unsure as to whether they should get onto detox, structured day programmes and drug interventions programmes (DIP).

The study found that although A8 nationals have not been swamping drug services, there are growing problems around the use of crystal methamphetamine, groin injecting and the fact that some drug using suspects have ended up remanded in custody because after being barred from entering DIP.

See Vulnerable EU Migrants Pose Challenge to Drug Services p.11

news update

TRAFFICKED CHILDREN WORKING ON CANNABIS FARMS

Vietnamese children are being brought illegally into the UK to work in the growing number of indoor cannabis farms in London. The children are coerced into doing the work - highly dangerous because of the illegal wiring of electricity needed to cultivate the plants - after being trafficked into the UK. Some have been prosecuted and jailed for cannabis cultivation despite demands that they be treated as victims not criminals. The Metropolitan police say that more than 1500 cannabis farms have been closed down in the capital over the last two years - three times the number between 2003 and 2005. About two thirds of the farms are run by Vietnamese gangs.
Debate Reigns Over Complexities of Improving Access

What does a Tamil torture survivor, Lithuanian sex worker and black teenage gang member have in common? They may well all be members of a very diverse and marginalised group in London - black and minority ethnic drug and alcohol users, and they are all probably having more difficulties accessing treatment than their white British peers, but for different reasons.

The subject of BME drug and alcohol use is complex and controversial but for some time there has been agreement that minority ethnic groups are misusing substances and in need of help, but face considerable barriers to treatment. Notwithstanding race relations legislation, which obliges publicly funded agencies including DATs and PCTs to treat all groups equally, drug and alcohol treatment has had, in short, a white Eurocentric bias.

Models of Care for Drugs itself admitted as much when it stated there were "institutional failings" in meeting black and minority ethnic drug users needs "especially true for residential rehabilitation facilities, but also of the whole treatment system", while in 2002 an Alcohol Concern commission said BME alcohol users were not being catered for adequately either.

Barriers to Treatment

There was however considerable consensus about what the main barriers to treatment were: opiate focused services; Eurocentric treatment approaches including a focus on the individual; an inability on the part of staff to understand and respond to the needs of BME users; too few BME workers; language barriers; poor awareness among BME groups about services available; concerns around confidentiality; and anxiety among refugees and asylum seekers about being reported to the authorities.

The chief remedies prescribed were better ethnic monitoring; more outreach work, community engagement and working with families; targeted literature; and the substantive implementation of equal opportunities policies. It was also recognised that more minority ethnic workers needed to be recruited in diverse areas like London. Mainstream services though staffed with culturally competent workers were to drive forward improvements on BME access.

So are things getting any better?

Flawed Treatment System

Practitioners working with BME groups say there is a growing need in minority ethnic communities for drug and alcohol services but the treatment system makes it difficult to cater for it, as there is so much pressure to meet centrally imposed targets around numbers and retention times. This does little to promote the time consuming relationship building and awareness raising work necessary to access users in diverse communities, while the focus on Class A drugs makes it difficult to work with those using other substances like khat problematically.

Most also contend that there is a need for specialist services, as mainstream services are not as accessible to diverse groups. Though these may have workers from minority ethnic backgrounds, BME practitioners say the working practices and culture of mainstream services are still very much geared towards the majority population - something that does not pass minority ethnic users by.

They also say that many clients prefer a specialist service as people are naturally more comfortable among those they regard their peers - particularly when they are feeling vulnerable.

The lack of resources for alcohol treatment is another problem as alcohol is being used and misused by all communities. But the treatment system too has been criticised as inappropriate for BME groups. Writing in Drink and Drugs News last year, Don Shenker from Alcohol Concern said the then just published Models of Care for Alcohol, regarded treatment as "a strict mono-cultural, individualistic and bureaucratic top down model, passing only scant reference to the needs of Black, Asian and other ethnic groups… No examples, suggestions or guidelines are given on how to engage with diverse community groups."

Progress Being Made?

A recent NTA report suggests progress is being made in drug treatment. Based on National Drug Treatment Monitoring System data for 2005-2006, it says many minority ethnic users in London are accessing and being retained in treatment. While Asian drug users are under represented, the report states the black population has been "successfully engaged by treatment providers." In fact, it says that based on a comparison between the treatment population and overall population, black users are over represented in some London boroughs. Blacks and Asians are also more likely to be retained in treatment than other ethnic groups, something it ascribes to "ethnic-specific services, effective assertive outreach and local prioritisation."

Trevor McCarthy, NTA best practice manager, says that while there is clearly room for improvement - the improvement review this year is looking at diversity - many mainstream services are effectively catering for BME communities. "Many people are happy with mainstream services and just go and use them," he says, adding that those using specialist services may be disproportionately critical of mainstream services because of a bad
**BME Substance Use - Setting the Facts Straight**

London’s ethnic minority communities appear to be using drugs and alcohol increasingly. But not as much is known about the nature and extent of their consumption as is known about substance use in the wider population. Below we set out some statistics and research findings about the capital’s BME’s population, drug use and treatment record. Overall it amounts to a complex picture and one set against a backdrop of social exclusion and racism.

**LONDON**
- One in three Londoners is in a black and minority ethnic group.
- Indians are the largest ethnic minority group making up 6% of Londoners. Black Caribbeans and black Africans each make up 5%. There are also large numbers of Pakistanis, Bangladeshis and Chinese.
- Newham and Brent are the most diverse boroughs. Both have majority ethnic minority populations. Havering is the least diverse. According to 2001 census figures, it is the only London borough with a BME population below the national average.
- Bangladeshis are the most heavily concentrated BME population in the country. Almost half live in Tower Hamlets.

**DRUG USE**
- Drug use is lower among black and minority ethnic groups than in the white population. In particular, there are low levels of use among South Asians and black Africans.
- Opiates are the most commonly used drug but there are important differences between different communities - take the role of khat within the Somali community.
- Black Caribbeans have a similar level of drug use to the white population but this is primarily driven by cannabis use. They also have a significant level of problematic crack use.
- BME drug users are less likely to inject than their white peers and more likely to smoke.

**DRUG TREATMENT**
- According to the NTA, once engaged in treatment black and Asian users are more likely to be retained in treatment than other ethnic groups.
- Pointing to 2005-2006 NDTMS data for London, it says that while Asians are under represented in treatment in the capital compared to their population size, the black population has been “successfully engaged by treatment providers”.
- Overall, those from a mixed ethnic background are most likely to access treatment.
- A disproportionately large number of people in the criminal justice system accessing treatment are from BME groups. According to the NDTMS 2005-2006 data, 59% of CJS clients were White, 7% Mixed, 7% Asian, 22% Black and 3% ‘Other’.

**POVERTY AND RACISM**
- People from BME groups are more likely to be poor and live in socially deprived areas than the white population. Risks are highest for Bangladeshis, Pakistanis and Black Africans. 70% of children in Pakistani and Bangladeshi communities in London are growing up in poverty.
- Unemployment rates among BME groups are 10 to 15 points higher than for the white population. Indians and Chinese fare better than other groups.
- According to Government figures, black and minority ethnic people are three times more likely to be homeless than the white population.
- Despite their lower drug use, black Londoners are six times as likely to be stopped and searched by police as white Londoners, while Asians are twice as likely.

**ALCOHOL USE**
- There is a dearth of robust data available on BME alcohol use, but generally men and especially women from ethnic minorities, are less likely to drink alcohol than the wider population. Alcohol use is lowest among the Muslim Bangladeshi and Pakistani communities.
- Low overall drinking levels within the South Asian community mask differences between ethnic and religious groups - studies have found higher alcohol use among Sikh men.
- Patterns of drinking across London are influenced by the local BME population. According to GLADA’s Highs and Lows 2 report, levels of binge drinking are lowest in Newham and Brent, the capital’s two most diverse boroughs.
- ANARP, the Department of Health’s audit of alcohol misuse in 2004 concluded that while BME communities drink less, overall they have a similar prevalence of dependent drinkers as the white population.
big issue

Unwitting Focus on “White UK” Means Crack Users Lose Out

Crack specialists COCA say not enough priority is attached to treating crack users. Despite the publication of several reports in recent years criticising the opiate focused nature of drug services, and a national crack plan, COCA’s Tony D’agostino says there are still not enough specialist services while mainstream services are not being reconfigured to engage crack users.

D’agostino says the problem is services do not have the resources to reconfigure and train their workers to deal with crack users - of which a significant proportion are black Caribbean - while the treatment system does little to promote it.

“The 12 week retention target was thought up with opiate users in mind. Why aren’t there targets around cognitive behavioural therapy, motivational interviewing and alternative therapies to encourage work with stimulant users?” he asks.

“Stimulant users are much more difficult to work with, need more intensive help and do not have the incentive of a script to come back for,” he continues. “But because there is not one target around crack or cocaine use, agencies with a full caseload quickly get the message that they don’t have to work with stimulant users.”

D’agostino is critical of the Department of Health’s and NTA’s harm reduction strategy published earlier this year, for focusing heavily on opiate users “despite the fact that crack use is attributed to higher risk behaviour and linked to the increased prevalence of Hepatitis C.” He says there is a need for more information around safer smoking and pipe exchanges should be introduced.

His criticism comes despite mounting concern in recent years about the extent to which crack users are catered for. One Home Office report described the focus on opiate injecting as an “important source of institutional racism”.

D’agostino thinks the institutionally racist label inappropriate, but says that by focusing on injecting users, services are unwittingly focusing on “white UK”. If services want to widen their reach they need to adapt to cater for smokers and snorters, he says. “The South Asian community smoke heroin. African Caribbeans are more likely to snort or smoke. If you provide services that cater for a wide range of drugs, you will see more people from BME communities coming through the door.”

Debate Reigns Over Complexities of Improving Access

cont from page 4

experience they have had in one." They may not have liked staff or how they were treated there," he said.

But Abd Al-Rahman from the Federation thinks the problem is more systemic and much more priority needs to be given at strategic level to the needs of BME users, as at service level workers have a poor understanding of diversity issues and their role in increasing accessibility. He wants the Government to undertake a thorough review of the progress made on black and minority ethnic issues in recent years so it can identify problem areas.

He also thinks more stringent performance monitoring should be introduced for drug action teams.

Complex Issue

Jane Fountain from the University of Central Lancashire’s Centre for Ethnicity and Health has spent much of the past seven years immersed in issues surrounding drug use and service provision for BME communities. She has been working on the Department of Health’s Black and Minority Ethnic Drugs Needs Assessment Project that was conducted throughout England in 2000-2006. This huge and ambitious project employed a community engagement model to train and support 179 community organisations to conduct needs assessments, and Professor Fountain is now in the process of writing up the project’s results to inform drug service planning and provision.

Part of the reason why progress on service provision is difficult is because it is very complex area, she says. “There are a lot of barriers to access other than the obvious ones like language. Black Africans often don’t want to come out as a drug user in case they will be reported to the Home Office. The idea of services being confidential is completely alien to them. Some will have come from less than democratic countries and will have spent several years getting to the UK. The last thing they want is to be sent back. For South Asians on the other hand, the issue is often about gossip in the community and not wanting to let the family down.”

Fountain says it is difficult to accurately measure whether BME groups are adequately represented in treatment, but straightforward statistical comparisons between the treatment population and overall ethnic minority population in a given area do not give the full picture. Many black users are in treatment because they are over represented in the criminal justice system due in part to discriminatory stop and search procedures, she says. Other communities like the Bangladeshis have a very young population so would have more people at risk of drug use than the older white population, another factor that should be taken into account.

Overall, she says cultural competence is key to improving access. One of many complicated definitions defines this as, ensuring the “knowledge, information and data about individuals and groups is integrated and transformed into clinical standards, skills, service approaches, techniques and marketing programmes to match the individuals culture and increase both quality and appropriateness of health and health outcomes.”

So not easily achieved, especially when as Fountain points out diversity training is more often than not a “one-off” exercise.
young people

Trying to Save Young Men From Prison and “The Slab”

By the time many young black men in south London reach the age of 15 or 16, they have come to terms with the fact they have only have two options, writes Rebecca Norris. According to Lee Parker, a coordinator of the Phoenix Programme in Lambeth, these are prison or “the slab”, a street name for the mortuary bench.

The Phoenix programme is trying to shift these expectations. Launched 18 months ago as a partnership between Lambeth’s community safety division, Youth Offending Service, police, and eight third sector organisations (see column opposite), it aims to provide a "community response" to the various drivers behind gun crime and prevent young men from becoming embedded in the criminal justice system.

"Within our programme we address substance misuse, attitudes to offending behaviour and lifestyles, perceptions of self, emotional wellbeing and education," Lorraine Redmond, the programme’s other coordinator explains. "In addition to this, we provide a supportive service to the parents and extended family members of the young people. With this type of collective community work, we are better able to equip young people to be re-integrated back into mainstream society."

Many of the young men, who are referred to the programme from the YOS, use and sell drugs. Drugs, and the money they make from selling them, are the currency used to command respect from their peers, Parker says: "These young men become ‘entrepreneurs’ of the street. They all want to be the main man, who mustn’t be disrespected. Early on it’s skunk, but crack is the one that sells very fast and makes lucrative amounts of money."

Turning Point’s ACAPS Youth Service is a member of the Phoenix consortium. Phoenix referrals work there with a dedicated worker who grew up on a local estate and was once at risk of crime. He is now a qualified social worker and weekend DJ on the house and garage scene.

ACAPS manager Ira Campbell says this background, like that of other ACAPS staff, give them credibility. "They are not people who are parachuted in and have lived quiet nice lives and have no idea. They have the understanding, empathy and connection with these young people, which is really important."

Most of the young men use cannabis but crack use is also common. Campbell says: "We use a community detox method, trying to get young people to recognise what their triggers are, explore how they feel when they’re smoking and when they don’t, and their risky behaviour around crime and sex. We try to compensate it with positive things."

These include the opportunity to work as volunteers at ACAPS once they have completed the programme, and to train as paid peer educators who go into schools and local estates to describe how they have overcome drug use and crime. They are also offered opportunities to gain basic certificates in English and maths, health and safety and first aid, and even young football manager badges. "It’s not just about the drugs, but giving them self-belief and helping them become better citizens," says Campbell.

The Phoenix Programme team co-ordinates the different providers’ work, the timetable of attendance by young people and reporting systems. Now in its second year, it coordinated support for 80 young men in its first year, which were split 50/50 between those subject to court orders and those attending voluntarily. Since the start of the programme’s second year, most referrals are backed by orders so non-attenders can be breached and sent back to court.

Funded to the tune of £350,000 via the Lambeth Strategic Partnership and police, there is uncertainty, however, about the programme’s funding.

Parker admits that it faces an uphill task. Though it has strengthened partnership working, making real progress with young men is hard, he says not least because "we struggle to change their minds that going to a young offenders institution is the way it should be".
In London new communities are establishing themselves all the time. Each has their own experience of drugs and alcohol based on their cultural traditions and faiths. That’s why workers drawn from ethnic minority communities have a vital role to play making drug treatment more accessible, as KATHY OXTOBY finds out.

Milgo Muhammed
Equinox Lewisham

Milgo Muhammed is one of the few outreach workers in the field working with the Somali community. She has first hand experience of many of the difficulties they face. "In 1997, when I was just a teenager, I left Somalia because of the civil war. It was a matter of life and death. My father was killed. But coming to England as an asylum seeker gave me hope."

First she learned English. Then she began doing voluntary work with Somali women in London, helping them to integrate into the mainstream community, take English classes, register with their GP and feel more empowered. "It was my natural instinct to want to empower these women. When I left my home I had nothing, so I could easily put myself in these women’s shoes. But I also knew just how much they would benefit from having support."

One of the main problems for the Somali community is the language barrier. "People from Somalia come to the UK with qualifications and skills but then, because they can’t speak English they are unable to express themselves."

"Some are suffering from post traumatic stress disorder as a result of the traumas they have witnessed. But even in their own language, they are reluctant to talk about their problems because the Somali culture does not encourage this."

Winning the community’s trust is vital, she says, particularly when working with drugs misusers. "Drugs are a big problem for the Somali community, particularly khat and increasingly for the younger people, cocaine and heroin. I work hard to build relationships with clients so they feel comfortable discussing their problems with me."

Ignorance among the Somali community was her biggest challenge when she started her role. "Everything was questioned and forbidden. I respected the religion but I wanted to change the culture - to tell people it was ok to be who they wanted to be. Even now some people are surprised when they see a Somali woman handing out condoms or giving out clean needles. I tell them how proud I am to be doing this job."

Now, with her sights set on studying for a PhD in social care, she wants to help others to achieve what she has. "I want to motivate people to reach for a better life. And because of what I’ve lost, I don’t want to waste any time."

Vulong Ngygen
Addaction Hackney

Vulong Ngygen was one of the first boat people to come to England in 1979. Now a community outreach worker with Addaction, he works with the Vietnamese community in Hackney, mainly with Class A drug users. His role can involve anything from client assessments to giving acupuncture, to helping service users understand UK drug policies.

He says many of the people he works with have lived through terrible traumas caused by the Vietnam War and conflict between Vietnam and China. Some used opium to ease the pain. Now in London, some of their children have turned to heroin and crack cocaine. "They tend not to seek help because to do so would make them a traitor in the eyes of their culture. I need to break down those barriers and make sure these communities have access to support and treatment."

Vulong understands their problems. He fled to Hong Kong from Vietnam in 1978 at the age of 17 following the Vietnam-China conflict. Initially, he went to Southampton and started studying for
an art and design course. He changed track after seeing an ad in the local paper for a job working with Vietnamese refugees. "I wanted to help them get back some kind of normality in their lives."

He says there is a need to increase awareness about why people turn to drugs and why it is important to support them. "I remember one Vietnamese female user taking hard drugs whose life was chaotic, both physically and mentally. When I asked her about her family life she explained that after leaving a poor province in Vietnam to come to England, her family had fallen apart. Unable to sleep, a friend had told her that heroin would help. I helped her to get her own flat and build a more stable life. She later married and now runs a small restaurant."

**Zeynep Thirlwell**
Addaction Hackney

Zeynep Thirlwell has spent many years working with the Turkish community. But it is only in the past year, as development worker at Addaction in Hackney, that she has worked with clients affected by drug and alcohol misuse. The experience has been an eye opener and has made her less judgemental about people using drugs.

Turkish communities have specific problems when it comes to drug misuse, she says. "Drugs are taboo. There's an enormous stigma which makes it difficult for Turkish people to acknowledge and talk about their drug problems. Then there's the lack of education about drugs. Often parents, unlike their children who were born here, don't know much about Western culture, and know, for example, that drug use can be experimental. They can't distinguish between soft drugs and Class A and think that their children will die if they take cannabis."

"There's also the language barrier. If people can't speak English, then how can they talk about their problems - and who can they talk to? It can make them feel extremely isolated."

Coming from Turkey herself, Zeynep says she is better able to help people overcome these barriers. "Because I understand the culture, I know how to talk to people, to get them to open up so I can ask questions about their drug problems."

Much of her work involves visiting clients in their homes or places where they feel safe, such as a GP's surgery or community centre. "Some clients are refugees whose drug problems have escalated because they lack access to healthcare, housing and employment. It's important that they get the right advice and support to help them overcome these obstacles."

She also works with Turkish community centres to educate people about drug misuse, and in doing so hopes to encourage more Turkish people to get involved. "I wish there were more Turkish drug workers in this area, but because drugs are taboo it doesn't make it easy to find staff. I'm trying to talk to people in my community to let them know they can work as volunteers."

**Sook Mun Chow**
Hungerford Project

Sook Mun Chow set up a drug and alcohol outreach service in 1998 for Soho's Chinese community. "At that time there wasn't a dedicated outreach service for the Chinese community. Given that we were based in the middle of China town and I'm bilingual in English and Cantonese, it seemed the ideal opportunity to set up a service."

With her managers' support, she looked for examples of good practice from other groups working with Chinese communities but they were hard to find. "There were few substance misuse workers doing outreach work with this community. I learnt on the job but was fortunate to have good policies and guidelines already in place at the Hungerford Project to help me."

Winning trust was a priority when the service first started. "Many Chinese people don't trust outreach workers. They associate them with the police and punishment. So I had to get Chinese community organisations on board. It took a while to convince them there were drug issues but I had evidence to back me up."

Another challenge was having to translate English terms used by drug workers - such as 'clean needles' - into Cantonese. But she says it helped to speak the language as some clients are more comfortable speaking one-to-one about their problems rather than through an interpreter.

Understanding the culture helped. For example in the early days of the service, the idea of group therapy and counselling was alien to many service users, as discussing personal issues is considered inappropriate. Now a team leader at the Hungerford Project, Sook still provides training to Chinese community groups about drug awareness and to other organisations about the cultural sensitivities of these groups.

Though treatment can include anything from English classes to massage to getting a methadone script, Sook says that sometimes it is the simple things that make a big difference."One Chinese client, who couldn't speak English, was arrested for possessing illicit methadone. He was using it to come off heroin but didn't know he was doing anything wrong. For him it wasn't illegal, it was medicine. I was able to explain the situation to him in just 20 seconds and get him into treatment.\"
PARTNERSHIP WORK THAT CAN REQUIRE A LEAP OF FAITH

Some drug workers are sceptical about the benefits of mixing drugs and religion. Others believe faith groups have a very positive role to play helping individuals and drug services.

About 200 Christian Street Pastors patrol high crime areas in London talking to people on the streets, many of them drug users. Their aim is to cut down on crime and antisocial behaviour by bringing hope and the Christian message to marginalised Londoners. The volunteers are all local Church members highly motivated and committed to the cause. Founded in Brixton in 2003, and now operating in ten London boroughs, they are probably the best known faith group engaged in drug and alcohol work.

They are a phenomenon the Government is keen to encourage. Convinced that faith groups have a vital role to play combating drug use at local level, it has been keen to highlight their potential and to encourage voluntary and statutory agencies to work more with them.

Some in the field are sceptical concerned that faith groups primary focus is to proselytise. But others see plenty of merit in working with faith organisations, especially when it comes to accessing very marginalised black and minority ethnic drug users.

The Government Office of London (GOL) has promoted faith groups involvement in drug and alcohol misuse. David Mackintosh, policy adviser of GOL’s London Drug Policy Forum, says there are clear advantages in working with them. "They tend to be well rooted locally, they often have facilities from which you can do things and many of them have an impressive track record in responding to local community concerns and reaching out to people," he says.

He thinks it is important that faith groups improve their awareness of drug issues, treatment models and local statutory and voluntary services. "There are a lot of well motivated, caring, and skilled people within faith groups who could do a lot more if they were better educated and supported around drug and alcohol use," he says.

Lennox Drayton, manager of New Roots, a specialist service targeted at BME communities in inner London, says that working with faith groups helps demystify substance misuse, and removes the barrier between communities and treatment agencies. He says working with them can also be a way into some communities even where there is a stigma or religious injunction attached to drug or alcohol use.

But not all faith groups will be amenable to working with drug agencies, he says. "We have had a range of responses - from those who say 'alcohol and drugs is forbidden, we don't want anything to do with it', to others who say, 'it will be great to have you along, you can have ten minutes after prayers'." Faith though is always an important issue to address, as it will shape users attitudes to drug and alcohol use even if they are no longer practising, and can help rebuild lives once users are in treatment. Drayton says: "I know that when a couple of my clients of Muslim background got into a residential detox centre, one of the things they negotiated was a space to pray. My sense is that once many of these individuals are getting treated, they want to get back into their faith and those networks again. While they're drinking or using drugs they don't."

Abd Al-Rahman, head of strategic development at the Federation, says that sometimes faith is the only support some people need to stop using. While not discounting the benefits of treatment and harm reduction, he says he has met people who have come off drugs simply by "embedding themselves in their faith in terms of the practice and support structures, without any traditional interventions."

But he says it is important not just to think in terms of faith communities as having a spiritual function, but as having cultural and community functions as well. People will often look for help first within their own faith network because it is such an integral part of their identity, he says.

"I remember some years ago doing work with Muslim communities and being told 'you won't get any funding if you mention the word Muslim, but if you mention the Pakistani community you will get the funding for it'. I think that we need to be much more open to the fact that if you're talking about the Pakistani community you are talking about the Muslim community by and large."

Eustace Constance says the Street Pastors fulfil a much-needed social as well as a spiritual need. Volunteers are required to complete 12 training sessions, including drug awareness, before they can take part in patrols.

"We say to people we're here to listen, express care and offer help. If they say they're an addict, we will ask if they will accept help. If there is some spirituality already there, we will refer them to a local agency run by Christian men and women ...but where there is no apparent spirituality we will refer elsewhere. Part of the responsibility of the local co-ordinator is to make contact with DAATs, and to be aware of the referral criteria that operate."
Vulnerable EU Migrants Pose Challenge to Drug Services

Hundreds of thousands of Eastern Europeans have migrated to London since joining the EU in 2004. While most find work, some with alcohol and drug problems end up living on the streets.

Like other London boroughs, Hammersmith and Fulham has seen a large number of Eastern Europeans or A8 nationals arrive over the last few years. The majority of these find work and settle into life here. Others return home. But it is becoming increasingly clear that some are ending up unemployed, homeless and living on the streets, and many of these have alcohol and drug problems.

James Morris, Hammersmith and Fulham’s alcohol strategy development officer, says their A8 status makes them especially vulnerable. "People with A8 status have accession rights on the general grounds of gaining employment and therefore being self sufficient. Those who don’t find work and end up on the streets cannot access housing support, and while they have entitlement to primary care this doesn’t extend to most drink and drug treatment."

Many of those living on the streets have difficulties before they arrive but these can be quickly compounded, he says. "Some may be escaping difficulties back home, particularly debt or personal problems. But a lack of English skills and other issues such as homelessness or drug and alcohol problems prevent them from securing employment. Those who have high hopes for change or success will be reluctant to return home because of the shame."

Though information about newly arrived migrants is sparse, some research has been done into the needs of A8 migrants.

A Homeless Link survey in 2006 found that about 15% of people accessing homelessness services in London were from A8 countries. The majority were Polish and most were unemployed and sleeping rough. Most accessed only limited support, such as food and laundry facilities, and the report suggests these needed just short-term help finding a job and somewhere to live. A smaller group, however, had higher support needs associated with entrenched rough sleeping, including alcohol and drug use and mental health problems.

A report commissioned by the National Treatment Agency Beyond Boundaries: offering substance misuse services to new migrants in London, agrees. It points out that while many A8 migrants settle successfully, others are less well prepared for the transition and quickly become destitute because they do not qualify for benefits, unless they sort out work and housing fast. A third group, however, have more entrenched problems and it is this group that is now presenting to treatment services.

Based on interviews with drug action teams, and treatment and support services, Beyond Boundaries says that the numbers approaching drug services are not on the same scale as for homelessness services. It says that alcohol is the biggest problem but drug misuse exists, with heroin the most commonly used drug. Many users problems predate their arrival in London, but their drug use is also influenced by what drugs are available locally. Poles in one borough were using khat because of its prevalence among the Somali community there. Other issues raised by the report are risky injecting practices like injecting into the groin, and concern that some women are being drawn into drug use through sex work.

Notwithstanding problems over eligibility for treatment, the report states that it is incumbent on policy makers and agencies to respond creatively to the challenge posed by A8 nationals, as to "do otherwise is to ignore the plight of London’s vulnerable population while seeking to benefit from the tax payments which migration brings."

Hammersmith and Fulham is working with a Polish charity to help those who want to to return home. The six-month pilot scheme with the Barka Foundation offers Polish rough sleepers the chance to return to Poland and be integrated into some of the Foundation’s social enterprise schemes there. Barka staff make contact with Poles living on the street and offer them support back in the Broadway Centre. There, they talk to them about the possibility of returning home and about their fears around doing so. Often these focus on the shame attached to failure.

John Downie, singles project manager for Hammersmith and Fulham, who helped set up the scheme, says for some people returning home is the right thing to do. “We want to reconnect Polish rough sleepers to the place where they have a network of support - such as friends and family - which in most cases is back home,” he says.

Beyond Boundaries can be downloaded at www.ldan.org.uk

- A8 status was given to 8 poor countries which joined the EU in 2004 - Poland, Lithuania, Estonia, Latvia, Slovenia, Slovakia, Hungary and the Czech Republic.
- People from A8 countries can come to the UK to find work but they are expected to be self-sufficient and have very limited access to benefits and housing support.
- A8 nationals are entitled to primary health care but not to most drug and alcohol treatment.
- Often their problems are compounded by a lack of knowledge about life in the UK and language barriers.
- A8 restrictions are in place until 2009 but they can be extended for another two years. After this A8 nationals will have the same rights as other EU citizens.
Helping Young People Battle Unfavourable Odds

The odds are stacked against many of the young people attending ACAPS Young People’s Service. Brought up on south London’s deprived estates, they can be struggling to overcome a troubled family background, poor school attendance and a pre-teen involvement in gangs and drugs.

"Some clients are using drugs from the age of 10 when they are running and selling drugs," says ACAPS manager Ira Campbell. "By the time they are 13 or 14 they are moving off cannabis and onto crack and are taking ecstasy and alcohol. By the time they are 18 they are hooked into drugs and crime."

Many ACAPS referrals are from the Youth Offending Service and much of its work is aimed at diverting young offenders and would-be offenders away from crime.

One of its initiatives Da Project trains 16-25 year old drug dealers to be peer educators. Now in its third year, about 50 clients have completed the six-month training course, 12 are working - some as drug workers - while others have gone onto further education. Less than ten have re-offended.

ACAPS is also involved in the Phoenix Project, a multi-agency initiative in Lambeth, aimed at preventing young men from getting involved in gun crime and the criminal justice system.

Most clients are black British, African or Caribbean, though staff are seeing an increasing number of southern and central Europeans, including Kosovans and Czech gypsies, as well as Poles. Campbell says the fact that ACAPS is essentially a BME service is key to its success as many clients will not approach services they regard as white.

In order to access and engage BME clients, services have to do more than have a few black workers, he says. Pointing to ACAPS staff who grew up on surrounding estates, he says staff have to be able to understand and empathise with clients, and be prepared to do things differently - western counselling, for example, does not work with a lot of black clients.

Despite the bleak start to life, many of the young people he encounters have had, Campbell gets satisfaction from the job. "It’s good to see people who have a lot stacked against them making changes to their lives. If they are staying out of jail, that’s a success. If they are staying alive that’s a success."

Highlighting Issues Some Would Rather Kept Hidden

When DAAP’s Women Against Drugs event last March failed to get coverage in the local paper, despite a capacity crowd and high profile speakers, Permindar Dhillon took it to task, organising a petition signed by 350 women accusing the editor of censorship.

Her action was typical in that ever since the Drug and Alcohol Action Programme was set up, the organisation along with its chief executive, have been highlighting issues about drug use some members of the community might prefer remained hidden.

DAAP grew out of a two-year drugs education project in Southall targeted at the large surrounding south Asian population. Part funded by the Ethnicity and Health Unit of the University of Central Lancashire where Dhillon worked, its job was to raise awareness about drugs among hitherto neglected communities.

The work was well received and when the funding ran out, local people got together and along with Dhillon set up its successor DAAP.

Now funded by Ealing primary care trust and DAAT, DAAP works primarily with BME communities in the borough. Its main activities include providing drug and alcohol education in a range of languages - Punjabi, Urdu, Bengali, Gujarati, Somali, Farsi as well as English - giving culturally appropriate drugs education in schools and training local volunteers to raise drug awareness in their communities.

The project also runs a Women Against Drugs group and Woman of the Year award, for women who have either given up drugs themselves or helped someone else to. Both broke new ground because of the secrecy surrounded drug use in the Asian community.

Despite being relatively new, DAAP has not been afraid to highlight difficult issues. It does work around domestic violence and crime, and attracted publicity once by highlighting the fact that some young men were being sent back to Pakistan for rehab and detox where they were chained up.

Forced marriages, and how drug use can be a factor in them, are now on its agenda. Dhillon says this is because DAAP has come across a number of cases where young men, often heroin users, are forcibly sent back to India or Pakistan for treatment. The family then marries them off as they think the responsibility will keep them off drugs. Their wives are then brought back to London "with no idea of what life is like and that their husband is on drugs."
 Generic services have to be creative in order to access BME communities, says Harrinder Dhillon, DASL’s service director, as funding is targeted at dependent users and many minority ethnic users are in the hazardous category.

For DASL, which has services in Newham, the most diverse borough in the country, and Tower Hamlets, home to the largest Bangladeshi community, this means keeping a presence in the community - whether stands at local festivals or doing work with the local mosque. The agency recently produced credit card-sized cards with the East London Mosque, advertising the times of festivals or doing work with the local mosque. The agency recently produced credit card-sized cards with the East London Mosque, advertising the times of festivals or doing work with the local mosque. The agency recently produced credit card-sized cards with the East London Mosque, advertising the times of festivals or doing work with the local mosque.

Dhillon joined DASL - then Alcohol East - as an Asian development worker in 1991. Back then, he thinks it was definitely easier to do work with BME communities as services could invest more time building relationships and trust with them.

"It took me six months to get into some groups," he says. "Do people have the time to do that now? In the current climate it is not so easy. There is so much emphasis on results."

Community engagement is essential if generic services are to access minority ethnic users, he says. "Mainstreaming only works if generic services are creative and engage people through tier 1 and 2 work. You won’t get diverse groups in tier 3 if you don’t do that and do it consistently."

About a quarter of DASL’s clients are from BME communities, though it does have a long established Bengali alcohol project, which provides advice and information on alcohol issues, as well as counselling for users and their families.

Dhillon believes there is a need for more alcohol work with BME groups. He has noticed an increase in the numbers of second generation Bangladeshis and Somalis, often in their late thirties, approaching the service, as well as more recently arrived Eastern Europeans. He says it is important that alcohol information is appropriately targeted at these groups as the "unit system does not mean anything to them and usually they don’t drink in pubs".

Primary care trusts could also play a greater role combating misuse by including alcohol information in wider health campaigns around blood pressure, smoking and healthy eating.

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Dispelling Myths and Helping Substance Misusing Women

Asian women do not drink. This is one myth staff at EACH would like to dispel. Women from all backgrounds and religions drink and use drugs, says deputy director Lakhvir Randhawa. Drinking is common among younger women and second generation women who drink openly, but older women are drinking at home, she says.

"Drinking is also more prevalent now in the home countries whether among Hindus, Muslims or Sikhs."

EACH was set up in 1991 after research into alcohol use among BME groups in Hounslow found a relatively large number of Asians with serious alcohol related problems in the local specialist alcohol unit.

Now expanded into other west London boroughs, EACH has been very successful in attracting women to its services as they make up 60% of the client base. These range widely from Tamil rape victims to drug using sex workers to mothers concerned about the impact of their daughter’s drinking on her marriage prospects.

The stigma attached to drug and alcohol use in South Asian cultures and tendency to keep problems hidden, means EACH has to work hard to engage the local community. “We go out and do presentations at community centres and women’s organisations,” explains senior counsellor Harsha Rai. “We have satellites at GP surgeries, women’s refuges and Somali centres. We also see Asian women in their homes if they have childcare issues or because of the stigma attached to alcohol. It can take time but you have to work this way to engage the community”.

One measure of the agency’s success is the fact that a third of its clients are self-referrals.

Sixteen years established and though EACH now has an open door policy, Randhawa is convinced the need for specialist services and projects still exist. If a service is set up specifically as a BME service you will reach BME groups, she says, something that is not guaranteed in a mainstream service. “Even in generic services when there are staff representative of local communities, some people will not come through the door,” she says. “We run a domestic violence and substance misuse service for Asian women. That wouldn’t work if it wasn’t a specialist service.”
Faith plays a big part in Muslim drug users thinking and way of life, even if they are no longer practising and have rebelled against their upbringing. So says Syed Tohel Ahmed, manager of Nafas in Tower Hamlets. "They will have massive guilt about letting their family down and will know religiously that it is wrong. That is why you need key workers with an Islamic perspective on drugs so they know what the issues are and can be sensitive to them, but also so they can use faith positively to help people overcome their drug use".

The word Nafas is not an acronym but an Arabic Asian word with wide resonance among Muslims. It means life, freedom or new beginnings and helps reinforce the message the service has been sending out to the large surrounding Bangladeshi community since it was set up in 1999 - trying to stay abstinent.

Day programme meanwhile caters for up to 250 drug users every year - mostly men though the service is seeing increasing numbers of women - while an aftercare programme provides support to those

That drug users deserve a second chance.

The formula works well, says Drayton. "Some communities are reluctant to engage for religious reasons and would prefer to believe drug and alcohol problems don’t exist. But there are always people in the community who will be more open to discussing these issues and because we have a presence in the community, they will engage with us."

Employing staff from BME groups helps and New Roots workers are drawn from the surrounding Somali, Bengali and Caribbean communities. "If you have someone who is reflective of the community you are trying to engage, it is much easier to get in, rather than if you’re coming from a western perspective," says Drayton. "That means for example our Somali worker can go off to the khat house or mafreshi in Camden to do engagement work and has set up a group for users there."

Drayton thinks that the current target-driven climate makes it more difficult to work with BME communities. The focus on Class A drugs, and ambitious targets for numbers in treatment and retention figures, make it hard to fund work that by necessity involves a lot of relationship building, and awareness raising and education around drugs, he says. "We have had to remodel to keep afloat, but this work is essential if BME communities are to be able to access services."

Community Engagement Key to Accessing Diverse Groups

Building up a relationship with a community is similar to building a relationship with a client, says Lennox Drayton, manager of New Roots. You need to invest time and establish trust so you can work out what their needs are before you can progress. "That way you can have some real breakthroughs. We are working with a Bengali women’s group in south Kensington that has not worked with any other agency before."

Set up a decade ago to work specifically with ethnic minorities, New Roots now has strong links with local communities in the four inner London boroughs it works in, thanks to its method of working - community engagement.

This model sees staff making inroads into a community by networking with community groups and voluntary organisations, having stalls at local festivals and seeing clients in community settings like health and community centres. Once a link is established, staff can carry out a needs assessment, start awareness raising about drug and alcohol issues, organise workshops and training, and make referrals.

The service provides tier one, two and three interventions. Staff do drug education and prevention work in surrounding schools, youth clubs and colleges. Outreach workers visit local drug hot spots befriending drug users and giving out harm reduction advice. The structured
Building Cohesion Through Empowerment

Over the past five years, DAAP has made its services accessible to diverse communities by empowering them to overcome drug, alcohol and other addictions through appropriate education and interventions. Below DAAP chief executive Perminder Dhillon outlines the principles underpinning its success.

Acknowledgement
We see everyone who comes to DAAP whatever their presenting problem. We treat individuals whether users, carers, spouses, partners, family members or significant others with dignity and with respect. This means that we acknowledge their needs and their problems from their perspective. However we stress that with rights come responsibilities and that we operate within a framework of equality for all, confidentiality and risk management.

Appropriate Information
Language and culturally specific drug and alcohol and khat education resources help us to challenge the age old myth of "no problem here", by focusing on specific community problems, health and legal issues, as well as sources of help and support. To date we have produced education resources in eight local languages, while targeted education has been disseminated to 5000 individuals and organisations in at least ten languages. In a three-week campaign last year, information on alcohol issues was disseminated in six languages to over 9000 people. In addition, we have raised public awareness about specific issues in several languages on television and radio and in the print media.

Different levels of intervention
We support clients through talk therapy in order that they can determine their own solutions. Talk therapy provides an interactive session between those seeking help and those able to offer or signpost it. It removes the straight-jacket of some types of counselling that are on offer; by allowing greater flexibility in working in different language and cultural settings. We will also work with users who wish to pursue non-traditional interventions to overcome their addiction, largely in the complementary therapy field. We do however expose and challenge malpractice which masquerades as "alternative therapy". Wider issues of family conflict, domestic and sexual violence, child protection, inter-community strife, crime, community safety, homelessness, sex work, mental health and immigration are tackled through specific initiatives. These include outreach engagement work; awareness raising; training; as well as action based research.

Building Capacity
We build the capacity of young people, adults, families, community organisations, professionals and businesses to tackle addiction and wider issues. One of the ways we do this is by training individuals to be community inter-acters so they can disseminate awareness and knowledge about addiction issues to their communities. Two hundred people from 12 language and cultural backgrounds have been trained as community inter-acters.

We also support those caring for people with an addiction problem. Members of the Punjabi speaking women's support group we run, for example, are actively involved in peer support, research issues, advocacy work, and in planning and setting up specific projects. Ex-users and users currently engaged with services play a pivotal role in challenging the addiction cycle of a user. We encourage users and ex-users to train as volunteers and to offer peer support to those still struggling with addiction.

Effective Challenge
For us, the client isn't always right! At times as professionals, we have acted on certain issues or cultural practices that have transgressed safety and legal issues. We make it clear that we do not support any oppressive practice. As well as giving a very clear message of no collusion with malpractice, this has enabled some individuals themselves to reframe the issue. Sometimes sectarianism and separatism disguised as individual and community rights has sought to enter our organisation. Our stance is very clear on what constitutes autonomy as distinct from what is exclusion.

Engaging individuals
We do not only start the support process when the person with the addiction problem presents to us. Very often, as is the norm in some cultures, a parent, carer, elder or friend may approach us with a concern about the addiction problem of someone. We build on the initial contact and provide support to all concerned so that issues of relationship and trust can be addressed. We will approach the user after the concerned person has obtained permission that we can do this. This often leads to the user becoming engaged with a service.

Community empowerment
Community empowerment means ensuring that local communities are fully involved and consulted in decisions that affect their lives and their environment. Empowerment is about treating people equally to ensure that individuals from diverse backgrounds, as well as from different cultures, languages, traditions and ways of life can fully participate. We believe that community empowerment builds community cohesion as experiences and perceptions are shared between individuals.
LINCOLN HALL

“My parents came here from Jamaica in the 1950s. There were six of us so there wasn’t much money to go around. I started robbing as it was the only way to get what I wanted. I was into clothes, big brands, and wanted to look good.

I started using drugs in my early teens. I was introduced to them at school at the lunchtime disco. I saw other kids doing it and wanted to try myself. I was always into the in thing. First it was cannabis, then cocaine, then later I got into heroin. I had a difficult, violent relationship with my father and took comfort from using drugs.

I left school at 14. I wanted to be a carpenter’s apprentice and the school set me up with an interview in a local carpenters. But when I went there he just waved me away. He didn’t want blacks in his place. I never asked for a job again. I was street wise and got what I wanted without one.

I know about racism - I was once chased down the street by the National Front - but I haven’t experienced it in treatment. I was kicked out of rehab a couple of years ago but that wasn’t because I was black. But someone once did refuse to shake my hand at a Narcotics Anonymous meeting. I couldn’t believe it because we were all there to share.

A lot of people who use drugs blame it on other things in their life. I know the way I grew up helped me become a drug user. But I don’t blame my drug use on that. If I did that I’d still be using drugs.”

HERCULES IACOVOU

“I’m Greek Cypriot. My dad was from Cyprus, my mum from Greece. I was born in London but was brought up to be a typical Greek. That meant having Greek friends, liking Greek music and if you ever went on holiday it had to be to Greece. It was a very tight-knit community. I rebelled. I wanted to go out and spread my wings.

My father ruled the family with an iron fist. He didn’t like that I wanted to do my own thing and he was always telling me that I was useless and beating me up. I had a poor school record because I couldn’t go to school when I was black and blue.

People said my dad was like that because of the pressure he was under after coming over here. They also blamed it on his alcoholism. Alcohol is big thing in the Greek community. Greeks think if a man can’t drink a bottle of whiskey then they’re not a man - and my dad drank a lot. He started giving me whiskey in my milk when I was a baby so that by the time I was four or five I liked it and used to steal drink from the bottle.

You could say my drug use started when I was a baby. I began using illegal drugs when I was 12 and used them for 38 years. I know my background influenced my drug use but I’m totally abstinent now and think I have enough tools under my belt not to go back.”

Both Lincoln and Hercules are involved in BUBIC (Bringing Unity Back into the Community) a BME focused, service user project in Haringey.