Issues surrounding drug use and drug services among the Kurdish, Turkish Cypriot and Turkish communities in England

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This is the fourth of a series of publications to inform drug service planning and provision by presenting results from the Department of Health’s Black and minority ethnic drug misuse needs assessment project that was conducted throughout England in three phases during 2000-2001, 2004-2005, and 2006. This project employed the Centre for Ethnicity and Health’s Community Engagement Model to train and support 179 community organisations to conduct the needs assessments (Fountain, Patel and Buffin, 2007; Winters and Patel, 2003). Each community organisation was also supported by a steering group whose membership included local drug service planners, commissioners and providers.

This publication collates the findings from nine reports from community organisations on issues surrounding drug use and drug services among England’s Kurdish, Turkish Cypriot and Turkish populations. The study reports also used the terms Turkish Kurdish, Iranian Kurdish and Iraqi Kurdish to describe the ethnicity of their samples. In total, 1,395 members of these communities provided the data for the reports.

The Kurdish, Turkish Cypriot and Turkish communities can be examined together because:

• these communities’ migration patterns to England (usefully detailed by Enneli, Modood and Bradley, 2005) mean that the majority have come to be working and living in the same areas of London;
• there are commonalities in terms of their economic situation, culture and religion (predominantly Muslim);
all the community organisations participating in this project provided services for members of more than one of the communities, despite their names (such as the Enfield Turkish Cypriot Association and the Kurdish Advice Centre); and

the samples of six of the nine studies reported here comprised members of all three communities.

That said, the Kurdish, Turkish Cypriot and Turkish communities are not homogenous due to their historical, social and cultural backgrounds, some aspects of which affect relationships between them in England today. For example:

- Until recently, the language and culture of Kurds in Turkey have been harshly suppressed. During the internal war in Turkey between the Turkish army and the Kurdish Workers Party (PKK), that officially ended in 1998, Kurds were forcibly removed from their villages, tortured, and many ‘disappeared’ (Enneli, Modood and Bradley, 2005).

- Kurdish is an official language in Iraq, but banned in Syria. Until 2002, the Turkish government placed severe restrictions on the use of the language and in Iran, although it is used in some local media and newspapers, it is forbidden in schools.

- The Kurdish, Turkish and Turkish Cypriot communities are often collectively referred to as the Turkish-speaking and/or the Kurdish-speaking communities. However, only Kurds from Turkey are likely to speak Turkish. The different forms of the Kurdish language (including its two main dialects, Kurmanji and Sorani) mean that when Kurds from different countries get together, they cannot communicate in Kurdish\(^1\), and one of the community organisations participating in this project reported that the Turkish dialects used by those from mainland Turkey and by Turkish Cypriots also make it difficult for them to understand each other.
Foreword

This UCLAN series of reports – of which this is the fourth volume – examines knowledge of and information about drugs and drug services among a range of Black and minority ethnic groups in England.

Overall, the series has shown that various ethnic groups require more and better targeted information which not only enables community members to understand the impact of drugs on their communities more fully but also helps them to access and to trust drug services when needed.

The NTA endorses these reports.

One of the questions which the reports did not set out to answer was whether – once they have entered drug treatment – drug users from Black and ethnic minority backgrounds have different treatment experiences and outcomes as a result of their ethnicity.

An analysis of 2006/07 data from the National Drug Treatment Monitoring System (NDTMS) suggests that generally there is no ethnicity-related differential impact when it comes to drug treatment itself. While different people respond to treatment differently, service user demographic characteristics do not have a major impact on the treatment provided to them – and this applies as much to gender and age as it does to ethnicity.

The characteristics of the service provider and the service user’s main drug of use are more likely to affect how an individual responds to treatment.

For instance, when compared to service users in general, Black service users (defined as Black Caribbean, Black African and ‘other’ Black) were half as likely in 2006/07 to be primary heroin users and five times more likely to be primary crack users.

One of the functions of being a primary crack user was that they were also found to have shorter waiting times for drug treatment as well as shorter treatment episodes. These differential impacts were reflected among Black service users, but it is the crack use and not the ethnicity per se which is the stronger driver of any difference.

As for discharge, the strongest factor which was linked to whether someone had a planned or unplanned discharge from treatment was also their drug of choice. In particular, the main factor that impacted negatively on planned discharge was the use of heroin and crack cocaine together, followed by opiate use alone then crack use alone.

That said, the range of possible factors which can impact on treatment outcomes is so wide and varied that even the main drug of use is not a particularly strong driver.

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1 This analysis is available on the NTA website at website at http://www.nta.nhs.uk/areas/diversity/docs/differential_impact_assessment_ndtms_0607_%20120309.pdf
What this means for the treatment sector is that we may need to intensify our efforts to ensure that staff and organisational competence is sustained and enhanced to ensure that drug services meet the needs of a range of drug misusers.

Evidence-based psychosocial interventions that promote freedom from dependence and a route towards recovery are of particular importance as the ‘golden thread’ that runs through all drug treatment. In turn, this will enable drug treatment services to improve their organisational functioning and have a greater impact on the outcomes of all their service users, whatever their ethnic background or primary drug of use.

In accordance with the Agency’s Equality and Diversity Strategy, the NTA will therefore continue to conduct an annual analysis of the differential impact of drug treatment on different groups.
**Key messages**

**Drug service needs**

- This report represents the evidence and recommendations for drug service planners, providers and commissioners to address the needs of Kurdish, Turkish Cypriot and Turkish communities. To be effective, however, this work must take place at a local level, in order that the heterogeneity of these communities is addressed: ‘what works’ for one may be inappropriate for another.

- Meeting these needs relies not only on action by drug service planners, commissioners and providers, but also by the Kurdish, Turkish Cypriot and Turkish communities themselves.

- The drug service needs presented in this report are interrelated: a ‘pick and mix’ approach to meeting them will be ineffective because other barriers to drug service access will remain.

- The overall picture painted by the results from the participation of 1,395 Kurdish, Turkish Cypriot and Turkish people in the Department of Health’s Black and minority ethnic drug misuse needs assessment project is that illicit drug use is perceived as firmly connected to crime in the study areas and stigmatises the communities. The result is that community members ostracise drug users and are reluctant to discuss drugs and the related issues.

**Patterns of drug use**

- The British Crime Survey (Murphy and Roe, 2007) surveyed a representative sample of the whole population in England and Wales and provides details of the illicit drugs used and the characteristics of users. The sample of 1,395 Kurdish, Turkish Cypriot and Turkish people from nine studies was not representative of all members of these communities, and only 220 drug users specified which substances they had used, but the results indicate that:

  As in the general population, cannabis was most common illicit drug to be ever used by all age groups, although the majority are aged 30 and under.

  Compared to the lifetime drug use of the whole population, a smaller proportion of Kurdish, Turkish Cypriot and Turkish people may have used amphetamines and magic mushrooms, and a larger proportion may have used heroin.

  A far smaller proportion of Kurdish, Turkish Cypriot and Turkish females have used illicit drugs when compared to females in the general population.
Help-seeking
• The study reports strongly indicate that, compared to the white population, Kurdish, Turkish Cypriot and Turkish people are under-represented as recipients of drug information, advice and treatment services.

• The most commonly cited sources of support for drug problems were GPs, private doctors and community organisations, followed by friends and family.

Information needs
• By far the largest barrier to drug service access by Kurdish, Turkish Cypriot and Turkish people is a lack of awareness of drugs and of drug services and their functions.

• If community members are to participate in awareness-raising initiatives, the stigma of drug use that hampers public discussion of drug-related issues must first be overcome.

• Many of the studies therefore saw the primary aim of drug education to be that of encouraging the communities to acknowledge drug use within them by addressing this stigma and lifting the taboo on discussing drug-related issues.

Cultural competence
• A basic framework for cultural competence is provided in Section 6.

• Overall, study participants thought that drug services ‘have not been either sensitive or responsive to the specific needs’ of the Kurdish, Turkish Cypriot and Turkish communities, which have been treated ‘as if we do not exist’. The study reports therefore strongly recommended that drug service planners, commissioners and providers should understand and address how the cultures of these communities affect access to drug information, advice and treatment services in terms of:

  Language: including drug education materials in the appropriate languages and dialects, and drug service staff who speak these languages.

  Ethnicity of drug workers: employing some Kurdish, Turkish Cypriot and Turkish staff would encourage members of these communities to access drug services.

  Stigma and the need for confidentiality: if access to drug services is to be increased, it is essential that community members trust that confidentiality will not be breached.

  Suspicion and mistrust: drug services need to recognise and accommodate a widespread suspicion and lack of trust in ‘officialdom’, including GPs, the police, the government, the media (especially the Turkish media) and local authorities.
For instance, some community members felt that confidentiality would be better maintained by private doctors than by GPs.

**Social exclusion:** The risk factors for drug use and problematic use – especially unemployment, a lack of English language skills and the consequent lack of integration – should be considered when planning drug services for the Kurdish, Turkish Cypriot and Turkish communities.

**Engagement**

- Overall, community organisations see the delivery of drug information, advice and treatment to the Kurdish, Turkish Cypriot and Turkish communities as primarily the responsibility of statutory drug services. Rather than plan and deliver the services themselves, the community organisations saw their role as providing:
  
  - venues and participants for drug education workshops and seminars;
  - translation services;
  - advice to drug service providers on cultural competence; and
  - workspace at community centres for a drug worker who is employed by a drug service or drug action team.

- This perceived role of community organisations reflects the view among some organisations that – due to the stigma of drug use within their communities – their members may object if they became involved in drug service provision. Furthermore, some organisations may not yet have the confidence to take a leading role in planning and delivery, and the majority of study participants would not necessarily seek help for drug-related issues from a community organisation.

- Adaptation, flexibility and commitment to engagement – among community members, community organisations and by drug service planners, commissioners and providers – are clearly required so that the barriers to drug service access by Kurdish, Turkish Cypriot and Turkish people begin to be overcome. However, because the stigma of drug use is high and the trust and confidence in drug services is low, increased access by members of these communities is unlikely to be an immediate outcome of any changes.

**Funding**

- Community organisations need funding to increase their capacity to assist their communities with a range of drug-related needs and to fulfil their role as partners of drug services.

- Funding for further research is also needed, including studies to clarify the best means of encouraging the use of drug information, advice and treatment service by members of the Kurdish, Turkish Cypriot and Turkish communities.
Population profile

- **Kurdistan** is an area inhabited mainly by Kurds that covers large parts of eastern Turkey, northern Iraq, north-western Iran and smaller parts of northern Syria and Armenia. Iraqi Kurdistan is the only region that has gained official recognition internationally as an autonomous federal entity.\[^2\]

  Kurdish people began to arrive in the UK in the late 1980s/early 1990s.

- **Turkey** is located across two continents – Europe and Asia. Because of its geographical position, Turkey’s culture is a unique blend of Eastern and Western tradition. Turkey has applied for full membership of the European Union (EU).\[^3\]

  Migration to the UK from Turkey began in the late 1960s/early 1970s.

- **Cyprus**, formerly a British colony, is the largest island in the Mediterranean. Turkish Cypriots have lived in the UK for longer than Turkish and Kurdish people. Migration to the UK began in the mid-1940s and peaked in the early 1960s during fighting between Turkish and Greek Cypriots that, in 1974, culminated in a Turkish invasion and partitioning of the island.

  Although Cyprus is a member of the European Union (EU), the EU’s laws are suspended in Northern Cyprus, a de facto Turkish republic, and this ‘prevents the Turkish Cypriot community from taking advantage of the benefits of full EU membership’.\[^4\]

The 2001 census reported that:

- 0.1% (49,536) of the population of England and Wales were **Turkish**.\[^5\]

- 0.03% (15,364) were **Turkish Cypriot**.\[^5\]

- a further 0.02% (11,200) were Cypriot, but did not specify whether they were Greek or Turkish.\[^5\]

- 0.02% (12,279) were **Kurdish**.\[^5\]

- 0.1% (52,893) of the population were born in Turkey\[^6\] (it can be assumed that this statistic includes some Turkish Kurds).

However, several of the study reports made the point that the 2001 census statistics – a total of at least 77,179 Kurdish, Turkish Cypriot and Turkish people – do not give an accurate picture of these populations in the UK, because of the compound nature of the census ethnicity questions. These were especially difficult for those who did not read and write English well, as they had to tick an ‘other’ ethnic category. It was suggested
that many may not have followed the instructions to then write in their ethnic background.

The study reports therefore quoted a variety of statistical sources to make different estimates of the sizes of the three populations in the UK. These estimates were complicated by the different categories their sources used, such as ‘Turkish-speaking’ and ‘Turkish and Kurdish’. Thus, for example, it was variously reported that the populations comprise:

- 135,000 Turkish Cypriots, 85,000 Kurds from Turkey and 35,000 ‘Turkish speakers’ (a total of 255,000);
- 100,000 Turkish and Kurdish people and 130,000 Turkish Cypriots (a total of 230,000); and
- 100,000 Turkish Cypriots, 50,000 ‘mainland Turks’ and 50,000 Kurds (a total of 200,000).
Data for the needs assessments were collected by community researchers, most of whom were Kurdish, Turkish Cypriot or Turkish and who could speak the languages of the samples the studies targeted. These researchers were selected by each community organisation and attended a series of accredited workshops run by the Centre for Ethnicity and Health (now part of the International School for Communities, Rights and Inclusion) on drugs and the related issues (including drug policy) and on research methods.

All nine studies used a semi-structured questionnaire to collect data and several also conducted focus groups. Most questionnaires were administered in a one-to-one interview, although some were self-completed. Three studies held a drug education workshop and one a social event, after which they administered questionnaires and/or held focus groups, while another distributed a leaflet on drugs and sources of help. The sample recruitment process therefore achieved one of the aims of the Centre for Ethnicity and Health’s Community Engagement Programme – to raise the awareness of community members of the issue in question.

Most of the questionnaires were in English, but the community researchers verbally translated them on the spot for those who wanted to communicate in another language. The variety of languages spoken by the target samples meant that the Centre for Ethnicity and Health’s Community Engagement Model’s use of researchers from the same community as those being researched was crucial to the data collection process.

Community members were generally recruited through the community organisations’ networks and member databases, but respondents were also accessed via restaurants, mosques, in a shopping centre, in the street, at youth clubs, in their homes, from a local authority estate, in barbershops and in cafés (also known as coffee shops or kahvehane, where male members of the Kurdish, Turkish Cypriot and Turkish communities meet to socialise, play cards and snooker, and drink tea and coffee). One community organisation advertised for respondents in local Turkish language newspapers.

One study was concerned with gang membership and used an outreach worker to recruit 30 current and 30 ex-gang members, while another interviewed 37 schoolchildren aged 11-15 about their awareness of drugs. Another study investigated drug-related issues from the viewpoint of the owners of retail businesses and their sample was made up of the owners of grocers, off-licences, restaurants, takeaways and hairdressers.

Several study reports described the difficulties they had when asking community members to discuss issues relating to illicit drugs. For example:

- This is clearly a taboo issue for many in the Kurdish, Turkish and Turkish Cypriot communities.
One community organisation held a workshop to discuss drugs and the related issues, but only a fifth of those invited turned up:

We started by asking their opinion as to why despite inviting 100 people only 21 attended this workshop. Most of them said that in the Turkish community, the word ‘drugs’ equals ‘danger’ … Accordingly, people do not want to be involved directly and/or indirectly with the workshop.

Some felt we were seeking information for the police and did not want to participate and were encouraging others not to participate.

People looked on the research as suspicious. Some accused us of spying for the government … The majority of the people approached by the research team did not want to respond as they thought there was an ulterior motive behind the research.

It is therefore greatly to the credit of the community organisations that they devised and asked questions – especially those about personal drug use – with sensitivity, in order to maximise participation in the studies. The results were the credible snapshots of substance use and the related issues that are collated here.

Note
As the community organisations reported both qualitative and quantitative data, this publication sometimes uses the following terms to give an indication of proportion: small minority (around 5% or less); minority (around 10%-15%); significant minority (around 20%-30%); majority (more than 50%); and large majority (more than 75%).
2 The sample

- The total sample of community members was 1,395, whose ethnicity was reported as:

  23.0% Kurdish;
  18.6% Turkish Cypriot;
  15.2% Turkish;
  13.8% Turkish Kurdish;
  13.0% Iraqi Kurdish;
  4.5% Iranian Kurdish;
  0.3% mixed: Turkish and white; and
  11.6% unspecified, but one of the above.

- 3% of the sample were under 16 years of age and 45% were aged 16-24. A further 45% were aged 25-49 and 7% were over 50.

- 60% of the sample were male and 40% were female.

- 928 study participants were asked if they had been born in the UK and almost two-thirds (65%) had not.

- Of the 772 who were asked how long they had lived in the UK, 38% said eleven or more years, 32% for between six and ten years, and 30% for five years or less.

- Of the 1,065 study participants who reported their citizenship status, two-thirds (67%) were British citizens, 15% were refugees, 15% were asylum seekers and 2% had leave to remain in the UK. 0.4% had a visa to visit, study or work in the UK.

- The sample’s major fluently spoken languages were Turkish (72%), English (63%) and Kurdish (45%) – all three in some cases. Fewer could read and write in the languages they spoke, especially the Kurdish speakers (as discussed earlier, the use of Kurdish is restricted in some of their countries of origin).

- Geographically, the nine studies covered the four London boroughs of Enfield, Hackney, Haringey and Islington, which have large populations of Kurdish, Turkish Cypriot and Turkish people (the 2001 census reported that almost half of those who were born in Turkey but who lived in England and Wales lived in these four boroughs).\[7\]

- In addition to community members, one study interviewed a total of 16 individuals involved with the Kurdish, Turkish Cypriot and Turkish communities in a professional capacity. Seven of these were community organisation representatives and nine were drug service providers.
3 Patterns of drug use

See Key messages for a summary of this section

It must be stressed that no inferences on the prevalence of illicit drug use among the Kurdish, Turkish Cypriot and Turkish communities should be made from the data presented in this section. The Department of Health’s Black and minority ethnic drug misuse needs assessment project was not intended to be a prevalence survey, but aimed to provide an overview of drug-using patterns and drug service needs. Some studies did not intend to document the personal drug use of their samples, others targeted current drug users, and many were conducted among young people and/or in disadvantaged areas, where it is expected that the prevalence of drug use is higher than in the whole population of England. The proportion of those who have used each of the substances discussed below is therefore intended to demonstrate only their relative popularity among those who reported this use.

3.1 Lifetime drug use

Eight of the nine studies asked a total of 1,119 participants whether or not they had ever used an illicit drug. Overall, 275 (24.6%) had done so at least once. Of these, 220 specified which drugs they had ever used.

- Over three-quarters (77.7%) of these lifetime drug users had used cannabis (in herbal or resin form).
- Almost one in five (19.1%) of the drug users had used cocaine powder.
- 18.1% had used ecstasy.
- 13.2% had used heroin.
- 10% had used LSD.
- Smaller proportions had used other illicit substances: amphetamines (6.4%), crack cocaine (3.6%) and magic mushrooms (1.8%).

The age range of the lifetime drug users was wide (from 16 to over 50), although the majority were aged 30 and under.

Six studies recorded the gender of lifetime drug users, which was around six males to every female.
3.2 Current drug use

258 of the 275 who had ever used an illicit drug were asked if they were still doing so, and over half (55.8%) said that they were currently using at least one drug. As with lifetime users, the majority were male and aged 30 and under.

Only 56 current drug users were asked to specify the drugs they used. They had all used cannabis, but the proportions using other drugs were too small for meaningful statements on current drug use to be made.

3.3 Perceptions of drug use

Overall, around half of the study participants could name an illicit drug and had some awareness of the health problems use can cause. However, a large majority of these were young people: as one study report discovered at a workshop that delivered drug education to 70 people, those aged over 45 and who were not born in the UK ‘have little or no knowledge about drugs’ and ‘when they find drugs in the pockets/bags of their children [parents] do not know what the substance is’.

The study samples were asked for their perceptions of illicit drug use among members of the Kurdish, Turkish Cypriot and Turkish communities. Overall, the responses showed that:

- A large majority believed that drugs were used in their community, and that use had increased over the years.
- The most commonly used drug was believed to be cannabis, followed by heroin and cocaine powder, and then ecstasy. The prevalence of crack cocaine use was generally believed to be far lower than the use of these other drugs.
- A majority thought that drugs were easily available, especially in the street, clubs, pubs, bars and cafés.
- A minority thought that drugs were available in schools.
- A minority thought that drug use begins in adolescence. This proportion included two-thirds of a sample of 11-15 year-olds.
- Regular drug users were thought to be in the 17-25 year-old age group.
- Although more males were thought to use drugs than females, a large majority thought that females also used them.
- Three studies asked their samples if they had friends or a family member who used drugs. A significant minority said that they had.
- When study participants were asked how their communities perceived illicit drugs and drug users, the majority reported that drugs were considered ‘unacceptable’,
although a small minority thought that cannabis use was acceptable. Consequently, the majority also reported that drug users were stigmatised and ostracised by their communities:

*Anyone who admits to taking drugs is automatically excluded from the community.*

One study’s sample of drug users agreed that they were stigmatised by their community, ‘humiliated’, and seen as ‘useless’ and ‘filth’, adding that this reaction to drug users was ‘common’.

That said, the majority of a sample of 362 Iranian, Iraqi and Turkish Kurds reported that drug users had their sympathy and pity, and needed help.

### 3.4 Community members’ concerns surrounding illicit drug use

The majority of participants reported that they lived in areas where they were exposed to drug use and dealing. They were most concerned about the effect on their communities (especially on perceptions of community safety) and on young people, and drug-related crime (especially dealing). For example:

*Drug use* is destroying the value system of our community, causing break ups of family and cultural codes.

Dealers only want to make money, they don’t care that [young] lives are lost and ruined.

I am seriously thinking about leaving the United Kingdom for the future of my children and a better life.

People who don’t live here seem to like the ‘ethnic diversity’ but living here amongst the drug users, pushers and the drug gangs it certainly is not a village atmosphere.

As one study report put it, there was a ‘general consensus that there is a drug problem and that crime within the local area is drug related’.

Several community organisations introduced their drug service needs assessment reports by cataloguing the crime in their locality.

*I avoid the alleyways even during the daytime – muggers and drug takers are often lurking around.*

However, several reports made the point that perceptions of drug-related crime (including dealing) among the Kurdish, Turkish Cypriot and Turkish communities may be exaggerated, because the media (particularly the Turkish media) ‘sensationalise’ drug-
related crime reports involving these communities and because information among community members is transmitted mainly by gossip that exaggerated the problem.

For instance, one study asked 96 community members if they had ever been a victim of crime. Only 11 had and only two of them thought the crime had been motivated by drugs. That said, as one study participant pointed out:

*It will not be correct to say that our community is not involved in such crimes. When we consider the international route for trafficking drugs and scrutinise the role pursued by Turkey within this route, we can claim our community has associated itself with such crimes.*

A minority of study participants were concerned about the aspects of social exclusion that are risk factors for illicit drug use and problematic use, especially unemployment, poverty, living in socially and economically disadvantaged areas, and ‘integration problems’.
4 Help-seeking

See Key messages for a summary of this section

This section reports on the perceived and reported sources of drug information, advice and treatment. The most commonly cited sources were GPs, private doctors and community organisations, followed by friends and family.

4.1 GPs and private doctors

Although GPs were cited as a source of help for drug problems, some members of the Kurdish, Turkish Cypriot and Turkish communities were reported to have more trust in the confidentiality of private doctors. Their reasons for this were that private practitioners do not have patients’ previous medical records and it was thought that GPs would inform drug users’ families of their visit. In addition, private treatment was perceived to be superior:

If you got money and want to give up [using drugs], use private channels and get proper help. Do not spend your time with NHS – ten minutes [in] one or two sessions weekly.

One study reported that a few of their participants ‘considered GPs to be agents for chemists and not the right people to seek treatment from’.

One study asked drug users where they had sought help and confirmed the preference for private doctors. Of the seven who had sought help from a doctor, one had gone to a GP, while six had gone to a private doctor.

4.2 Community organisations

The study reports showed that Kurdish, Turkish Cypriot and/or Turkish community organisations provide a wide range of health, cultural, educational and social support services to members of their communities, and are well-used by them.

Around a third of study participants from three studies said they would approach a community organisation for information and advice on drugs and the same proportion of drug users from another two studies had done so. It is likely that this proportion reflects the role community organisations as providers of help on a wide range of issues, but also the stigma of drug use (discussed in Section 3.3) and some community organisations’ reluctance to provide services for drug users.

This is demonstrated by three community organisations reporting that drug users did not participate in their general activities because other community members ‘had biases about drug users’ and stigmatised them. Three other organisations discussed their reluctance to increase their drug services:
They thought if they provided such services they would lose their acceptability in the eyes of the communities they serviced. One thought that drug dealers would threaten community organisations providing these services.

That said, some of the community organisations participating in this study did provide drug information and advice services. One of them questioned seven other organisations about their services for drug users and their families, reporting that although all seven said they provided some drug education and advice, none of them did this regularly and three did so only on a 'very limited' basis (such as providing leaflets on drugs in the appropriate languages).

4.3 Friends and family

When two studies asked a total of 60 drug users if they had experienced any problems related to their drug use, the main problem they reported was the negative effect on their relationships with their families and friends. This may explain why only a minority of community members said they would ask friends and, particularly, their family for help with a drug problem, and only a minority of drug users had done so.

One study asked 52 drug users about their families’ reactions on discovering their drug use. The main responses were that their families had been very angry and had felt ashamed. Only a quarter said their family had been supportive and most of the rest said that their families had not known how to help.

Although only a minority of the drug users reported that their families had ignored or denied their drug use, one study reported that this was a common reaction from family and friends:

Due to the fact that there is a stigma attached to drugs and drug taking, friends and family members may, and often do, attempt to hide the drug addiction instead of confronting it and seeking help.

4.4 Other sources of help

Telephone helplines, community leaders, teachers, religious organisations/leaders and drug services were mentioned as sources of help by far fewer study participants than cited GPs, private doctors, community organisations, and friends and family.

4.4.1 Drug services

Four studies asked Kurdish, Turkish Cypriot and Turkish community members if they would approach a drug agency for information, advice or treatment, and the majority said they would. However, the question was asked in a tick-box, yes/no form, and it was clear from the rest of the four studies’ findings that a very large majority of their samples were unaware of what drug services were available locally, and of their
functions. If the question had been open-ended and asked ‘Where would you go to seek help?’, it appears unlikely that drug services would have been cited as frequently.

Overall, drug users were more knowledgeable about drug services than non-users, but despite this, only a minority of those who reported drug-related problems or who wanted to stop using had sought help from them. Most of these reported that the service had been helpful and that they had had a good experience.

A study that interviewed nine local drug service providers reported that most said they had ‘very few’ Kurdish, Turkish Cypriot and Turkish clients.

The barriers to drug information, advice and treatment service access identified by the studies were:

- above all, a lack of information on illicit drugs, drug services and their functions;
- language-based communication difficulties;
- a perception that drug services are culturally insensitive; and
- a mistrust of drug services’ confidentiality.

The remaining sections of this report cover the drug service needs of the Kurdish, Turkish Cypriot and Turkish communities as identified by the nine community organisations on the basis of their findings. These findings strongly indicate that, compared to the white population, Kurdish, Turkish Cypriot and Turkish people are under-represented as recipients of drug information, advice and treatment services. More sophisticated ethnic monitoring at a local level may be required to test this.

The communities’ drug service needs are categorised as information needs, cultural competence, engagement and funding.

Of course, not all the drug service needs identified in this publication apply exclusively to Kurdish, Turkish Cypriot and Turkish people, nor indeed only to members of Black and minority ethnic communities. However, although the data collected during this project indicate that the drug-using patterns among the Kurdish, Turkish Cypriot and Turkish communities are not substantially different from those of the general population, it does not follow that they can simply ‘slot into’ existing drug services. Responses may have to be different so that the barriers to drug service access that they face can be overcome.

The concentration on unmet needs in the following sections is not intended to deny that there have been creditable efforts by some drug service planners, commissioners and providers to address the needs of drug users from Black and minority ethnic populations – including the adoption of some of the measures detailed below.
5 Information needs

See Key messages for a summary of this section

The study reports agreed that by far the largest barrier to drug service access was a lack of awareness of drugs and of drug services and their functions. As discussed in Sections 1 and 3.3, however, several studies reported that the stigma surrounding drug use, the taboo on discussing it and the suspicion of questions to assess their awareness may have led to their respondents’ reluctance to reveal their knowledge.

One study report added that this stigma and taboo means that community members may also be resistant to increasing their knowledge: ‘people just do not wish to realise the true extent of what is and isn’t going on’.

- Many of the studies therefore saw the aims of education on drugs and drug services as encouraging communities to acknowledge drug use within them, addressing the stigma and lifting the taboo on discussing drug-related issues:

  [The aim is] to make drug issues discussable in the community and overcome the existing taboos.

  If someone in our community says they are substance users, they are rejected from our community. They can’t get the help they need and this leads to worse consequences. We should attempt to change our community’s perception towards drug users.

  This information needs to be hard hitting and be progressive so that attitudes [to drug use and users] can be changed in a positive way.

  Because of the sensationalist reporting [Section 3.4], people see the problem as being much more serious than other communities similarly affected by drugs. Work must be done to inform people of the real nature of the problem so parents, family and the community do not overreact when they encounter a problem.

- Community centres and schools were most often cited as appropriate venues in which to deliver awareness-raising sessions. To ensure that the sessions reach all community members, several study reports recommended that community centres held social events and encouraged Kurdish, Turkish Cypriot and Turkish people who do not usually visit them to attend.

  Other recommendations were that information should be available in colleges, universities, cafés, hairdressers, restaurants, shops, and via outreach work in parks and local authority housing estates.

- Most study reports recommended workshops and seminars as the best way to transmit information about drugs and drug services. It was stressed that drug service
providers should attend these, and introduce and promote themselves and their work:

*By doing this they can build a rapport and develop a sense of trust of everyone involved. At present, organisations like [local drug services] are just names, which no one seems to know or more importantly know how to contact. They lack the personal touch which people need when they need advice. If people are able to associate a face with a name and some contact has already been established (however informal), then a feeling of trust may then be possible.*

The study reports also variously recommended that information should be transmitted using leaflets and posters, Turkish and local newspapers, Turkish radio, community newsletters, and videos and DVDs.

- There was a consensus that all community members needed drug education, although several study reports thought that *young people* and *women* should be particularly targeted.

- The study reports stressed that drug education must be available in the *languages* of the target communities.
Cultural competency is a term that is being increasingly used within the public sector, but there is little agreement over what it means and how it can be implemented. While most organisations conduct some training around race, culture and diversity, the content of their training programmes varies considerably (Tamkin et al., 2002). Moreover, the diverse meanings of ‘cultural competence’ are often highly dependent on local contexts:

>Cultural competency of care and services may be proposed in quite diverse ways depending on the local context. This mandates the need for careful research and quality checks on what is proposed and implemented and applied. (Bhui et al., 2007 p.14)

There are no nationally recognised standards by which cultural competence can be measured, let alone defined. However, a basic framework for assessing cultural competence can still be developed. The following framework is intended as a guide and contains only examples of the various skills, processes and abilities that are involved.

It is based on both individual and organisational competence. As detailed below, individual competence is skills-based and relates to individual practitioners’ professional practice in working with diverse communities and individuals. Organisational competence, on the other hand, is defined by the level of maturity in the organisation for addressing equality and diversity across the full range of its functions and policies.

**Individual competence**

Individual competence is based on the skills of acknowledging, accepting and valuing cultural difference in others – that is, between and among culturally diverse groups and individuals. Individual competence is built up through a developmental process that includes:

- **Improving knowledge of local communities**, such as demographics, religious beliefs, sectors and practices, common languages, migration and settlement patterns, health and social care needs, diet and cultural norms.
- **Developing skills in reflective practice** including empathy, the ability to challenge assumptions and prejudices in self and others, and the ability to work through communication difficulties and differences with a sensitive aptitude and attitude.
- **Developing communication skills** in working with people whose first language is not English and the ability to work sensitively and competently with interpreters.

**Organisational competence**

Organisational competence is demonstrated through a clear commitment to recognising diversity and the development of proactive policies which embed equality and skills in working with diverse communities throughout the organisation. This process includes:

- **A clear commitment to equality**, valuing diversity and human rights, which is articulated in the aims and objectives of the organisation.
- **Provision of staff training programmes** that meet the needs of a range of personnel, from basic induction through to higher-level learning.
- **A system for engaging and consulting with local communities** and ensuring that services take account of local diversity.
- **Leadership and management** of equality and diversity through performance and monitoring systems.

It should be recognised that individual and organisational cultural competence are inter-dependent: one cannot be effective without the other. No matter how skilled or competent the individual, they require the support of the organisation in order to achieve effective cultural competence. Similarly, however well-developed an organisation’s policies and procedures are, it will fail to meet the needs of a culturally diverse population without skilled and competent staff to carry them out.

Taking a maturity approach to cultural competence recognises that there are various levels through which individuals and organisation might pass as they move towards a fully-developed level of competence. This is also in keeping with models of lifelong learning and organisational development.
A culturally competent service operates effectively in different cultural contexts so that the needs of all members of their target population can be met by equitable access, experience, and outcome.

Several studies reported that their samples thought that drug services (and indeed, all statutory services) are culturally insensitive. One study report commented:

It is…evident that service planners/providers have not been either sensitive or responsive to the specific needs of the members of the Turkish speaking communities who to date have been treated as somewhat invisible and in the words of one of the respondents ‘as if we do not exist’.

The diversity within a local population which includes Kurds, Turkish Cypriots and Turkish people is a crucial consideration when local services are seeking to improve their cultural competence. As one report put it:

It needs to be understood and appreciated by statutory agencies that specific communities have specific issues and specific needs which would require a particular approach [rather than] simply lumping and categorising communities together under the umbrella of ‘Turkish speaking’.

As discussed in the following sections, the recommendations from the nine needs assessment reports add up to a strong need for increased cultural competence on the part of drug services in terms of consideration of language, the ethnicity of drug workers, stigma and the need for confidentiality, suspicion and mistrust, and social exclusion.

6.1 Language

The study reports recommended that drug information, advice and treatment services should have more staff who can communicate in the Kurdish and Turkish languages and dialects used by the local populations, and that written materials are produced in these languages. This need is evidenced by the fact that although – as shown in Section 2 – almost two-thirds of the total sample could speak English fluently, fewer could read it, especially (though not exclusively) those in the older generations.

Furthermore, one study interviewed nine drug service providers in an area with large Kurdish, Turkish Cypriot and Turkish populations. Two-thirds of them did not have and/or did not know how to obtain written materials on drugs in Turkish and Kurdish.

Another study reported that a local drug service had only one Turkish-speaking member of staff, and as there was a waiting list to see this worker, some drug users consequently abandoned their attempt to seek support.
6.2 Ethnicity of drug workers

Three of the nine study reports briefly discussed the ethnicity of drug service staff. They stressed that the presence of Kurdish, Turkish Cypriot and Turkish staff would encourage access by those who did not speak English well. Moreover, as they would understand these clients’ backgrounds, it was thought that they would make the service more culturally competent.

It was also thought that these workers, especially those not born in the UK, would be more trusted by Kurdish, Turkish Cypriot and Turkish people because ‘outsiders are not trusted to deal with the issues that concern them’.

However, staffing is a more complex issue than simply employing workers who are from the same ethnic group as potential clients. A Kurdish, Turkish Cypriot or Turkish worker should not be expected to be an expert at providing a service to all drug users from those communities, single-handedly, without appropriate and adequate support. All workers, including those who are white, have an explicit role to play in the delivery of culturally competent services. That said, ethnically diverse teams communicate an implicit message that such teams can respond to the needs of the whole population.

6.3 Stigma and the need for confidentiality

The stigma members of the Kurdish, Turkish Cypriot and Turkish communities attach to illicit drugs and users has been discussed throughout this report. Stigma was perceived as a barrier faced not only by drug users when considering whether to access drug services, but also by their families who wanted to support them and community members who wanted to learn more about drugs. Therefore, if access to drug services is to be increased, it is essential that community members trust that confidentiality will not be breached:

*This is particularly important as the Kurdish/Turkish communities are very close knit and nothing seems to remain confidential … People need to have confidence that what they are divulging will not become public.*

One study reported that a large majority of their study participants felt that this lack of trust in the confidentiality of drug services was the biggest barrier to their access. The level of mistrust can be illustrated by comments from two study reports:

*Two of the [14] attendees [at a workshop] said drug helplines and/or services always say they are committed to confidentiality but whenever they were used, they asked the drug users their postcode. This, they thought, could be used to trace their identity.*

A study which recommended that a drug worker from a local drug service should be based at a community centre stressed that the worker should not be from the local area. It was felt that they should also have had no previous connection with the community organisation, have their own office and cabinets to which only
they had the key, as well as their own telephone line. In this way, it was argued, ‘the highest level of confidentiality can be seen to be in operation and maintained’. This particular study did not address whether such arrangements would compromise the quality of the support on offer, but this only goes to illustrate how over-riding the issue of confidentiality can sometimes become.

6.4 Suspicion and mistrust

It was clear from the study reports that to attract more Kurdish, Turkish Cypriot and Turkish clients, drug services need to recognise and accommodate a widespread suspicion and lack of trust in ‘officialdom’. Indications of this included:

- A mistrust of GPs (see Section 4.1).

- A minority of community members ‘felt that drug dealers, and especially traffickers, are known to everybody but are allowed to operate with impunity’. Indeed, two studies reported that a minority of their samples believed that the UK police and government were profiting from the illicit drugs trade, arguing that ‘if those in power wanted to stop it, they could do it overnight’.

- Four of the nine study reports discussed the ‘gang wars’ and killings in 2001-2002 that occurred in some of the areas studied for this project and were well-reported in the media. They agreed that these were related to the control of the heroin market and involved Turkish and Kurdish gangs or ‘mafia’. The majority of the reports described the media coverage of these incidents as ‘sensationalist’ and believed that it had stigmatised not only the areas where they took place, but also the Kurdish, Turkish Cypriot and Turkish communities living there and elsewhere.

It was felt that the local authority in one of these areas was ignoring the problems caused by the aftermath of the violence that included three-quarters of one sample (especially females) feeling unsafe there:

> It seems the council concentrates all its resources on the affluent areas … If this were happening there, the residents’ protests would be taken seriously and acted upon swiftly.

- Several study participants pointed out that all three communities were negatively affected by the actions of members of any one of them:

> The police and other authorities still do not differentiate between the Turkish Cypriot/Turkish/Kurdish communities. We all get tarred with the same brush.

- Although a large majority of study participants agreed that the police were not doing enough to stop drug dealing in their local area, there was no consensus on how the police should respond. Turkish and Turkish Kurdish study participants were especially reluctant to recommend more police presence:
Whilst some people thought that there should be more police on the streets, some respondents stated that this was not a good idea as the communities were very wary of the police because of how they behaved in Turkey. There was no trust in the Turkish police, as they often used unnecessary force in dealing with suspects … [who were] badly beaten up and legal rights were ignored.

A sample of business owners and community members from an area characterised by drug dealing and other crimes reported that the police reaction amounted to victimisation of the Kurdish, Turkish Cypriot and Turkish communities:

It is true that some members of our community are involved in drug-related crime … But [the police] raid anywhere at any given time without substantial evidence of involvement in drugs.

Most customers … are too scared to park their car or too scared to stay for a long shopping … How do you expect people to come to a shopping area if it is covered by the police or police cars? They feel uncomfortable.

Why victimise a whole community when it is a minority in that community that commit the crime?

6.5 Social exclusion

The suspicion and mistrust detailed in the previous section may explain, as one study report pointed out:

why people get suspicious when drugs override more urgent needs such as accessing services, employment and education.

Another reported added that, therefore:

‘Drug problems’ should not be seen as an isolated problem, but should be considered together with other problems, such as integration, education, unemployment and with other social and economic deprivation.

The majority of the study reports recognised that the factors characterising social exclusion put their communities at risk of drug use and problematic use, and created barriers to drug service access:

This situation is likely to continue unless the statutory agencies and the Turkish grass-root organisations develop more partnerships that will address the particular needs of the Turkish speaking communities, such as language and cultural barriers, lack of sufficient resources and integration.
To tackle this, various recommendations were made:

- The provision of more so-called ‘diversionary activities’ for young people (such as sports centres and youth clubs), especially at community centres, where adult males currently dominate.

- **Unemployment** among the Kurdish, Turkish Cypriot and Turkish communities should be tackled because:

  - those who are not working do not have the opportunity to learn English; unemployment ‘pushes the teenagers into the arms of drug pushers’ whereas employment would mean they had ‘less spare time and more aim in life’; and the money earned from employment would discourage unemployed people from earning a living by selling illicit drugs.

  It was also recommended that the asylum-seeking process should be speeded up and asylum seekers allowed to work, because anxiety about the outcome of applications for asylum and the poverty of unemployment are risk factors for drug use.

- Community members should be strongly encouraged to attend ESOL (English for Speakers of Other Languages) courses.

- Community organisations need to understand better the **issues facing young Kurdish, Turkish Cypriot and Turkish people** who were born in the UK, and communicate these to parents.
7 Engagement

See Key messages for a summary of this section

The Department of Health’s Black and minority ethnic drug misuse needs assessment project has not only produced nine local needs assessments from community organisations on the drug-related needs of the Kurdish, Turkish and Turkish Cypriot communities, but has also engaged local population groups and local drug service planners, commissioners and providers – in most cases for the first time:

*The people who carried out the research did not previously have knowledge of drug misuse or social research. This project has enabled them to develop a new awareness and knowledge of drug misuse. Through this research they are now well connected with the [local] Drug Action Team and have an awareness of the need for partnership working in this field. They are also aware of the drug agencies’ work and the importance of establishing close working relations with these agencies."

Two community organisations reported that they had initiated drug services as a result of the project. One thought the research meant that ‘we have become closer to the community we serve’, including becoming aware of their drug-related needs, and began to provide information about drugs to their members. The other reported that:

*When we started conducting the research project, families started approaching us for counselling and services, which resulted in us developing a new project to meet the demands coming from the Turkish speaking communities. The project which evolved from this … started attracting many referrals from the local hospitals, GPs and other agencies."

The studies’ reports agreed that the engagement the project had initiated with drug services should continue and expand, because the Kurdish, Turkish and Turkish Cypriot communities:

*feel frustrated and isolated due to the fact that their specific needs are not considered in service planning by the statutory agencies and funders.*

• The most common recommendation for the way forward was the fostering of partnerships between community organisations and drug service providers. However, it appears from the study reports that community organisations saw the delivery of drug information, advice and treatment to the Kurdish, Turkish Cypriot and Turkish communities as primarily the responsibility of statutory drug services. Rather than plan and deliver services themselves, community organisations saw their role as providing:

venues (community centres) for drug education workshops and seminars and attracting community members to these;
translation when required;
advice to drug service providers on cultural appropriateness; and
workspace at community centres for a drug worker employed by a local drug service or drug action team (DAT), to run a drop-in and referral service.

The recommendation that community organisations host rather than plan and deliver drug services may be a pragmatic conclusion: some community organisations thought that, because of the stigma of drug use, their members would object if they became involved in drug service provision. It should also be noted that the majority of study participants in five of the nine studies said that they would not seek help for drug-related issues from a community organisation (Section 4.2).

It was also felt that some community organisations may not yet have the confidence to take a leading role in planning and delivery. For example, several study reports emphasised the need for a ‘professional drug worker’ based at their community centre and more Kurdish, Turkish Cypriot and Turkish drug workers, but they did not suggest that members of their communities should be trained for this role.

- One study report stressed that community organisation/drug service partnerships should operate on a cross-borough basis, as this would recognise:

  the need for a common approach to events and problems from a wide range of Turkish, Kurdish and Cypriot community groups across the four boroughs of Hackney, Haringey, Islington and Enfield … Too often work with the community is hampered by restrictions of post-codes, arbitrary cut-off points, funding restrictions and petty inter-borough politics. The community does not recognise these barriers and borders, and moves in and out of the boroughs for business, schools and other core services as if they do not exist.

- Reflecting the mistrust of the police discussed in Section 6.4, only one of the nine community organisations recommended that they should work in partnership with the police, such as hosting police surgeries in community centres. This ‘two-way liaison’, they argued, would tackle the stereotypes of the Kurdish, Turkish Cypriot and Turkish communities, such as groups of young people being perceived as ‘criminal gangs’, and would ‘develop a more informed policy of policing’.
8 Funding

See Key messages for a summary of this section

The majority of the study reports recommended funding for community organisations in order to increase their capacity to assist their communities with a range of drug-related needs. Their recommendations comprised:

- Training and support for community organisations to identify funding sources and make successful bids for funds.

- Funding community organisations to hold events and run programmes into which drug education can be incorporated (given community members’ reluctance to attend events that focus solely on drugs). Suggestions for these included parenting classes and dance, music and social events.

- Funding for drug workers based at a community centres, to act as initial points of contact for advice and referral, so that barriers to drug service access can be addressed.

- The need for the Kurdish, Turkish Cypriot and Turkish communities to ‘integrate into mainstream society’ was highlighted by several study reports as a means of alleviating the risks of drug use and problematic use (Section 6.5). They recommended funding to facilitate this because:

  the statutory agencies to date have not made any real attempt to integrate the Turkish speaking community and funding towards integration strategies has been conspicuous by its absence.

Initiatives to address the lack of integration included the provision of vocational training courses in community centres, held jointly by community organisations and local colleges.

- Funding for further research was recommended by three study reports, one of which commented that:

  Research into the community seems to focus too much on sensationalist issues such as drugs, gangs and crime, and is feeding the notion that these are major issues in the community whilst not addressing the real day-to-day problems.

Suggestions for the topics of future research comprised:

- clarification of the best means of encouraging drug service use;
- establishing what is culturally appropriate for the Kurdish, Turkish Cypriot and Turkish communities;
- drug use among school pupils; and
- determining – by improved ethnic monitoring – how many Kurdish, Turkish Cypriot and Turkish people are living in the UK and are clients of drug services.
Notes
[6] Calculated from census data provided by Office for National Statistics, March 2008 (0247-02-08-Theme Table 7-Turkey.xls: Residents of England and Wales by country of birth).

References

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| Day-Mer Turkish and Kurdish Community Centre, Hackney (conducted two studies within this project, in 2001 and 2005) | Enfield Turkish Cypriot Association (ETCA) |
| Faith Cultural Centre, Haringey | Halkevi Community Centre, Hackney |
| Kurdish Advice Centre, Haringey | Kurdish Information and Advocacy Centre (KIAC), Islington |
| Turkish Cypriot Women’s Project, Haringey | Turkish Women’s Support Group, Enfield |