Merchants Quay Ireland

Drug use among new communities in Ireland

an exploratory study

Community/Voluntary Sector Research Grant Scheme

NACD
National Advisory Committee on Drugs

Drug use among new communities in Ireland:

an exploratory study

By

Caroline Corr

Merchants Quay Ireland (MQI)

Merchants Quay Ireland is a leading Irish charity established by the Franciscan Friars to provide services aimed at reducing harm related to drug use and homelessness and at providing pathways towards rehabilitation and settlement. To this end, MQI provides a wide range of services for drug users and homeless people including a health promotion and needle exchange service, a day centre for homeless people, stabilisation services, residential programmes and settlement and integration services.

Merchants Quay Ireland, 4 Merchants Quay, Dublin 8.
Tel: 01 679 0044
Email: info@mqi.ie

National Advisory Committee on Drugs
Shelbourne House (3rd Flr)
Shelbourne Road
Ballsbridge
Dublin 4

Tel: +353 1 667 0760
Fax:+353 1 667 0828
email: info@nacd.ie
website: www. nacd.ie

ISBN 0-9548772-0-9

This research study was funded through the Community/Voluntary Sector Research Grant Scheme of the National Advisory Committee on Drugs. The views expressed in this study are the author's own and do not necessarily reflect the views and opinions of the National Advisory Committee on Drugs.

Designed by First Impression

Dedicated to the memory of Tommy Larkin

Table of Contents

Foreword

I am delighted to be able to introduce these excellent reports from the Community & Voluntary Sector Research Grant scheme. The Terms of Reference of the National Advisory Committee on Drugs (NACD) commits to finding ways "to maximise the use of information available from the Community and Voluntary Sector". Thus a research grant scheme aimed directly at this sector was developed. Such was its centrality to the work of the NACD that its development and implementation was designated as a key role for the Research Officer.

After launching the grant scheme, the NACD received over 100 enquiries and received 35 applications from across the country. Following a review and short-listing of the applications, eleven groups were invited to participate in a training workshop and finally five grants were issued. Four organisations completed their research projects and this report is one of the four launched by the Minister of State with responsibility for the National Drugs Strategy in October 2004. Clearly the aims of the research grant scheme were achieved: to build capacity; to inform gaps in our knowledge and to contribute to the development of public policy.

The NACD's Research Officer, Ms Aileen O'Gorman developed the grant scheme and provided ongoing liaison and support to each group helping them to implement their research studies and bring them to publication. My colleagues and I wish to place on record our deep appreciation of the significant contribution she has made to this project. The commitment of all those involved from the community projects and their Research Advisory Groups must be acknowledged and their achievement in producing such valuable information to the NACD and their own communities is to be commended.

The NACD is in the process of commissioning an external review of this scheme and subject to a positive evaluation, hopes to be in a position to recommend continuation of this grant scheme in the future.

I would like to thank everyone involved, the staff of the NACD and finally, Ms Kate Ennals who provided editorial support in bringing the reports to publication stage.

Dr Des Corrigan
Chairperson
National Advisory Committee on Drugs

Preface – NACD Community/Voluntary Sector Research Grant Scheme

NACD

The National Advisory Committee on Drugs (NACD) was established in July 2000 to advise the Government in relation to problem drug use in Ireland, based on the analysis of research findings and information. The Committee, whose members are drawn from statutory, community, voluntary, academic and research organisations as well as relevant Government Departments, oversees the delivery of a comprehensive drugs research programme on the extent, nature, causes and effects of drug use in Ireland. The Committee reports to the Minister of State responsible for the National Drugs Strategy in the Department of Community, Rural and Gaeltacht Affairs.

Community/voluntary sector research grant scheme

In December 2001 the NACD launched a *Community/Voluntary Sector Research Grant Scheme* to generate innovative, community-based drugs research. In a nationwide advertising campaign, groups working in the community/voluntary sector that were interested in conducting research in the areas of prevalence, prevention, treatment/rehabilitation and the consequences of problem drug use, were invited to submit applications to the scheme.

Application process

The grant scheme was developed with monitoring and support mechanisms built in at all stages from initial application to the conclusion of the research studies, in order to encourage applications from groups who had interesting research ideas but may have had little research experience. For example, a two-phase assessment process was developed to facilitate the development of the research proposals. The first assessment stage focused on the applicant organisation; its understanding of drug issues; its links with the local community, service providers and planners; and the relevance of the proposed research to the NACD's programme of work.

Thirty-five applications were received from groups around the country. From these, eleven organisations were shortlisted and invited to attend a research training workshop to further develop their research idea. Fourteen people from the eleven groups attended the one-day workshop which dealt with issues such as literature reviews, fieldwork, research ethics, data gathering and analysis, costing research proposals, etc.

Following the training workshop, the short-listed applicants submitted a fully developed research proposal outlining the aims and objectives of the research, the methodology, project management and costs. While all eleven proposals were highly regarded by the NACD assessment committee, a maximum of five research studies could be funded from the set-aside budget of €125,000. Consequently, five research grants of between €20,000 to €25,000 each were awarded. However, one study was unable to proceed due to the restructuring of the organisation and staff changes.

The research studies began towards the end of 2002 and were completed by June 2004. Throughout this period the groups were supported by the NACD Research Officer and the Research Advisory Groups established to work with each group.

Research Grant Recipients

Ballymun Youth Action Project (BYAP)

Study of the role of benzodiazepines in the development of substance misuse problems in Ballymun.

This research investigates the pattern of benzodiazepine use and misuse in Ballymun, identifies the problematic elements involved, and examines the relationship between benzodiazepine use and the use of other substances. It explores the dynamics of supply and demand in the local context, and highlights the factors that allow the continuance of a relatively high level of benzodiazepine use within the community. In this context the research explores the role played by benzodiazepines in the development of substance misuse problems in Ballymun, and identifies strategies that may facilitate change.

Kilbarrack Coast Community Programme (KCCP)

Research study on drug misuse among 10-17-year-olds in the Kilbarrack area.

This study establishes the patterns and trends of drug misuse in the Kilbarrack area by young people aged 10-17 and examines their attitudes to drug use, and the risk factors accompanying their use. The study also assesses the drug use among a sample of early school leavers and examines the views of community members on the drug situation in the area.

Merchants Quay Ireland (MQI)

Drug use among new communities in Ireland: an exploratory study.

This exploratory study examines the patterns of drug use among new communities; explores the reasons and motivations for drug use; establishes risks the users may be exposed to; examines the level of awareness of health promotion / harm minimisation strategies and drug treatment services; and identifies barriers to accessing services.

Tallaght Homeless Advice Unit (THAU)

The links between homelessness and drug use.

This research examines the nature of drug use amongst the homeless population in Tallaght; explore the reasons behind their homelessness; examines the policies and practices of local authorities in relation to the housing of homeless drug users; and explores the experiences of homeless drug users with special reference to the policies and practices of homeless services.

Further information on the Community Research Grant Scheme is available on the NACD website www.nacd.ie or, by contacting:

Aileen O'Gorman
Research Officer

National Advisory Committee on Drugs (NACD),
Shelbourne House (3rd Floor), Shelbourne Road, Dublin 4, Ireland
Tel: + 353 (1) 667 0760
email: info@nacd.ie

Acknowledgements

Firstly, I would like to thank each individual drug user who participated in this study especially as drug use is often perceived as such a taboo subject among new communities. Thank you also to all the people met during the fieldwork who engaged in discussions about drug use with the fieldworkers.

I would like to congratulate the three fieldworkers, Erina Tihomirova, Armie Iulian Ioan and Ackiem Aina Majola, for carrying out the fieldwork which was particularly challenging and demanding. Thank you for persevering with the fieldwork during the 6 months.

A special thanks is due to the outreach team at Dublin AIDS Alliance, and in particular Erin Nugent, for sharing their valuable expertise and knowledge with the fieldworkers and for helping the fieldworkers to contact particularly difficult to reach drug users.

I would like to express my gratitude to each member of the Advisory Committee who provided valuable feedback and advice throughout the whole research process: Dermot Kavanagh, (Merchants Quay Ireland), Aileen O'Gorman, (National Advisory Committee on Drugs), Erin Nugent, (Dublin AIDS Alliance), Tommy Larkin, (U.I.S.C.E.), Iwa Sebid Sykes (ARASI) and Romeo Gomulescu, (Community of Romanians in Ireland).

Thank you to Dr. Jane Fountain, Centre of Ethnicity and Health, University of Central Lancashire, for her welcome cooperation in sending over numerous reports from England on drug service provision for black and minority ethnic groups.

Thank you to Gabriel Kinahan for designing the ID cards for the fieldworkers and Niamh Randall (Social Policy and Communications Officer) for designing flyers advertising the research project.

I would like to express my thanks to my colleagues at Merchants Quay Ireland for their on-going support and comments on the project, especially Dermot Kavanagh (Assistant Director, Research, Education and Development) and Marie Lawless (Research Officer). A special thanks to Seamus Killeen who proof-read the report.

Finally, I would like to thank the National Advisory Committee on Drugs (NACD) for funding the research through their *Community/Voluntary Sector Research Grant Scheme.*

The views expressed are those of the author and do not necessarily reflect the views of the National Advisory Committee on Drugs (NACD) or Merchants Quay Ireland.

Caroline Corr

Executive Summary

Problematic drug use is considered a global phenomenon. Substantial information is available through the European Monitoring Centre for Drug and Drug Addiction (EMCDDA) about drug use amongst various national groups that make up the European Union. However, Fountain *et al*. (2002: 8) argue that drug use among Black and minority ethnic groups in the EU is "under-researched, unacknowledged, ignored, unrecognised, or hidden by some policy-makers, drug researchers, drug service planners and commissioners, and by some members of some Black and minority ethnic groups". The absence of any Irish research has meant a lack of information for drug service providers to identify and design appropriate treatment interventions or to address "the related challenges of cultural diversity, integration and racism" (Feldman *et al*., 2002: 4). Therefore, Merchants Quay Ireland applied to the National Advisory Committee on Drugs (NACD) for funding to carry out an exploratory study to address these issues. Funding was granted through the *Community/Voluntary Sector Research Grant Scheme*.

Research objectives

The aim of this research is to develop an in-depth understanding of problematic drug use[1] among new communities[2] in Ireland.

More specifically the objectives of the study are:

- to find out patterns of drug use;
- to examine different methods of drug use;
- to look at reasons and motivations for drug use;
- to establish risks the users may be exposed to;
- to examine level of awareness of strategies for health promotion / harm reduction;
- to investigate awareness of drug treatment services available; and
- to identify barriers to accessing support services.

Research methodology

This study was an action research project employing ethnographic research methods, including participant observation and in-depth interviews. Three members of new communities (a Russian, a Romanian and a Nigerian) were recruited and trained to carry out the fieldwork. They carried out 280 hours of fieldwork and kept daily research diaries of observations made and informal conversations. In-depth interviews were carried out with 10 problematic drug users from new communities. Two focus groups were carried out: one with individuals who work with new communities in Ireland and a second with drug service providers. Interviews and focus groups were tape-recorded with the participants' consent. Confidentiality and anonymity were assured. The interviews and focus groups were translated (where necessary), transcribed verbatim and analysed using Nud*ist 6.

Sample profile

Drug users were contacted through key informants or met in places they were likely to frequent (including local streets, community centres, drop-in centres, welfare offices, fast food places, internet cafes, amusement arcades, etc.) and through key informants. Interviews were carried out with 10 problematic drug users from new communities. The majority (n = 6) of the interview respondents were from Africa (one each from the Congo, Nigeria, the Republic of Niger and Kenya respectively and 2 interviewees were from Somalia). The remaining respondents were from the former USSR (Ukraine, Moldova and Georgia) and Central/Eastern Europe (Lithuania).

The vast majority of the respondents were male (n = 9) and 1 was female. The respondents ranged in age from 24 years to 44 years. Of the 10 interviewees, 4 were asylum seekers, 4 were undocumented immigrants, 1 had refugee status and 1 was a documented migrant worker. Seven of the interviewees reported that heroin was their drug of choice while the 3 remaining respondents were cocaine users. Five of the respondents injected heroin.

1 Problematic drug use is defined as drug taking by individuals who experience difficulties (social, physical, psychological and/or legal) as a result of it. They may be dependent on opiates (e.g. heroin, methadone) and/or other drugs (e.g. stimulants, cannabis) and may or may not be receiving treatment.

2 New communities refer to a number of communities that have recently arrived in Ireland, many of whom are refugees and asylum seekers.

Findings

Researching drug users from new communities

Carrying out research with drug users from new communities proved particularly challenging and demanding. Issues and problems that arose during the research are outlined below.

- Individuals and organisations (those working with new communities and drug services) were often not in a position to assist the fieldworkers in contacting drug users as they had no information, or no contact with drug users from new communities.
- Those that were in a position to offer support displayed leaflets advertising the project in their services, invited the fieldworkers to meetings and contacted the fieldworkers if they came across any potential respondents.
- Key informants who played a crucial role in contacting potential respondents included personal friends, experienced drugs outreach workers, Irish drug users and drug dealers.
- There was a general lack of awareness among new communities about most drugs and their effects. Drug-taking was often seen as a taboo subject and people were concerned about the confidentiality of the research.
- The fieldworkers found drug users from new communities difficult to reach as they remained hidden, were highly mobile and rarely associated with Irish drug users.
- Drug users encountered were sometimes hostile and suspicious of the research. They were also difficult to engage with, did not keep appointments and were preoccupied with other activities. In addition they were extremely concerned about the issue of confidentiality and the stigma associated with illicit drug use.
- One of the main challenges for the fieldworkers was building trust among the new communities and drug users, as they were often perceived as betraying their communities or acting as informants.

Patterns of drug use among new communities

The results of this research clearly indicate the existence of problematic drug use among new communities in Ireland with a range of drugs being used and administered in different ways. It is important to note that as this is a small qualitative study, the information offers an in-depth description of patterns and types of drugs used but it is not representative and generalisations cannot be made about national groups from the data presented.

- Drug use was reported among individuals from Central/Eastern Europe (Romania, Lithuania, the Czech Republic, Hungary, Poland, Estonia), from the former USSR (Ukraine, Moldova, Georgia, Russia, Kazakhstan), Africa (Sudan, Somalia, the Congo, Nigeria, Kenya, Ghana), South Africa, Pakistan and Jamaica.
- As is the case among the Irish population (NACD, 2003), cannabis seemed to be widely used among members of new communities. The vast majority of individuals using cannabis did not perceive their use as problematic.
- There were reports of the use of dance drugs (ecstasy, amphetamines and LSD) among younger members of new communities, in particular, Nigerians, Romanians, Ukrainians, Moldovans and Russians. Often ecstasy use was combined with cannabis.
- Seven of the interviewees (one Lithuanian, Ukrainian, Moldovan, Georgian and Congolese respectively, and 2 Somalis) reported that heroin was their drug of choice. Other groups reported to be using heroin included Sudanese, Nigerians, Algerians, South Africans, Romanians and Russians.
- It was reported that African Caribbeans, Romanians, Russians, Georgians and Ukrainians were on methadone maintenance programmes in Dublin. Others (mainly Somalis, Congolese and Georgians) were buying street methadone.

- Three of the 10 interviewees (one from Nigeria, Kenya and the Republic of Niger respectively) reported that cocaine was their drug of choice. Other groups reported to be involved in cocaine or crack use included individuals from the Congo, Somalia and to a lesser extent, Romania.
- Some of the first generation migrants were adopting drug using patterns similar to those in their countries of origin. Members of the Somali community were reported to be using khat[3] while some Russians were making a special porridge *(kasha)*[4], laced with cannabis. Younger members of new communities were more likely to be mixing with their Irish peers and adopting similar drug-using patterns (in particular cannabis and ecstasy use).
- Among the 10 respondents, four (from the Ukraine and Kenya and 2 from Somalia) had no history of problematic drug use prior to arriving Ireland and one (Nigerian) had ceased drug use for 10 years but had started again in Ireland. Five (from Moldova, Lithuania, Georgia, Congo and the Republic of Niger respectively) were involved in problematic drug use prior to arriving in Ireland.
- Half (n = 5) the respondents met were injecting heroin (from Lithuania, the Ukraine, Moldova, Georgia and Somalia). Other nationalities reported to be involved in intravenous drug use included Russians, Estonians and Pakistanis.
- There were some cultural variations in types of drugs used. Africans were more likely to smoke cocaine (although some were smoking heroin and there was some evidence of injecting heroin use), while Eastern Europeans were more likely to inject heroin.

Ethnicity, drug use and social exclusion

The following results show that the social situation of new communities, coupled with other stresses such as displacement and seeking asylum, constitute a risk for engagement in problematic drug use.

- The stress associated with applying for asylum and the implications of having an insecure legal status were often significant factors influencing drug using behaviour among new communities.
- Most of the interviewees were living in hostels. Consequently they have no family network or social support which often acts as a "protective" factor against drug use. In some cases this lack of family and community support led to immersion into a "street culture" and illicit drug use.
- Individuals from new communities, accommodated in socially deprived areas, are extremely concerned that their children will be exposed to heroin and other drugs.
- Many of the interviewees engaged in drug use because they were unemployed and did not have the right to work. Conversely, other respondents reported that their drug use prevented them from engaging in employment while others yet again were able to combine employment with the lifestyle associated with problematic drug use.
- In this study, many drug users reported that they stole or shoplifted to support their drug habit. There were also several reports that Africans were involved in drug distribution, in particular cocaine dealing.
- One of the main reasons given for engaging in drug use was that it was a means of escaping from current worries (linked to asylum process), exclusion and isolation. Experiences of post-traumatic stress disorder, war, torture and trauma were also cited as reasons for involvement in drug use.
- Younger members of new communities were reported to engage in drug use in order to gain acceptance from, or to "fit in" with their Irish peers.
- As well as the reasons outlined above, members of new communities in Ireland, especially younger members, engage in drug use for reasons similar to those cited by Irish drug users. These include peer influence, curiosity, boredom, relationship breakdown and accessibility.

3 Khat is is a natural stimulant from the Catha Edulis plant, found in the flowering evergreen tree or large shrub which grows in East Africa and Southern Arabia (Prasad, 2002).

4 In Russia, wild cannabis is gathered and made into a *kasha* (a kind of porridge) or "milk", which is then ingested (MPI, 2000).

Barriers to accessing drug services

- The most significant barrier to seeking help for drug use was the lack of knowledge of existing drug services and what these services have to offer.
- Lack of knowledge was also related to language difficulties as many respondents were unable to access information in their own language.
- Long waiting lists also acted as a deterrent to accessing drug services, especially in relation to methadone maintenance programmes.
- Drug users from new communities were also discouraged from accessing drug services, in particular methadone programmes, because of the assessment procedure (i.e., urinalysis, referral procedure, etc.).
- Group work often alienates drug users from new communities as they feel uncomfortable attending groups where the majority of participants are Irish.
- Many of the interviewees did not want to admit to a drugs worker that they were drug users as they were ashamed of their drug use and were concerned about being stigmatised as a drug user.
- Fear of breach of confidentiality was identified as a serious barrier and many drug users were worried that drug services might have connections with the Department of Justice or the Gardaí.
- Several drug users reported that they did not use drug services because they were concerned that they would encounter racism, either from the clients and/or workers.
- Often, drug users from new communities, in particular Russians and Georgians, were suspicious of offers of help from drug services and did not believe that drug workers were genuinely going to help them.
- Drug service provision in Ireland focuses on injecting opiate use. Therefore there is a lack of treatment options for drug users from new communities who are smoking heroin, smoking cocaine and snorting cocaine.
- Several interviewees reported that they did not want help and would be able to deal with their drug problem themselves.

Recommendations

The following is a list of recommendations based on the results of the research and best practice guidelines. It is hoped that these recommendations will assist drug services in responding to the needs of drug users from new communities and encourage liaison between community groups working with Black and minority ethnic groups and drug agency representatives.

- Drug services need to produce culturally, sensitive material in different languages, including English, which clearly highlight the confidentiality of and range of services provided.
- Images and posters should be displayed in drug services which promote diversity and which clearly show that an agency is there to meet the needs of a wide range of users.

While raising awareness of drug services is important, the main emphasis should be on providing accessible and culturally appropriate services.

- A drugs outreach team should be set up in Dublin specifically targeting drug users from new communities. The outreach team should incorporate a peer-based approach.
- Outreach teams and peer workers should target female drug users through general health, maternity and health promotion agencies.

- Services need to be set up specifically to target stimulant users. Interventions in these services should be culturally appropriate and focus on holistic therapies and give preference to one-to-one support over group work and counselling.
- Drug help-lines in Ireland should advertise their services in several languages. Also information on drug services should be posted in relevant languages on Internet sites, such as Merchant Quay Ireland's website, www.mqi.ie.
- There is a need for drug services to recruit staff from new communities.
- It is imperative that anti-racist training is provided for staff and clients in drug services to enable them to become more aware of issues surrounding race and ethnicity.
- Young people from new communities need to be targeted by drug prevention programmes.
- There is a need to raise awareness about drugs and drug services among new communities by providing culturally specific drug awareness training to young people, parents and local community groups.
- Community engagement should be promoted in the design and delivery of drug services. People representing new communities should be included in the decision-making process of drug agencies, such as management committees, as well as on local drugs task forces, especially in areas where many immigrants are accommodated.
- Ethnic monitoring would be a useful way for drug services and the National Drug Treatment Reporting System (NDTRS) of the Health Research Board, to measure up-take of services among new communities.
- The National Drug Strategy needs to set specific targets in relation to developing drug services for individuals from new communities.
- Anti-poverty policies in Ireland need to address social exclusion among members of new communities.
- Further research is needed on the nature and extent of drug use amongst Ireland's new communities so that drug services can remain responsive to their needs.
- Evaluations of drug services should be ongoing to ensure that the barriers to drug services for users from new communities are dismantled and to prevent further barriers being erected.
- More in-depth research should be carried out on the link between ethnicity, social exclusion and drug use.

Chapter 1 – Introduction

Since the early 1990s, Ireland has experienced a substantial increase in immigration. During the 1990s the majority of those immigrating to Ireland were Irish returnees, UK nationals and some from other EU countries and the US. The latest figures from the 2002 Census show that 644,400 long-term migrants are now living in Ireland. Of these, 366,800 are returned Irish emigrants. Since 1995, asylum seekers have constituted approximately 10% of all foreign immigrations to Ireland (MacEinri, 2001). The number of applications for asylum rose from 3,883 in 1997 to 10,938 in 2000 and fell to 7,900 in 2003.

Problematic drug use is considered a global phenomenon. Substantial information is available through the European Monitoring Centre for Drug and Drug Addiction (EMCDDA) about drug use amongst various national groups that make up the European Union. However, Fountain *et al*. (2002: 8) argue that drug use among Black and minority ethnic groups in the EU is "under-researched, unacknowledged, ignored, unrecognised, or hidden by some policy-makers, drug researchers, drug service planners and commissioners, and by some members of some Black and minority ethnic groups". The lack of any Irish research has meant a lack of information for drug service providers to identify and design appropriate treatment interventions or to address "the related challenges of cultural diversity, integration and racism" (Feldman *et al*., 2002: 4).

The only information on drug use among new communities[5] in Ireland is based on anecdotal evidence provided by service providers (Ana Liffey, 2001; Fountain *et al*., 2002) or sensational media reports. One such media report claimed that "*hundreds* of foreign heroin addicts are *flooding* into Ireland for drug treatment" *(italics added)*[6]. In the research carried out by Ana Liffey (2001) and Fountain *et al*. (2002) service providers reported that problematic drug use was taking place among Black Africans and Central and Eastern Europeans in Ireland. They also noted that there was an increase in contact with drug services for problematic use related to heroin, cocaine, methadone and benzodiazepines. More importantly, some groups were reported to have changed their pattern of drug use since arriving in Ireland. For instance, Eastern European drug users were believed to have begun to use street tablets (i.e. tranquillisers), in addition to their pre-existing use of heroin and alcohol. Barriers reported to accessing drug services in Ireland included lack of knowledge of services, language barriers and lack of experience in drug services to deal with different groups (Ana Liffey, 2001). Members of Black and minority ethnic groups have also complained about the difficulty of accessing information about harm reduction and treatment services (NICDTF, 2002). Drug agencies reported that many drug users from new communities were in contact with a wider group of users. Service providers were also concerned that drug use could increase among these groups when second generation immigrants start integrating into their local Irish communities.

To date, there has been no research in Ireland addressing the views of drug users from new communities themselves. Fountain *et al*. (2002: 149) recommended that "the combined phenomena of the recent rise in immigration, sensitivity surrounding ethnic monitoring, and the lack of data on drug use amongst Black and minority ethnic groups clearly need to be addressed [in Ireland], in order that the knowledge base is expanded and the appropriate responses can be developed".

Therefore Merchants Quay Ireland applied to the National Advisory Committee on Drugs (NACD) for funding to carry out an exploratory study to address these issues. Funding was granted through the *Community/Voluntary Sector Research Grant Scheme*. The aim of the Scheme is to generate innovative, community-based drugs research in the areas of prevalence, prevention, treatment/rehabilitation and the consequences of problem drug use.

1.1 Aims and objectives

The aim of this research was to develop an in-depth understanding of problematic drug use among new communities in Ireland. Problematic drug use is defined as drug taking by individuals who experience difficulties (social, physical, psychological and/or legal) as a result of it. They may be dependent on opiates (e.g. heroin, methadone) and/or other drugs (e.g. stimulants, cannabis) and may or may not be receiving treatment.

More specifically the objectives of the study are:

- to find out patterns of drug use;

5 *New Communities* refer to a number of communities that have recently arrived in Ireland, many of whom are refugees and asylum seekers.

6 Kinsella, Yvonne. 2003. *"Refugee Junkies"* in Daily Mirror, Thursday, January 23, 2003.

- to examine routes of administration of drugs used;
- to look at reasons and motivations for drug use;
- to establish risks the users may be exposed to;
- to examine level of awareness of strategies for health promotion / harm reduction;
- to investigate awareness of drug treatment services available; and
- to identify barriers to accessing services.

Therefore the prevalence and extent of problematic drug use among new communities is not pursued in this report. The focus is on access to drug services. In order to carry out the fieldwork, 3 fieldworkers (one from Russia, Romania and Nigeria respectively), were recruited and trained as fieldworkers. They carried out 280 hours of fieldwork and in-depth interviews with 10 problematic drug users.[7]

1.2 Outline of the report

Chapter 2 gives an overview of international literature and examines the nature and extent of drug use among Black and minority ethnic groups in different countries and concludes with an overview of barriers to accessing drug services.

Chapter 3 describes the methodology used in gathering and analysing the data.

Chapter 4 presents the processes and procedures adopted by the fieldworkers during the research and outlines the difficulties in researching drug users from new communities.

Chapter 5 reports on types and patterns of drug use among new communities in Ireland.

Chapter 6 examines the relationship between the socio-economic situation of drug users from new communities and problematic drug use.

Chapter 7 addresses two main areas: barriers to seeking help for drug use and ways in which drug services in Ireland could be made more attractive for individuals from new communities.

Finally, Chapter 8 presents some key recommendations.

7 See Chapter 3 for an overview of the methodology.

Chapter 2 – Literature Review

2.1 Introduction

While there is a growing interest in ethnic specific drugs research, many of the studies are methodologically flawed (Trimble, 1990) as there is inconsistency in the manner in which researchers describe ethnic populations (Trimble, 1990) or classify them (Reid *et al*., 2001). For instance Trimble (1990) criticised the uses of "ethnic glosses" (i.e. broad ethnic labels) to identify samples. Similarly Reid *et al*. (2001) highlighted that American literature has a tendency to classify ethnic groups into five racial groups (White, African-American, American Indian/Alaskan Native, Asian/Pacific/Islander or Hispanic) despite the existence of hundreds of minority ethnic groups. Moreover, American and European countries have all experienced different patterns of immigration so literature is often nationally specific. In light of this, the following chapter draws on broad common themes found in international literature and examines the nature and extent of drug use among Black and minority ethnic groups in different countries.[8] The chapter concludes with an overview of barriers to accessing drug services.

2.2 Drug policy and Black and minority ethnic groups

When drug prohibition was first introduced in Western society (the Opium Exclusion Act in 1874 in San Francisco) it is argued that the main aim was to protect the majority white population from the habits of minority ethnic groups (Jay, 2002). Therefore prohibition only applied to the Chinese population and was represented as being for their own good as well as protecting the "whites" from their "foreign habit" (Jay, 2002). Even when the Temperance Movement addressed drugs during prohibition, it was "in the particular contexts where ethnic minorities lived cheek-by-jowl with the white working class" (Jay, 2002: 3). After the failure of the American experiment with prohibition in 1932, many interests groups in America switched their focus from alcohol to drugs but the emphasis was still the link with minority ethnic groups (Jay, 2002). Even today, American drug laws are viewed as being "racist" (DPA, 2002) as they "have a disproportionate impact on minority communities" (Mulligan, 2002). For instance 90 percent of those serving time for drug offences in America are from Black and minority ethnic groups.

Similarly, in England and Wales "minorities tend to be convicted of relatively low-level drug offences at rates much higher than those of the majority of individuals" (Meares, 2001: 2916), often as a result of policing strategies (Marlow, 1999). However, in 1998 the British government identified diversity as one of the key strategic objectives of their national drug treatment plan. The British government's strategy *Tackling Drugs to Build a Better Britain* (1998) put the needs of Black and minority ethnic people on the drugs agenda for the first time. In particular, it acknowledged the need for specific support services for "Black and minority ethnic population when they are needed". Winters and Patel (2003) feel that "although this acknowledgement falls far short of aiding services to develop in practice, it does represent a significant sea change in thinking" (7).

Conversely, the latest Irish drugs strategy, *Building on Experience* (2001) makes no reference to new communities. Similarly policy-makers in Germany, Spain and Sweden have failed to address drug use among different Black and minority ethnic groups (Fountain *et al*., 2002). However, anti-poverty strategies in Ireland have begun to target migrants and minority ethnic groups. For instance, in 2002, the Irish government published a revised national anti-poverty strategy, *Building an Inclusive Society* (2002) and for the first time identified migrants and minority ethnic groups as a specific target for anti-poverty policy (Fanning, 2003).

2.3 Extent of drug use among Black and minority ethnic groups

There is a dearth of information on the extent of drug use among Black and minority ethnic groups. As a result, researchers often rely on indirect indicators such as drug treatment statistics and crime statistics. In regard to treatment in Ireland,

8 The term "Black and minority ethnic groups/communities" is taken from Fountain *et al.'s* (2002; 2003) work in Britain who used the term to reflect that their concern was "not only with those for whom "Black" is a political term, denoting those who identify around a basis of skin colour distinction or who may face discrimination because of this or their culture. "Black and minority ethnic" also acknowledges the diversity that exists within these communities and includes a wide range of those who may not consider their identity to be "Black", but who nevertheless constitute a distinct ethnic group" (2003: 2).

figures quoted from the National Drug Treatment Reporting System showed that in 1999 there was only 1 African among 6,443 drug users in treatment and in 2000 there was only 1 Black or ethnic minority person among 6,379 in treatment[9] (Fountain *et al*., 2002). Figures published from the Irish Prison Service reveal that the number of non-nationals committed to Irish prisons increased by 66% between 2001 and 2003, from 1,569 to 2,608. In 2003 non-nationals constituted 21% of the total number of committals. The majority however were committed on relation to immigration matters – not drug related crimes. Similar to other countries, these statistics reveal that non-nationals and people from Black and minority ethnic groups are often under-represented in drug treatment statistics and over-represented in crime statistics. Such data alone therefore "give an extremely distorted picture of the prevalence of drug use and of drug-using patterns, yet in some countries, comprise the bulk of the recorded knowledge base" (Fountain *et al*., 2002: 9).

Studies that have attempted to estimate the extent of drug use among new communities have found that it is not equally prevalent among all Black and minority ethnic groups. These differences may be explained by relative socioeconomic disadvantage, discrimination and by the values and traditions of specific ethnic groups (Johnson and Larison, 1998). For instance, Korf (2000) found in the Netherlands that drug use was high among Black people from former colonies in the Caribbean but low among migrant workers and their children. Similarly, in Britain in the early 1990s, treatment data from the Drug Misuse Database revealed that there were higher numbers of Black people (10%) than Asians (2%) using drugs (Daniel, 1992). In America, Native Americans, Mexicans, Puerto Ricans and non-Hispanic Black people have been found to have high prevalence of illicit drug use while the prevalence rates among Asian/Pacific Islanders, Caribbeans, Central Americans and Cubans are lower (Johnson and Larison, 1998).

Comparisons of Black and minority ethnic groups and indigenous populations are difficult due to methodological differences and unsophisticated prevalence measures. However, European research has mostly found that drug use among Black and minority ethnic groups is less than that found among the indigenous populations (Khan *et al*., 2000; Korf, 2000; Sangster *et al*., 2002). For instance, Khan *et al*. (1998) carried out a survey in Glasgow among Asian and white males, and found that drug use among Asian males was considerably less than that found among white males. However, recent British studies have found that drug use among some Black and minority ethnic communities is perceived to be increasing and may be as prevalent as within the indigenous population (Fountain *et al*., 2003). For instance, recently established young Vietnamese people in England are reported to have similar levels of drug use as English people (Sangster *et al*., 2002). One exception to research findings is that African Caribbeans in England are more likely to present to treatment for crack cocaine use than any other group (Sangster *et al*., 2002). This is one instance where British and American literature concur.

Unlike European literature, American research has found higher rates of drug use among Black and minority ethnic groups. The National Household Survey on Drug Abuse found that American Indians/Alaskan Natives had the highest prevalence of past-month use for drug taking, followed by Black people (NIDA, 1998). However American data on drug use among youths found that White youths have higher rates of drug use than youths from different minorities (EDC, 2001; NIDA, 1998).

2.4 Types of drugs used

British research has found that Black and minority ethnic groups use a similar range of substances to indigenous populations (Fountain *et al*., 2003; Sangster *et al*., 2002). However there are varying patterns and levels of drug use among different groups (EMCDDA, 2000; Fountain *et al*., 2003). For instance, cannabis and crack cocaine are often associated with African Caribbeans, while heroin is usually the drug of choice amongst young South Asians, particularly Pakistani and Bangladeshi males and Eastern Europeans (EMCDDA, 2000; Fountain *et al*., 2003; Sangster *et al*., 2002). Crack and opiate use are evident among more recently established Black and minority ethnic communities in England, such as the Vietnamese and Somali communities (Sangster *et al*., 2002). However, Sangster *et al*. (2002) point out that these statistics are more likely to reflect the nature of services provided rather than the extent of problematic drug use among various groups.

9 Zambian and Somali respectively.

There are some drugs which are specific to older generations of Black and minority ethnic groups such as pann,[10] bhang[11] and khat.[12] These are mostly used by the Somali, Yemeni, Ethiopian and Arab communities (Fountain *et al*., 2003). Although research is contradictory, younger immigrants in Britain have often been found to adopt drug using patterns of their peers in the host country, such as the use of dance drugs (ecstasy, amphetamines and LSD).

2.5 Risk behaviour

In Britain, intravenous drug use is prevalent among Black and minority ethnic groups although not to the same extent as amongst indigenous drug users (Fountain *et al*., 2003). For instance, even though South Asians are likely to use opiates the majority do not inject (Sangster *et al*., 2003).

Conversely, American research has found that African Americans and Hispanics prefer injecting drugs over other methods (NIDA, 1998) and they continue to represent increasing proportions of people reporting with AIDS, especially by AIDS transmission through injecting drug use (NIDA, 1998). American research has also shown that drug-related visits to A&E have increased, especially among Hispanic and African American adults (NIDA, 1998). This mostly involved heroin use. Furthermore, the highest percentage of drug-related deaths is reported among Hispanics, followed by African Americans and White people (NIDA, 1998).

2.6 Motivations towards drug use

Members of Black and minority ethnic groups are at risk of becoming involved in problem drug use as they are often socially marginalised and may have a history of poverty and social stress (EMCDDA, 2000). Furthermore, those from Eastern Europe and the former Soviet Union may have turned to drugs as an escape from the hardship and pain of unemployment, disillusionment and social dislocation that accompanied political and economic transformations in these countries (SFN, 2002). In addition they may be subject to discrimination in mainstream society (Schneider, 2001). Bashford *et al*. (2003: 23) found that "discrimination and the experience of racism are, in many instances, reported to be linked to involvement in drugs". Other important factors, especially for the South Asian community in England, are peer pressure and the influence of white British culture (Singh and Passi, 1997). Similarly in Glasgow, Asians reported engaging in drug use as it was seen as "white" behaviour (Khan and Ditton, 1998). In a study carried out in London, young refugee and asylum seekers reported that they and/or others used drugs because of boredom, peer pressure, emotional problems, depression and the availability and use of drugs in their local environment (Fountain, 2004).

2.7 Barriers to accessing drug services

Members of Black and minority ethnic groups are generally under-represented as clients in drugs agencies (Butt, 1992; Daniel, 1992; Fountain *et al*., 2003; Khan *et al*., 1998; Reid *et al*., 2001). This low uptake of drug services is often blamed on them being geared towards the needs of white users, who are generally, male, opiate users (Daniel, 1992; Khan and Ditton, 1998). For instance, in Britain the focus of drug services is on injecting opiate use, even though Asian heroin users are more likely to smoke heroin and African Caribbeans are more likely to need treatment for stimulant and cannabis use (Fountain *et al*., 2003). Therefore the differing needs and problems of Black and minority ethnic groups go unmet (Daniel, 1992; Sangster *et al*., 2002). This has led to Schneider (2001: 13) hypothesising that drug services reflect and perpetuate "patterns of exclusion, disadvantage and discrimination, as well as the overall status of ethnic minorities in each society".

A further barrier to accessing drugs services is that few agencies have employees from Black and minority ethnic groups (Perera *et al*., 1993; Yates and Gilman, 1990). This is related to minority drug users' difficulty in communicating effectively in the language of the majority. The absence of a worker who can translate or interpret information can deter clients from accessing drug services (Reid *et al*., 2001). Awiah *et al*. (1992) also reported that some drug users would not attend a drug service because of fear that their culture would be misunderstood. Furthermore, staff in these agencies sometimes show

10 "A leaf preparation stuffed with betel-nut and/or tobacco and chewed" (Fountain *et al.,* 2003: 17).

11 "A drink made of yogurt and fresh milk, together with herbs, sweets, sesame seeds, almonds and sultanas crushed in a mortar and pestle. This is a common drink in Pakistan and other parts of the Indian continent, known colloquially as a "milk shake". Depending upon the social event, the drink also contains ("Bhang") or opium" (Fountain *et al.* 2003: 17).

12 Khat is a natural stimulant from the Catha Edulis plant, found in the flowering evergreen tree or large shrub which grows in East Africa and Southern Arabia.

lack of cultural insight and display little affinity for diversity (Reid *et al*., 2001). This has led to drug services in England being perceived as "racist and prejudiced against Black drug users, specifically, and Black people in general" (Perera *et al*., 1993: 12).

Equally problematic is the doubt among drug users of the confidentiality of data held by drug agencies (Perera *et al*., 1993; SDF, 1999) as well as a general lack of knowledge of services (Butt, 1992; Patel, 2000; Reid *et al*., 2001; SDF, 1999). There is also a perception that drug services have developed in an ad hoc manner in order to meet the needs of Black and minority ethnic drug users (Fountain *et al*., 2003; Patel, 2000). Furthermore, drug users often see current drug treatment as incompatible with their culture and spiritual traditions (Fountain *et al*., 2003). For instance, African Caribbean drug users in England were particularly fearful of specialist residential treatment as they feared being kept in a medical institution for an illness they did not have (Sangster *et al*., 2002). Furthermore, group counselling was reported to alienate Vietnamese clients as it reminded them of the humiliation faced by drug users who were forced to "confess" under communist policies in Vietnam (Sangster *et al*., 2002).

2.8 Summary

There is a dearth of information on the extent of drug use among Black and minority ethnic groups, both nationally and internationally. Furthermore, much of the research carried out on drug use among different Black and minority ethnic groups is methodologically flawed and inconsistent.

Despite these issues, there are some common themes that reoccur. International research has found that drug use is not equally prevalent among all Black and minority ethnic groups. Furthermore drug use among these groups in Europe is generally less than that found among indigenous populations. However, recent British studies have found that drug use among some Black and minority ethnic communities is perceived to be increasing and may be as prevalent as within the indigenous population.

Black and minority ethnic groups use a similar range of substances to indigenous populations although there are varying patterns and levels of drug use among different groups. There are some drugs which are specific to older generations of Black and minority ethnic groups while younger members have often been found to adopt drug-using patterns of host countries. Often members of Black and minority ethnic groups are at risk of becoming involved in problematic drug use because of social exclusion and poverty. Furthermore younger members especially are influenced by the drug-using behaviours of other cultures.

Members of Black and minority ethnic groups are generally under-represented in drugs agencies as some feel drug services are not appropriate to their needs or offend their culture or spiritual tradition. Other factors include few agencies have employees from Black and minority ethnic groups, staff in drug agencies sometimes show lack of cultural insight, fears of breaches of confidentiality, as well as a general lack of knowledge of drug services.

Chapter 3 – Methodology

3.1 Introduction

This study was an action research project employing ethnographic methods. This chapter outlines the ethos behind action research and describes the different methods of qualitative research that were used during the fieldwork. Thereafter, the issues related to gaining access, sampling and ethics are discussed.

3.2 Action research

This was an action research project as the aim was for the research to have practical outcomes, produce usable knowledge, contribute to the capacity building of new communities (Feldman *et al*., 2002) and assist drug users from new communities to improve the quality of their lives. It is imperative that drug services are improved. as a result of this research, as different communities have complained in Britain that, while there has been a substantial amount of research carried out on drug use among Black and minority ethnic groups there, little action has resulted in terms of service development (Fountain *et al*., 2003).

3.3 Advisory committee

An Advisory Committee was set up which included representatives from organisations working with new communities. This was to avoid the pitfall that other researchers have fallen into where individuals from Black and minority ethnic groups have been excluded, both as researchers and as subjects, from playing significant decision-making roles in research projects involving members of their own populations (Feldman *et al*., 2003; Stanfield, 1993). Unfortunately the attendance of individuals from new communities was poor. While the inclusion of these groups on the Advisory Committee was in no way tokenistic, Feldman *et al*. (2002: 16) found that "offers of advisory roles are no longer necessarily welcome gestures [as participants feel that these committees] exploit their unpaid work and offer no real "teeth" with regard to shaping organisational decisions". The Advisory Group also consisted of representatives from Irish drug services and users' groups who had experience of working with new communities. It was important to include these groups as winning the approval, acceptance and personal support of professionals who may be in contact with potential respondents is crucial. (Shaffir, 1991).

3.4 Fieldworkers

There are a number of problems involved in members of the indigenous population carrying out ethnographic research (as well as other types of research) on Black and minority ethnic groups (see Andersen, 1993; Denis, 1993; Facio, 1993). Therefore, three members of new communities (a Russian, Romanian and Nigerian) were recruited through organisations working with these groups based on their knowledge of drug issues and/or poverty and social exclusion. This is considered the most reliable and objective method as British and American researchers have found that a research team composed solely of persons from the indigenous population may not have the trust and credibility of other communities (Andersen, 1993; Stanfield, 1993; Patel, 2000). Furthermore, access to Black and minority ethnic groups is relatively closed to indigenous researchers (Johnson and Cross, 1984; Walton, 1986). Using peer researchers also addressed other issues such as the need for cultural and religious sensitivity in research design and the problem of the lack of knowledge of, and trust in, services (Patel, 2000). The fieldworkers participated in an intensive 3 day training programme which covered: introduction to ethnographic research, gaining access, participant observation, recording fieldnotes, in-depth interviews, interview skills/techniques, asking open-ended questions, snowball sampling, research ethics and role plays. To ensure safety in the field they were given identification cards and mobile phones.

3.5 Ethnographic research

Ethnography is a form of qualitative research which combines several methods, including participant observation and in-depth interviewing (Fielding, 1993). It is particularly suited to field research especially "when one knows relatively little about the subject under investigation" (Singleton *et al*., 1988: 298-9).

3.5.1 Participant observation

The fieldworkers carried out 280 hours of fieldwork. This involved observing drug users in their own social settings and engaging in informal discussion with drug users and key informants. They kept daily diaries and recorded details of date, time, personnel and locations as well as notes on events, activities and conversations.

3.5.2 In-depth interviews

During the 280 hours of fieldwork, 10 problematic drug users agreed to participate in in-depth interviews. An interview schedule was devised based on findings from international literature and discussions with community workers. However, the interviews incorporated a high degree of flexibility so that the interviewees' views, interests and concerns guided the course of the interview. Therefore, answers to questions in the initial interviews subsequently shaped responses to further ones. This means that by gathering information, analysing it and testing it "you come closer to a clear and convincing model of the phenomenon you are studying" (Rubin and Rubin, 1995: 46).

3.5.3 Focus groups

Two focus groups were carried out as these are particularly suitable to exploratory studies (Kreuger, 1994). One focus group comprised of individuals working with new communities in Ireland and who therefore could offer insights into what was happening at a local level. A second focus group was carried out with drug service providers to discuss the impact drug use among new communities was having, or could have, on their services and to examine how drug services could be made more accessible for the target group.

3.6 Gaining access

This type of fieldwork research was particularly challenging as drug users from new communities are a particularly difficult to reach group. To overcome the problem of access, a great deal of time was invested by fieldworkers in establishing trusting relationships with prospective participants. Therefore the recruitment process involved the field researchers' regular presence and active participation in places frequented by drug users from new communities (including local streets, community centres, drop-in centres, welfare offices, fast food places, internet cafes, amusement arcades, etc.). This is because access to participants often depends on the field researcher becoming part of a social scene and accepted to some degree (May, 1997).

Letters were also sent to 46 key informants who may have been in contact with potential participants. These included people working in prisons, health and welfare services, hospitals, drug services, community groups, organisations working with those with HIV and AIDS and refugee and asylum seeker support groups. Some organisations were successful in introducing the fieldworkers to potential respondents. Furthermore, the outreach team from Dublin AIDS Alliance also acted as gatekeepers and helped the fieldworkers contact potential interviewees.

A flyer advertising the research project in Russian, Romanian and English was distributed by the fieldworkers at places where potential participants could be contacted (including drug services, shops, hostels, GP surgeries, health centres, hospitals, social welfare officers, information services, refugee centres, community groups and churches).

3.7 Sampling

The study did not seek a representative sample of individuals from the different communities but rather the emphasis was on gaining in-depth insights into key issues relating to emerging drug patterns among new communities. Snowball sampling was used to locate research participants as this is the most common method used in exploratory research (Babbie, 1998). This method is also most appropriate when members of a special population are difficult to locate, (i.e. problematic drug users from new communities) and when some degree of trust is required to initiate contact. "Cold" contacting was also used to some degree, where the fieldworkers approached drug users without prior introduction.

3.8 Sample profile

Interviews were carried out with 10 problematic drug users from new communities. The majority (n = 6) of the respondents were from Africa (one each from the Congo, Nigeria, the Republic of Niger and Kenya respectively and 2 interviewees were from Somalia). The remaining respondents were from the former USSR (Ukraine, Moldova and Georgia) and Central/Eastern Europe (Lithuania).[13]

The vast majority of the respondents were male (n = 9) and 1 was female. This may indicate that fewer women from new communities are involved in problematic drug use. Conversely it may mean that their drug use is even more hidden for fear of the stigma they might endure from within their community and belief that social services may intervene in relation to childcare (Awiah *et al*., 1992; Khan and Ditton, 1999).

The respondents ranged in age from 24 years to 44 years. Of the 10 interviewees, 4 were asylum seekers[14], 4 were undocumented immigrants[15], 1 had refugee status[16] and 1 was a migrant worker[17]. The majority of the respondents were staying in hostels (n = 7), while 2 were staying with friends and 1 interviewee was in private rented accommodation. Most of the interviewees were unemployed (n = 8) while 2 were in full-time employment. It is not surprising that the majority of interviewees were unemployed as asylum seekers and obviously undocumented immigrants do not have the right to work in Ireland. Seven of the interviewees reported that heroin was their drug of choice while the 3 remaining respondents were cocaine users. Five of the respondents injected heroin.

3.9 Ethical issues

Participation in the research was voluntary and each interviewee received a detailed explanation of the purpose of the study and a description of the research procedure. Confidentiality and anonymity were assured. This issue was of particular importance as not only was the research looking at illicit behaviour but participants might have felt that results could have future implications (e.g. on asylum process where applicable; on access to welfare or health services etc.) Interviews were tape-recorded, with participants' consent.

One of the fieldworkers would have preferred to have carried out covert research. This, however, would transgress the ethical guidelines of the funding body, and of Merchants Quay Ireland, especially in regard to the principle of informed consent. Furthermore, some sociologists would argue that covert research invades people's privacy; it could pose risks to research participants and diminishes public trust in sociology (Hornsby-Smith, 1993).

The fieldworkers would have also preferred to give respondents a monetary incentive for participation in the research as an acknowledgement for their time and support for the research. While this was not feasible for this research, some type of incentive should be incorporated into future research budgets. Payment for research participation is an ethical issue and "reflects the ethical principles of respect and dignity" as long as it does not "constitute an inducement so powerful as to render informed consent questionable" (Ritter *et al*., 2003: 3).

3.10 Data analysis

The interviews were translated (where necessary), transcribed verbatim and analysed using Nud*ist 6. Data were analysed using the grounded theory approach which involved attempts "to derive theories from an analysis of the patterns, themes and common categories discovered among observational data" (Babbie, 1998: 305).

13 Unfortunately, no drug users from Romania were interviewed as they were particularly difficult to reach. It was pointed out to the research team that Romanian drug users might have been more likely to engage with a non-Romanian fieldworker as drug use is so stigmatised in Romania.

14 An asylum seeker is "a person seeking protection in Ireland and subsequent recognition as a refugee by the Department of Justice. An asylum seeker is in effect making an application to *become* a refugee" (Cullen, 2000: 61).

15 An undocumented immigrant is "a person who comes to Ireland seeking work or a better standard of living without permission from the State and without official documentation such as a work visa" (Cullen, 2000: 61 – 62).

16 "This term in a global sense describes an individual fleeing persecution. In the official domestic sense, the Department of Justice uses it to identify those people who have successfully achieved recognition and resettlement and therefore have *become* refugees" (Cullen, 2000: 62).

17 A migrant worker is a non-EU resident who has been granted a work permit/visa or authorisation entitling them to work in Ireland.

3.11 Validity and reliability

Two of the main criticisms of ethnographic research, usually made by those from within the positivist tradition, are that it lacks *reliability* and *validity*. Reliability refers to "the degree of consistency with which instances are assigned to the same category by different observers and by the same observer on different occasions" (Hammersley, 1992: 67). The *reliability* of this research was increased by transcribing all the interviews verbatim and by analysing the data with Nud*st. According to Silverman (2000: 186-187), "computer-assisted recording and analysis of data means that one could be more confident that the patterns reported actually existed throughout the data rather than in favourable examples".

Hammersley (1990: 57) defined validity as "by validity, I mean truth: interpreted as the extent to which an account accurately represents the social phenomenon to which it refers". In order to increase the validity of the findings, different ways of analysing the data were employed, recommended by Silverman (2000: see pgs 177-185).

- The *refutability principle:* If initial assumptions cannot be refuted then these can be seen as 'objective' knowledge.
- The *constant comparative method:* Numerous cases and observations were used to test a provisional hypothesis.
- *Comprehensive data treatment:* All data were included in the analysis.
- *Deviant case analysis:* The perspectives and experiences of all respondents and people met during the research were included "to ensure that the standpoint of each group is presented as authentic and legitimate, rather than an aberration from an hypothetical norm" (Stringer, 1999: 206).

Furthermore, when the data analysis was completed the Research Advisory Committee and the 3 fieldworkers acted as a validation group and gave critical feedback on the analysis and results.

Although the validity and reliability of the research project were addressed, McNiff *et al*. (2003: 133) stress that in action research these issues are not as important as aiming "to understand rather than predict, to liberate rather than control".

3.12 Methodological limitations

While the results of this research are presented by nationality, the author recognises that each of these populations encompasses diverse and heterogeneous ethnic groups. Other researchers have acknowledged that researching drug use among Black and minority ethnic groups is complicated by the heterogeneity of the population (Wanigaratne *et al*., 2003). Therefore, any future research should "provide explicit definitions of the terms used to delineate ethnic categories" (Wanigaratne *et al*., 2003: 40).

Chapter 4 – Researching Drug Users from New Communities

4.1 Introduction

This chapter presents the processes and procedures adopted by the fieldworkers and outlines the difficulties in researching drug users from new communities. Many of these challenges are similar to drugs fieldwork in general. As no research has been carried out among these groups in the Irish context, it is important that the issues and problems faced by the fieldworkers are outlined, as this will assist those who wish to work with this target group in the future.

4.2 Gaining support

There was some degree of support gained from drug services, local communities and organisations working with refugees and asylum seekers. Several of the individuals who were met willingly engaged in discussions about drug use. Furthermore many organisations and local business people agreed to display leaflets advertising the research project or to distribute them among potential respondents.

> *I visited a Parish Centre and talked to a person who is providing an information service for refugees and asylum seekers. She is an expert. Knows everything. Very, very professional. She was very glad to hear that something is happening in connection with drug use. She thinks that it is very good to know about our project and to provide people with information about it. She has taken the leaflets and promised to keep in touch. I think that it is very important to meet people like her as she can really give first hand information about our services to clients.*
>
> (Fieldworker 1, 7th April, 2003)

In addition, some workers in organisations offered to contact the fieldworkers if they came across any relevant information or if they met individuals from new communities who showed signs of problematic drug use.

> *I left leaflets* [with an organisation that works with development workers] *and the people there were friendly and understanding. They had not met any drug users looking for help but they promised to let me know if they meet any drug users.*
>
> (Fieldworker 1, 11th February, 2003)

> *We went to a local Drug Team and spoke to a project worker. She promised to contact us or Merchants Quay with any information on drug use among ethnic minorities in the area. She was delighted to have some leaflets and promised to distribute them among the new communities in the area.*
>
> (Fieldworker 3, 25th March, 2003)

The fieldworkers were also often invited to attend meetings, with the hope of contacting some key informants.

> *The drugs worker invited me to a meeting in May and said he would introduce me to some of the community workers working with drug users and immigrants. He also said that it would be a good opportunity for me to inform them about the research project.*
>
> (Fieldworker 3, 29th April, 2003)

Key informants (such as personal friends, experienced drugs outreach workers or drug dealers) played a crucial role in contacting potential interviewees. Friends, especially those working in local communities, were able to introduce the fieldworkers to drug users:

> *My friend arranged for me to meet with a drug user. He is from Moldova, using heroin (injecting). He is 30 years old.*
>
> (Fieldworker 1, 10th April, 2003)

I phoned a friend who promised to find an active drug user for an interview. He managed to secure an interview for me with one of his friends who agreed to have the interview next week.

(Fieldworker 3, 6th February, 2003)

Drug dealers also offered valuable information on their own lives and those of their clients.

I met the drug dealer I knew again and he told me more about himself but refused to give me an interview. He promised to help me with my research and to pass on information to other friends dealing and using drugs.

(Fieldworker 3, 19th February, 2003).

Drugs outreach workers also invited the fieldworkers to join them in their work. Their expertise and experience were invaluable, not only in contacting potential respondents, but also in enlightening the fieldworkers on how to interact with the target group.

At 2.00 pm I met an outreach worker I knew. This meeting was very beneficial as he is influential among drug users and dealers in Dublin's north side [...] I did some fieldwork with him and went around the inner-city flats.

(Fieldworker 3, 17th February, 2003)

Overall, the fieldworkers found the Irish drug users very supportive and helpful during the project and they willingly shared any knowledge they had on drug use among new communities.

During the research the Irish drug users were excellent. Anytime I approached them they tried to give the best information they had. They were happy to collect the leaflets and share useful information with me.

(Fieldworker 3, June, 2003)

Drug users from new communities seemed to only really support the research if they felt that participation would help them access some type of drug treatment.

I asked him [Georgian male living in hostel] *about his friends in case some of them would talk to me. He said they are not interested because they are still enjoying using drugs. He himself is very tired of drug use and wants to give up. That is why he agreed to talk. He needs treatment.*

(Fieldworker 1, 7th April, 2003)

4.3 Barriers to carrying out the research

4.3.1 Lack of knowledge

One of the main barriers to gathering information for the research was the general lack of knowledge on drug use among new communities, even among drug service providers.

Drug agencies and the other organisations working in the field offered little help. I found it very frustrating going from one organisation to another without getting any information.

(Fieldworker 3, June, 2003)

The reaction was quite positive among drug service providers. I think because it is a new project and nobody has done it before and nobody knows the real picture of drug use among non-nationals. But they couldn't offer a lot of help because they don't really know what is happening in new communities in reality.

(Fieldworker 1, June, 2003)

Similarly, most organisations working with new communities were not in a position to assist the fieldworkers in recruiting participants as they had not come in contact with any drug users.

I visited an Intercultural Group and spoke to a person working with non-nationals. She said she had never met drug users among the non-national community.

(Fieldworker 1, 14th March, 2003)

I spent 4 to 5 hours walking in the areas where I would find Romanian nationals. I could not find anyone who knew anything about drugs or drug use.

(Fieldworker 2, 10th January, 2003)

Overall, there was a general lack of awareness among new communities about most drugs and their effects.

Most community groups and service providers [working with new communities] *are not trained in relation to the drugs issue. They have no idea even how to define this issue* [...] *Maybe there is problematic drug use under their nose and they don't see it; they cannot identify it. Maybe there is a need for more awareness among the service providers.*

(Focus Group 2 – individual working with new communities)

Therefore, individuals reported that they were not in a position to identify if certain individuals were using drugs at all. Consequently, any type of strange or peculiar behaviour was attributed to drug use.

At 11.30 I visited a Refugee Centre. I spoke to the receptionist and she introduced me to one of the project workers. I had a discussion with him and he promised to get in touch as a lot of their clients used drugs but they could not establish which type of drug they were using.

(Fieldworker 3, 17th February, 2003)

I met [my friend] *there* [Romanian shop] *along with his colleague and spoke to all three about the issue of drugs. But they knew little about drugs. They said that they know many "dodgy" Romanians. They know this from working there. They do not know if they are involved in drugs but they seem sinister.*

(Fieldworker 2, 15th April, 2003)

I visited a new Russian shop and explained about our project and left leaflets. The girl who was working in the shop said that she met a Moldovan guy who seemed to use something. He had that glassy appearance in his eyes but he came to the shop only once and she never met him again.

(Fieldworker 1, 6th May, 2003)

As a result, drug use generally went unacknowledged or unrecognised.

4.3.2 Stigma

The fieldworkers found that the stigma associated with drug use was often the reason why local communities denied the existence of a drug problem.

At 3.00 pm I went to [a local organisation working with children]. I spoke to [one of the project workers] who believed it was not in the Romanian culture to use drugs. She said that those who came to Ireland are here for a "better life".

(Fieldworker 2, 24th March, 2003)

Drug users also tried to hide their drug use because of fear of being ostracised by their local communities. Stigma associated with illicit drug use seemed most pronounced in African cultures.

We started talking about cigarettes and alcohol and we then discussed the attitude of the African community towards drug use. People agreed that Nigerians had a negative view of drug users and that the police in West Africa, Nigeria and Ghana often abused drug users.

(Fieldworker 3, 1st February, 2003)

I want to stop but it is very difficult. The drug is killing me. I can't go back to Somalia if I am a drug user. I will be killed or rejected by my family. My family hates drugs.

(Somali male, 30 years, smokes heroin)

4.3.3 Sensitivity

More often than not, the reaction among new communities to the research project was quite negative and many were reluctant to engage in a discussion about drug use. Drugs often seemed to be a sensitive/taboo subject and many people were frightened or shocked at the very mention of the issue.

> *I visited Russian shops and tried to talk with people about drug use but they looked frightened and do not want to talk about it.*
>
> (Fieldworker 1, 10th February, 2003)

> *I visited some ethnic shops again. I tried to talk with people. They listened really politely about our project but when you start asking them questions about drug use among non-nationals they are not really happy and don't want to talk.*
>
> (Fieldworker 1, 1st April, 2003)

> *I went to the Aliens' office with my friend on the quays in Dublin. I met Romanians there. While waiting in the queue I discussed the project with them. They were all relatively new in Ireland and drugs were still a new issue to them. Many were frightened when I even discussed it with them and did not want to continue the discussion.*
>
> (Fieldworker 2, 10th April, 2003)

4.3.4 Suspicion

The fieldworkers also encountered hostility and suspicion among drug users from new communities. Overall they were very secretive about their drug use and did not want to discuss their drug use, especially with a complete stranger.

> *I realised today that none of the African and Nigerian drug users are willing to talk about their drug use.*
>
> (Fieldworker 3, 21st January, 2003)

> *He* [heroin user from Moldova] *refused to talk about drug use at all. He is hiding his drug use from people and pretending that nothing is happening. He became very hysterical if somebody mentioned drug use.*
>
> (Fieldworker 1, 10th April, 2003)

Of greatest concern for drug users and people from the local communities was the issue of confidentiality. In particular, people were afraid that the results would be given to the media or Department of Justice (therefore impacting on people's asylum process).

> *He* [non-national living in a hostel] *explained that people don't trust even each other. Sometimes there is no trust between people living in just the same house. People are afraid that somebody will know they are using drugs and it can influence their asylum process.*
>
> (Fieldworker 1, 29th April, 2003)

> *I visited a supermarket that a lot of Russian speaking people use. I tried to talk to people but they didn't want to talk to me. They looked at me as if I were a spy and were not friendly. They didn't believe that we have no connections with the Department of Justice and that the results of our project won't be given to the media.*
>
> (Fieldworker 1, 5th March, 2003)

4.4 Issues for the fieldworkers

4.4.1 Difficult to reach

As already stated, drug users from new communities were particularly difficult to reach. Overall, they remained hidden to the fieldworkers and drug organisations.

> *I went to various amusement arcades and cafes. There does not seem to be as many Romanians visible as before. I felt confused as to what to do next. My luck seems to be running out and I wasn't meeting anyone. I spoke to some Irish beggars about Romanian drug users in the city but to no avail – either people did not want to engage in conversation or there are not many Romanian users about.*
>
> (Fieldworker 2, 21st March, 2003)

One of the main difficulties in contacting potential interviewees was that they were highly mobile, in part, as a result of police pressure.

I visited a Lithuanian shop and a place under the bridge. Sometimes the drug users are there but today there was nobody.

(Fieldworker 1, 4th March, 2003)

I went to a street in the city centre, notorious for drug dealing, but it was very quiet. There were no drug users there. I spoke to some people I knew and they told me the police were in the area a couple of weeks ago and raided drug dealers and users which led to some drug users being remanded in prison and some were actually deported.

(Fieldworker 3, 14th April, 2003)

Furthermore, drug users from new communities rarely associated with their Irish peers. Therefore, Irish drug users could only be of limited help to the fieldworkers.

From there we went straight to a local DART station where we met some [Irish] *drug users. We asked them if they knew where non-national drug users hang out. They replied that some non-nationals come around to buy drugs from dealers but they are not mixing with the Irish. We spoke to another couple of [Irish] drug users who said that if we were looking for non-nationals we should go to the other side of the city centre because most non-nationals don't like to mix with the Irish drug users and in that area there is a lot of dealing and buying among minority groups.*

(Fieldworker 3, 17th April, 2003)

Once the fieldworkers eventually met potential respondents they often found them difficult to engage.

I decided to go to the Canal where I met a few users and explained to them what I was doing. I offered them cigarettes but they were too high to talk and took advantage of me by sending me to buy coffee.

(Fieldworker 2, 12th February, 2003)

4.4.2 Missing appointments

The fieldworkers also had problems with potential interviewees not keeping their appointments.

At exactly 12.00 noon I arrived at the meeting place. I waited for more than half an hour but there was no sign of Mr. L. and his friends. I phoned to confirm if they were still coming for the interview. Mr. L. told me they would arrive and I should wait for them. I waited for half an hour and they didn't turn up. I decided to leave and make another phone call. They told me we should meet again at 2.00 pm at the same place we fixed for the first meeting. This time I was at the meeting place 5 minutes before the arranged time. Mr L. and his friends didn't show up. I decided to leave. On my way I met Mr. L and his friends. I asked him what happened to our appointment. He apologised and gave me another appointment for 7.00pm at a fast food restaurant. I was there at the time we arranged. Unfortunately Mr. L and his friends didn't arrive at all. I was really disappointed.

(Fieldworker 3, 12th March, 2003)

The main reason drug users gave for missing appointments was that they were too preoccupied with other activities, such as enjoying themselves, procuring drugs or using drugs.

I met a friend at a night club in the city centre who had promised to do an interview. I got on well with him but failed to conduct an interview as he wanted to have a good time. I asked him did he want to go somewhere else but he said, "no we can talk here while we are enjoying ourselves".

(Fieldworker 3, 7th February, 2003)

I went straight home to prepare for my appointment with Mr. H. After waiting for a while Mr. H. turned up just to apologise he could not make the interview. He had just had a fix and was goofing off.[18]

(Fieldworker 3, 25th February, 2003)

18 Term used to describe a person who appears sedate and listless as a result of drug intake.

4.4.3 Perceptions of fieldworkers

Despite being from the local communities themselves, the fieldworkers were often accused of betraying their communities and of acting as informants.

> *You know people are scared to talk about their drug problem. I don't know how you convinced me. You know there are a lot of women like me out there* [...] *I didn't trust you because I was scared then because I wasn't sure if you were an informant.*
>
> (Kenyan woman, 25 years, snorts cocaine)

> *There were some people in the shop and they were listening and were looking at me as if I was a spy from the KGB.*
>
> (Fieldworker 1, 20th January, 2003)

> *At 12.30 we went to a park and met some Romanians and asked if they knew anyone using drugs. They asked if I worked for the Department of Justice or for the Gardai. They called me a rat and traitor and asked if I had got papers or a passport to stay in Ireland for being a rat for the Department.*
>
> (Fieldworker 2, 22nd April, 2003)

This reaction is not surprising given that there were reports that members of new communities may be used by police as informants in their own community.

> *Her nephew is a drug user. He is injecting heroin. He was the person that informed the police about them* [i.e. their illegal status]. *He has a long criminal history. He has been arrested several times by the police but has never spent a day in prison. She explained that her nephew is working as an informant for the police and they are turning a blind eye to his case.*
>
> (Fieldworker 1, 7th May, 2003)

4.4.4 Gaining trust

Given the suspicion and distrust around the research it was not surprising that gaining people's trust was particularly difficult. Therefore, the fieldworkers had to spend a great deal of time building up trust with potential respondents. Sometimes this took days, sometimes weeks.[19]

> *I spoke with Mr. B, a Somali, today. It took several days to persuade him to talk to me.*
>
> (Fieldworker 3, 27th February, 2003)

In order to gain people's respect and trust, the fieldworkers employed several methods to enhance their credibility, such as helping people with social welfare or asylum applications, writing letters in English, translating leaflets, discussing issues of general interest, and accompanying people to doctor's appointments or to drug services.

> *I visited a hostel. I met a Georgian guy and had a chat with him, just to build up trust. I talked about Russian literature. He is a very knowledgeable person. He had a book with him and I said that I would like to read it. He was very friendly and gave me a book to read so now I have a chance to meet him again and to talk about drug use, hopefully.*
>
> (Fieldworker 1, 3rd April, 2003)

4.4.5 Avoiding harm

Ethnographic research on problematic drug use has the potential to place researchers at risk. Therefore, it was of utmost importance that the fieldworkers never put themselves in danger, and they remained constantly aware of this.

> *I asked her* [Irish drug user] *where the users usually hang out. She said as it's a nice day they are probably in the park. I went over there where I saw a few of them but was too scared to approach them as they were behaving violently and shouting.*
>
> (Fieldworker 2, 12th February, 2003)

19 The timescale for this research was quite limited (6 months). Building trust with this target group usually takes much longer. Similar projects in England lasted for 18 months (Butt, 1992) and 2 years (Patel, 2000).

We [fieldworker and Irish outreach worker] *visited some crack houses – places where many drug users buy and consume drugs on the spot. These places were rough, dirty and the walls were painted with various pictures* [...] *He advised me to never go to this area by myself because if I'm not well known to them they could attack me. He also said I should never answer my phone at any time in this area.*

(Fieldworker 3, 17th February, 2003)

4.4.6 Frustration of fieldwork

Given the fact that the target group was so difficult to locate, and that the amount of information on the subject among service providers and those working with new communities was limited, the fieldworkers' diaries indicated that they were becoming increasingly frustrated and discouraged during the fieldwork.

I visited hostels for asylum seekers. No news. There is nobody using drugs.

(Fieldworker 1, 1st May, 2003)

I had a meeting at MQI at 10.00 after which I wandered around all the usual haunts that I usually go to. No one was around to help at all, I looked in all the places I know users frequent but it was a wasted day.

(Fieldworker 2, 14th May, 2003)

4.5 Summary

The support offered by drugs agencies and organisation working with new communities proved beneficial especially offers to display leaflets advertising the research, invitations to meetings and contacting the fieldworkers with any information on potential respondents. In this regard key informants (in particular personal friends, experienced drugs outreach workers, Irish drug users and drug dealers) played a crucial role. But, as the methodological notes made by the fieldworkers show, the research was extremely demanding, and at times quite frustrating.

Unfortunately, most individuals met during the fieldwork were not in a position to assist the fieldworkers as they had no information, or no contact with any drug users. It is likely that drug service providers in Ireland do not have any information on the issue as it is so hidden and drug users from new communities generally do not access drug services.[20] However, they may also be reluctant to disclose information for "fear of accusations of racism by drawing attention to drug use in new communities and a desire to avoid increasing stigmatisation of them" (Fountain *et al*., 2002: 8). Furthermore, it also absolves them from any blame for under-provision of services (Awiah *et al*., 1992). Similarly it is likely that individuals from new communities are genuinely unaware of the drugs issue. Alternatively, they may be "protecting their community from being pathologised as deviants" (Patel, 2000: 129). Stigma associated with illicit drug use seemed most pronounced in African cultures. According to Sangster *et al*. (2002: 23) the Somali community particularly stigmatises drug use because of the "influence of Islam and a general cultural emphasis on discipline and responsibility". While it is understandable that people are concerned about their local communities being stigmatised and labelled as drug users, the denial of a drug problem poses a serious barrier to drug service development (Patel, 2000).

Furthermore, people from new communities were often reluctant to engage in a discussion about drug use as it was too sensitive a subject and they were concerned about confidentiality. In particular, drug users and people from the local communities were afraid that the results would be given to the Department of Justice (therefore impacting on people's asylum process) or the media. These concerns are understandable as, similar to other EU countries (Fountain *et al*., 2003), media reports in Ireland are sometimes quite biased against refugees and asylum seekers (Cullen, 2000). Similarly, research carried out in Britain among young refugees and asylum seekers found that they were unwilling to disclose problematic drug use or to seek help for it because they feared that this would negatively affect their asylum application (Fountain, 2004).

The fieldworkers found drug users from new communities difficult to reach as they remained hidden, were highly mobile and did not associate with their Irish peers. Those that they encountered were often hostile and suspicious of the research, were sometimes difficult to engage with, did not keep appointments and were preoccupied with other activities. In addition, they were extremely concerned about the issue of confidentiality and the stigma associated with illicit drug use.

20 Chapter 7 will examine the barriers to accessing drug services.

One of the main challenges was building trust with the new communities and drug users as the fieldworkers were often perceived as betraying their communities or acting as informants.

The processes and procedures outlined in this chapter could be adopted, adapted and developed by researchers planning to carry out any further research on the issue. Furthermore, the difficulties and barriers faced by the fieldworkers should be taken into consideration by any organisation planning to engage with this target group and develop more appropriate and culturally specific services.

Chapter 5 – Patterns of Drug Use among New Communities

5.1 Introduction

This chapter reports on types and patterns of drug use among new communities in Ireland. Drug use was reported among individuals from Central/Eastern Europe (Romania, Lithuania, the Czech Republic, Hungary, Poland, Estonia), from the former USSR (Russia, Ukraine, Moldova, Georgia, Kazakhstan), Africa (Sudan, Somalia, the Congo, Nigeria, Kenya, Ghana), South Africa, Pakistan and Jamaica. It is important to note that as this is a small qualitative study, the information herein offers an in-depth description of patterns and types of drugs used but it is not representative and generalisations cannot be made about national groups from the data presented.

5.2 Drugs used

This study found that there are a range of drugs being used by new communities in Ireland.

5.2.1 Alcohol

Although the aim of the research was to concentrate on problematic drug use, alcohol use was reported among individuals from Nigeria, the Ukraine, Moldova, Russia, Kazakhstan, the Roma community and in particular the Romanian community.

> *He* [shopkeeper] *said the Romanians don't use drugs but drink lots of alcohol. He is regularly asked for a loan of money by needy Romanians who think he can help as he has a business.*
>
> (Fieldworker 2, 15th April, 2003)

> *He* [22-year-old-Romanian] *said that most of his friends are Irish but his brother and older Romanians hang out with each other and just reminisce about "home" which he finds boring. He said the older Romanians just drink.*
>
> (Fieldworker 2, 24th April, 2003)

5.2.2 Cannabis

Cannabis seemed to be widely used among members of new communities. Seven of the 10 respondents reported using cannabis and its use was also associated with Nigerians, Somalis, Ghanaians, Jamaicans, Romanians, Ukrainians and Moldovans in Ireland.

> *The next day I continued to meet people. It came out that about half the people in* [a reception centre for asylum seekers] *are smoking cannabis (hash) in different dosages.*
>
> (Fieldworker 1, 5th February, 2003)

> *I met a Nigerian who told me he was dealing drugs* [...] *He knew plenty of Nigerians who smoked marijuana.*
>
> (Fieldworker 3, 1st March, 2003)

> *I was in a park and I met quite a few Romanians and chatted a bit. Many were with their girlfriends and/or babies. No one knew of people using "hard drugs" but a few admitted they smoked hash after work but they did not think this was bad. They never purchased drugs they said.*
>
> (Fieldworker 2, 27th March, 2003)

As the following quotes illustrate the vast majority of individuals using cannabis did not perceive its use as problematic:

> *He* [Nigerian] *said that he didn't have a problem because he takes cannabis daily but he doesn't have a problem with it.*
>
> (Fieldworker 3, 7th February, 2003)

I also asked the men if they thought they had a problem and they told me that the people who are smoking grass and hash have been doing it from Africa and it was not a health issue there, so they don't see why it should be a health issue here.

(Focus Group 2 – individual working with new communities)

There were some concerns, however, that cannabis use could become problematic, as was the case with one young girl in a reception centre for asylum seekers:

Later I met a woman from [a reception centre]. *She said that they have lots of new people there. One girl who had been heavily smoking hash had been taken to hospital.*

(Fieldworker 1, 2nd April, 2003)

5.2.3 Dance drugs

There were reports of the use of dance drugs (ecstasy, amphetamines and LSD) among younger members of new communities, in particular, Nigerians, Romanians, Ukrainians, Moldovans and Russians. Often ecstasy use was combined with cannabis.

I visited some ethnic shops again. I tried to talk with people [...] *They said that young people are smoking hash and using E.*

(Fieldworker 1, 1st April, 2003)

M. has 5 sons [Russian family]. *The oldest is 15. He left school and spends lots of time with his Irish friends who are using drugs (E and hash). She said that her son is using E and smoking hash. She is trying to stop him by explaining that it is dangerous but he doesn't want to listen to her.*

(Fieldworker 1, 15th May, 2003)

When he arrived in Ireland [22-year-old-Romanian] *he started working in a restaurant and continued to smoke cannabis after work. One night after work he went to a nightclub with his Irish colleagues and took ecstasy. Since then he takes it once or twice a week.*

(Fieldworker 2, 24th April)

The above quotes show that younger members of new communities are often introduced to ecstasy through their Irish friends and its use is associated with social activities and events.

5.2.4 Heroin

Seven of the interviewees (one Lithuanian, Ukrainian, Moldovan, Georgian and Congolese respectively, and 2 Somalis) reported that heroin was their drug of choice. This dispels the myth that Africans do not use heroin. In fact, during the study, other groups of Africans were also reported to be using heroin; including Sudanese, Nigerians, Algerians and South Africans, as were Romanians and Russians.

Several chose heroin as their drug of choice because of its positive physical effects as explained by the following two respondents:

I prefer heroin because you need to smoke cocaine every half an hour and when it is finished you need another one [...] *That is why I don't like it as much as heroin. With heroin you calm down; you cool down.*

(Congolese male, 25 years, smokes heroin)

I use drugs like heroin, you know like heroin is okay it makes my brain cool down so when I need help it makes my brain cool down. I don't think too much when I use heroin.

(Somali male, 29 years, injects heroin)

Other interviewees, continued to use heroin to avoid physical withdrawals:

> *Because at the moment I am injecting only to not feel sick and from now on I am not looking for any high. I saw all that is to be seen, all the good. All the good is an illusion, a temporary illusion.*
>
> (Moldovan male, 30 years, injecting heroin)

> *If I don't take drugs I will be in constant pain. To reduce the pain I have to use heroin. There is no way I can stop using heroin. If I stop I will have pains 24 hours a day. When I take heroin I don't feel any more pain. I know I am killing myself.*
>
> (Georgian male, 44 years, injecting heroin)

There were conflicting reports among key informants in relation to heroin use among the Roma community in Ireland, although overall it was thought that this group were not engaged in heroin use.

> *I asked if they* [Roma support group] *knew anybody who used drugs. They were very shocked to hear me ask this and said they knew nobody using heroin.*
>
> (Fieldworker 2, 25th March, 2003).

5.2.5 Methadone

It was reported that African Caribbeans, Romanians, Russians, Georgians and Ukrainians were on methadone maintenance programmes in Dublin. Others (mainly Somalis, Congolese and Georgians) were buying street methadone. One interviewee who was smoking heroin stated that he preferred to use methadone as he felt more "normal":

> *I prefer phy* [methadone] *to heroin because I know phy is like medicine. Phy is not a drug but gear* [heroin] *is a drug. If someone smokes heroin you can't be normal, you have to do something like stealing or something which is not normal. That is why I prefer to drink phy and I like phy. You can take it in the morning and that will hold you until the next day.*
>
> (Congolese male, 26 years, smokes heroin)

Other drug users stated that they used methadone to counteract the physical withdrawals from heroin when they could not access it, or did not have enough money for heroin.

> *Mr. L's friend said that that there are other Africans in his hostel who are into drugs. These Africans were also smoking heroin and also buying methadone illegally when they didn't have the money for heroin.*
>
> (Fieldworker 3, 14th March, 2003)

> *The Congolese guy said that he had not used gear [heroin] for 2 days now because he was staying in a hostel and does not have enough money to buy heroin. He said he wanted to buy phy [methadone] as he felt sick.*
>
> (Fieldworker 3, 28th March, 2003)

5.2.6 Cocaine and crack cocaine

Three of the 10 interviewees (one from Nigeria, Kenya and the Republic of Niger respectively) reported that cocaine was their drug of choice. Other groups reported to be involved in cocaine or crack use were individuals from the Congo, Somalia and to a lesser extent Romania.

5.2.7 Traditional drugs

Khat (kat, qat)[21] was found to be part of the drug-using repertoire of Somalis in Dublin.

> *It is transported from Nairobi then to London – within three days. You have no appetite for food. It is quite expensive. You consume all the family income for khat. You have to chew lots of it. That's why there are a lot of Somalis using cocaine and heroin because they're used to getting high. They have that habit from khat. You can move from khat which is a mild drug to heroin. I was afraid when I saw how many people were using it. I thought, is this Dublin?*
>
> (Focus group 2 – individual working with new communities)

21 If used in moderation, khat creates a feeling of well-being and exaltation. If chewed habitually, it "kills appetite and causes infections and cancer of the mouth and tongue, constipation, insomnia and impotence. But it is the impact on mental health – users can become psychologically dependent on the drug – that leads to depression, paranoia, mood swings and aggression" (Prasad, 2002).

One of the fieldworkers came across Russians making a porridge, laced with cannabis, at a reception centre. This is described in the following extract:

> *I went to* [the reception centre] *again and talked to people. They trust me now. They are smoking hash mostly but they said that they are also taking something special; a mixture they call porridge. They eat it. They can become excited after use but can also be very scared and sit in the corner of the room for hours.*[22]
>
> (Fieldworker 1, 28th February, 2003)

5.3 Initiation into drug use

Among the 10 respondents, 5 (from Moldova, Lithuania, Georgia, Congo and the Republic of Niger respectively) became involved in problematic drug use prior to arriving in Ireland. For four respondents the transition to problematic drug use occurred in their country of origin. Similar to the Irish drug using population, the quotes below demonstrate that their initiation into problematic drug use was usually through friends or friendship networks.

> *I started to score when I joined the army. I was placed on the border with Moldova. A big wagon of goods had been confiscated and among the goods we found a bag of heroin. I do not remember now whose idea it was but we decided to try it. One guy said that he had once seen how to do it. We found everything we needed. When we finished the bag we realised that we needed more.*
>
> (Lithuanian male, 34 years, injecting heroin)

> *I started using drugs in my country. I was around 20 years old, I think. I was together with my brother and we started to smoke. My step-brother had smoked before and once when we were together I was curious so I smoked* [heroin] *that day and I've been smoking since then till now.*
>
> (Congolese male, 25 years, smoking heroin)

> *The first time I used drugs was when I was – I think I was twenty the time I started to use drugs* [...] *I got involved through my friends and some people I was hanging around with. Those are the people who introduced me to street drugs.*
>
> (25 year old male from Republic of Niger, smokes cocaine)

One respondent from Moldova believed that he was targeted by drug dealers as he was earning a substantial amount of money at the time:

> *I've been using drugs since I was 26/27, if I am not wrong approximately 4 years. I started with opium [...] I believe money introduced me; made me want to try and also curiosity; because I had so much money. The drug addicts targeted people with money. That's how I think I started.*
>
> (Moldovan male, 30 years, injecting heroin)

One of the respondents started using drugs in Belgium, before arriving in Ireland, as a result of a combination of his asylum application being rejected and being homeless.

> *I was seeking asylum in Belgium in 1994 and I was rejected because they didn't believe me when I told them I was a genuine asylum seeker. I had no place to sleep and I became homeless, sleeping on the streets. I met other people who were sleeping rough and they told me that to survive the cold you need to take drugs.*
>
> Interviewer: What type of drugs did you take?
> *Heroin.*
> Interviewer: Did you ever take drugs in Georgia?
> *No I never took drugs in Georgia. Belgium was the first place I took drugs.*
>
> (Georgian male, 44 years, injecting heroin)

22 This sounds similar to practices in Russia where wild cannabis is gathered and made into a kasha (a kind of porridge) or "milk", which is then ingested (MPI, 2000).

Among the five remaining respondents, four had no history of problematic drug use prior to arriving Ireland while one had ceased drug use for 10 years but had started again in Ireland. The following quote demonstrates how he became involved again in the drug scene in Ireland:

> *I stopped using in 1992. I only started using a few months back.*
> Interviewer: How did you become involved in drugs in Ireland?
> *I think I started mixing with the wrong people and I was using with them. I'm hoping to stop using drugs now because it's not good for me.*
>
> (Nigerian male, 36 years, smokes cocaine)

Among the remaining respondents, three had been involved in recreational drug use in their countries of origin. Two Somalis had smoked grass while a Ukrainian respondent had experimented with ecstasy, LSD and cannabis at parties. However, none of them had ever tried cocaine or heroin prior to arriving in Ireland. The quotes below illustrate how the respondents initiated their heroin or cocaine career in Ireland:

> *I just started to inject heroin eight months ago here in Ireland* [...]. *I started to drink a lot; there were lots of wild parties, friends using drugs [heroin]. I started to smoke just to relax and forget about my nightmare.*
> Interviewer: Are your friends mostly Russian speaking or Irish?
> *Both.*
>
> (Ukrainian male, 25 years, injects heroin)

> *I went out with a friend of mine and their Irish girlfriends to a club. When we got to the club they brought something out in tin foil and they smoked the shit and asked me to smoke. I refused. Then one of them convinced me that it was nice, I would dance well and forget any problems I had.*
>
> (Somali male, 30 years, smokes heroin)

> *I used in Dublin* [...] *Yes I was introduced to it by my Irish friends. They told me it's gonna cool down your mind you know. It will cool you down. Just try smoking it, try smoking it.*
>
> (Somali male, 29 years, injecting heroin)

Interestingly, drug taking was often embarked upon with a group of Irish peers who were drug users themselves and could therefore recommend and endorse the benefits of drug taking. These Irish users were able to introduce the respondents into a social context where heroin and cocaine were readily available. Similarly, the remaining respondent became involved in cocaine use through association with her Irish partner:

> *We went to a nightclub one day and I met this Irish man. I fell for him and later I discovered he was smoking cannabis and he said to me just try it, it's okay you will enjoy it. I tried it once and then again the second day and that is how I got involved in drugs you know.*
> Interviewer: So you mean the first drug you used was cannabis?
> *I started with cannabis you know.*
> Interviewer: Did you use any other drugs?
> *Yes, yes I used the white powder. He was smoking cocaine and he taught me how to snort cocaine.*
>
> (Kenyan female, 24 years, snorts cocaine)

5.4 Changes in patterns of drug use

Among the five respondents who became involved in problematic drug use prior to arriving in Ireland, 3 continued using drugs as they had done previously. One respondent from Moldova reported using opium in his country of origin but as it is not available in Ireland he substituted opium with heroin.

> *I was 26 years old when I first tried and then I began with MAC (opium)* [...] *It wasn't heroin, it was opium. Heroin I injected in Ireland.*
>
> (Moldovan male, 30 years, injecting heroin)

Another respondent from the Republic of Niger noticed his drug use deteriorating since arriving in Ireland.

I find I actually became worse due to the situation that I am facing.

(25 year old from Republic of Niger, smokes cocaine)

5.5 Risk behaviour

Half (n = 5) the respondents reported that they were injecting heroin (one from Lithuania, the Ukraine, Moldova, Georgia and Somalia). Other nationalities reported to be involved in intravenous drug use included Russians, Estonians and Pakistanis. Therefore, injecting drug use is not just an issue for the Irish drug using community. Although there were some reports of intravenous African users, they generally smoked their drug of choice. The reasons for this were explained by the following two respondents:

I remember I injected only once but I didn't like it because I am not used to it where I come from. I used it once I didn't like it and I see the pain my friends are going through because of injecting.

(25-year-old male from Republic of Niger, smokes cocaine)

I smoke it. I don't inject heroin. Only white people inject heroin. I don't because it's dangerous.

(Somali male, 30 years, smokes heroin)

Only one respondent admitted that he shared needles when he was unable to access clean injecting equipment:

I am trying to be careful. Mostly I am not sharing equipment but sometimes when I am really drunk and I need an immediate dose and I am in company where there is no spare needle I have to share.

(Ukrainian male, 25 years, injects heroin)

Due to lack of awareness of needle exchange programmes, most respondents found it difficult to access clean needles. As one respondent stated:

I bought needles and all the stuff I need to inject. I did not know that you could get syringes for free.
Interviewer: Did you buy the syringes from the dealer?
Yes. I bought each syringe for 5 Euro [...] *I use my own ones and I do not share with anybody. I always use new needles and in case I do not have a new one, I use my old one. I never give anyone my needles as a principle! And I'm not saying that just for the sake of it, that is the truth.*

(Moldovan male, 30 years, injects heroin)

In this study most of the respondents were aware of the risks, especially in relation to sharing needles.

But do not tell me all the stuff about Hepatitis and HIV. I know how to use. I'm not a fool. I do not share needles if you know what I mean.

(Lithuanian male, 34 years, injecting heroin)

Interviewer: Are you aware of your Hepatitis C or HIV status?
I know what you mean. I am not a fool. I have some knowledge.

(Ukrainian male, 25 years, injects heroin)

There were no reports of HIV, but there were several reports of Hepatitis C in particular among the Georgian, Moldovan, Lithuanian and Kazakhstan respondents. One respondent, who was Hepatitis C positive, was unaware of the implications of sharing paraphernalia with other individuals who were also Hepatitis C positive.

Now I don't share needles with people because I am Hepatitis C positive. I only share needles with people who are Hepatitis C.

(Georgian male, 44 years, injects heroin)

Other respondents had not heard of the Hepatitis C virus.

Me, I'm not aware of Hepatitis C. What is Hepatitis C?

(Male from Republic of Niger, 25 years, smokes cocaine)

Some of the respondents were interested in establishing their HIV and Hepatitis status. However, those who did have Hepatitis had difficulty accessing treatment for it.

He [Georgian living in hostel] *has been here for 6 and a half years and applied for humanitarian leave to remain but there has been no answer. He has no medical card and no ID card. He has Hepatitis C and can't see a doctor because of not having a medical card.*

(Fieldworker 1, 7th April, 2003)

I went to a clinic and they found out that I had Hepatitis C. The woman told me that half the Irish drug users have Hepatitis C. She said they would treat me when they were finished with them.

(Georgian male, 44 years, injecting heroin)

5.6 Extent of problematic drug use

It is beyond the scope of this study to estimate the extent of problematic drug use among new communities. As the results above show, problematic drug use is occurring and the perception among key informants was that problematic drug use will increase among new communities.

The participants of this meeting agreed that drug use is becoming more visible than before among the African community but they did not know why this was so.

(Fieldworker 3, 8th March, 2003)

Maybe they have not graduated to heroin and other things but I'd say that could be the next step [...] *So I would say it is just a matter of time before we have a real explosion just like that in the Irish community.*

(Focus Group 2 – individual working with new communities)

People working in organisations were particularly concerned that second generations of new communities would become exposed to drug use.

I visited an information service for asylum seekers and refugees in Dublin 24. I talked to mostly non-nationals who were coming here for advice on social welfare, housing, information and legal advice. In their opinion when young people start integrating into their local Irish communities drug use among them could start, or might have started already.

(Fieldworker 1, 13th February, 2003)

5.7 Summary

The results of this research clearly indicate the existence of problematic drug use among new communities in Ireland. Similar to findings of research carried out in Britain (see Fountain *et al*., 2003; Sangster *et al*., 2002) this study found that there are a range of drugs being used.

Drugs used were broadly similar to the range of substances used by Irish drug users (NACD, 2003) such as cannabis, ecstasy, heroin, methadone and cocaine. While the vast majority of individuals using cannabis and ecstasy did not perceive its use problematic, there were fears, however, that cannabis use could become more problematic. For instance, in England, cannabis has become problematic for some Black Caribbeans who are now presenting for treatment for its use (Fountain *et al*., 2003; Sangster *et al*., 2002). Problematic drug use was more likely to be associated with heroin and cocaine use. There were reports of heroin use among Africans as well as Eastern Europeans which dispels the myth that Africans do not use heroin. It was thought that the Roma community did not engage in heroin use although it may be hidden as Fountain *et al*.'s (2002) research found that the Roma community may not admit to a drug problem because of the associated shame, which is also the case for other groups. Similar to reports in England (Fountain *et al*., 2003; Sangster *et al*., 2002) and Europe (Fountain *et al*., 2002), khat was found to be part of the drug-using repertoire of Somalis, while Russians were reported to be making a porridge laced with cannabis (kasha). These results are not surprising as Oyefesso *et al*. (2000) and

Patel *et al*. (1995)[23] have found that first generation migrants are likely to adopt drug-using patterns similar to those in their home countries. Younger members of new communities were more likely to mix with their Irish peers and adopt similar drug using patterns (in particular cannabis and ecstasy use).

While there were similarities between different communities there were also some cultural variations in types of drugs used. Cocaine and crack were more likely to be included in the drug-using repertoire of Africans. This is consistent with findings from British research (Daniel, 1993) where African Caribbeans in contact with drug services are more likely than other groups to be asking for help to address their use of crack (Sangster *et al*., 2002). Similar to British research (Daniel, 1993; Sangster *et al*., 2003) this research found that Africans were more likely to smoke their drug of choice, while Eastern Europeans were more likely to inject heroin. The continued focus by drug services in Ireland on heroin injecting may deter those who smoke heroin and also those who use stimulants, such as cocaine, from accessing services.

Five of the 10 respondents interviewed had no history of problematic drug use prior to arriving in Ireland, while the remaining 5 had a history of problematic drug use. British research found that drug use among young refugees and asylum seekers can escalate once the person settles in a new community (Fountain, 2004). Local communities were very concerned about second generation immigrants becoming exposed to problematic drug use. The following chapter will examine this issue and show that it is not actually a community's ethnic or minority status that puts them at risk but the economic and social disadvantages they encounter.

23 Quoted in Fountain et al., (2003).

Chapter 6 – Ethnicity, Drug Use and Social Exclusion

6.1 Introduction

This chapter examines the relationship between the socio-economic situation of new communities in Ireland and problematic drug use. In particular it looks at legal and employment status, as well as accommodation, and their impact on drug use. The drugs-crime nexus is also examined in relation to new communities and the chapter concludes with a discussion on factors influencing drug use among new communities in Ireland.

6.2 Legal status

Of the 10 interviewees, 4 were asylum seekers, 4 were undocumented immigrants, 1 had refugee status and 1 was a documented migrant worker. Many of the other drug users met during the fieldwork were either asylum seekers or undocumented immigrants. It transpired during the interviews that the stress associated with applying for asylum and their insecure legal status were often significant factors influencing an individual's drug using behaviour.

> *I take drugs because of my pain. I am very stressed out about my situation and part of it is the asylum process because I can't work and I am unable to travel to see my family.*
>
> (Nigerian male, 25 years, smokes cocaine)

> *I started to use heroin in 2000* [i.e. 2 years after arriving in Ireland] *when I got frustrated because my application was rejected.*
>
> (Somali male, 30 years, smokes heroin)

> *I met a group of African dealers hanging around looking for customers* [...] *One of them came to me and asked me if I wanted something. Said he had nice stuff. I told him what I was doing and he was keen to talk to me. He told me he was a heroin user due to lack of status. He said he had been in Ireland for 6 years with no right to work and no support from the State.*
>
> (Fieldworker 3, 25th February, 2003)

6.3 Accommodation

Among the 10 interviewees, the majority were staying in hostels (n = 7), while 2 were staying with friends and 1 interviewee was in private rented accommodation. As, most of the interviewees were living in hostels, consequently they have no family network or social support which often acts as a "protective" factor against drug use. One respondent described how this lack of support and contact with other members of their own community can be particularly isolating.

> *I feel so isolated. The guy that sleeps on top of me in the hostel is an Iberian; the guys on the other side are from Russia, Kosovo and Turkey. I don't like to talk to them and have no rapport with them. I don't know what they've been through and they don't know what I've been through.*
>
> (Nigerian male, 36 years, smokes cocaine)

The following case shows that this lack of family and community support can lead to immersion into a "street culture" and illicit drug use.

> *I became involved through friends and the people I was staying with. I was staying in a hostel and lots of the boys were using drugs and some of my friends on the streets were using drugs and that's how I found myself involved in drug use and trading in Ireland.*
>
> (25-year-old male from the Republic of Niger, smokes cocaine)

> *I went back to the solicitor's and spoke with the client. He is 30, from Moldova and using heroin (injecting). He started to use drugs in Ireland when he was living in the hostel (he has been seeking asylum for 4 years).*
>
> (Fieldworker 1, 27th March, 2003)

The Congolese guy agreed to meet me the next day on Saturday at 2 pm. He told me he was 27 years old and has been living here for the past 10 months. Heroin is his problem. He was introduced to heroin by friends living in the hostel.

(Fieldworker 3, 28th March, 2003)

The accessibility of drugs through individuals living in hostels means that drug users arriving in Ireland can quickly learn where and how to procure drugs. The following interviewee, who started his drug using career in Moldova, describes how he promptly became involved in the drug scene in Dublin.

I used to live in a hostel and a Georgian guy who used drugs stayed there too. He asked me if I knew where to get drugs in Dublin and I said I don't know but I am interested in finding some as well. I went with him in town and we saw a couple of people he knew that were users [...] *We asked them where to get some heroin and then they told me.*

(Moldovan male, 30 years, injecting heroin)

Some immigrants in Ireland end up homeless. This is a cause for concern as homelessness is a risk factor for problematic drug use (as is problematic drug use for homelessness) in that drug use is often a means of adapting to life on the streets and coping with the stress of homelessness (Johnson *et al*., 1997). Furthermore, research studies have found that drug use increases when people are homeless (Cox and Lawless, 1999) and homeless drug users are more likely to share injecting equipment and paraphernalia (Cox and Lawless, 2000). One interviewee began to use heroin while sleeping on the streets in Belgium:

Interviewer: So what is the main reason why you started taking heroin?
I was homeless and if you don't use drugs when you are sleeping outside you can freeze to death. After I took the shit I felt okay and my cold disappeared. Many people who are sleeping outside are taking drugs otherwise most of these people will just die of the cold.

(Georgian male, 44 years, injecting heroin)

Immigrants, in particular asylum seekers, are often housed in the poorest parts of Dublin, in areas already suffering from unemployment, crime and social exclusion (Cullen, 2000). Individuals from new communities, accommodated in these areas, are extremely concerned that their children will be exposed to heroin and other drugs.

I do work with women living in the Dublin 1 area. We held a workshop addressing the concerns of women living here. They were very concerned about their children going outside in case they mix with other teenagers injecting drugs. So they keep their children inside. But they have no choice for economic reasons and financially [...] *It is not their choice to be in Dublin 1.*

(Focus Group 2 – individual working with new communities)

6.4 Employment

There is a significant relationship between drug use and unemployment. Among those attending treatment for problem drug use in the Republic of Ireland in 2000, 72% were unemployed, (O'Brien *et al*., 2003). Most of the interviewees in this study were unemployed (n = 8) while 2 were in full-time employment. Those who were seeking asylum or who were undocumented immigrants were more likely to be unemployed.[24] The following quotes show how being unable to work can impact on an individual's drug use:

I was really unhappy. I could not find a job. My English was not very good. I met an Irish girl who was a prostitute and she gave me a place to live and I started to score again.
Interviewer: Could you tell me where you bought heroin?
She was buying it as I had no money.

(Lithuanian male, 34 years, injecting heroin)

24 It is not surprising that the majority of interviewees and people met during the fieldwork were unemployed as asylum seekers, and obviously undocumented immigrants, do not have the right to work in Ireland. However, those asylum seekers who made their application for asylum in Ireland on or before the 27th July, 1999 and who would subsequently have been in the State for 12 months have the right to work. Although this group of asylum seekers have the right to work, they face barriers to gaining employment such as lesser entitlements to various forms of training and support, lack of recognition of qualifications, skills and experience and issues of racism (Fanning *et al.,* 2000).

You know I was smoking because of my problems. I don't work as I am an asylum seeker waiting for refugee status. You see I don't have the right to work. I was smoking in my country as I was not working. You just want something to pass your time like smoking. That is why I was smoking.

(Congolese male, 25 years, smokes heroin)

While several interviewees engaged in drug use because they were unemployed, other respondents reported that their drug use prevented them from engaging in employment.

I need help so much please because there are a lot of things I want to do myself but I have to find money to smoke drugs, you know what I mean. I can't get any job because if you go to work you feel sick, you know, because you want to go and smoke drugs, you know what I mean. It's not good like this, you know. I need to stop forever.

(Somali male, 29 years, injecting heroin)

While it is generally considered difficult, sometimes impossible, to combine employment with the lifestyle associated with problematic drug use, some drug users were able to do so:

I am working and nobody knows at work that I am using drugs. It seems to me that I can control myself.

(Ukrainian male, 25 years, injecting heroin)

He is from Lithuania, is 32 years old and is injecting heroin. He just started to inject heroin 8 months ago. He is working here. It seems to him that he can control his drug use and he doesn't need treatment.

(Fieldworker 1, 26th April, 2003)

6.5 Crime

There is a strong link between drug use and crime as many drug users often turn to drug dealing and other criminal activities to finance their habit (Coveney *et al*., 1999). In this study many drug users reported that they stole or shoplifted to support their habit.

I borrow money from people. Sometimes I shoplift. Now I have many court cases and have just finished my sentence.

(Georgian male, 44 years, injects heroin)

You know you have to find money; you have to rob everything you know. It's not good like that so I need help to stop you know what I mean.

(Somali male, 29 years, injects heroin)

One Kenyan woman, who is an undocumented immigrant, was forced into stealing money in nightclubs by an abusive partner.

I have problems like I don't have a proper job, and I have to rely on my boyfriend [...] *I have constant fights with my boyfriend because he is so demanding. He is pushing me to get money* [i.e. stealing money in nightclubs] *and I don't want to do it anymore. But because I rely on him and I am a foreigner here, I can't say no to him. He is frightening me. He threatens me most of the time. I am scared.*

(Kenyan woman, 24 years, snorts cocaine)

There were several reports that Africans were involved in drug distribution, in particular cocaine dealing.

Sometimes I have to steal you know! I steal from people; I have to rob – maybe shoplifting. I have to do other things like sell drugs myself. I'll do anything that gets money for drugs.

(25 year old male from Republic of Niger, smokes cocaine)

I am buying drugs from the Nigerians as it is better than from the Irish.

(Lithuanian male, 34 years, injects heroin)

I have a Nigerian friend who sells it to me. I phone him sometimes. He meets me in [a street known for drug dealing].

(Somali male, 30 years, smokes heroin)

The general consensus among individuals met during the fieldwork was that dealing was increasing among these groups.

> *We went to a local Drug Team and spoke to a project worker* [...] *She felt that the number of Africans engaging in drug dealing and using was increasing rapidly. She cited her local area in Dublin 8 as an example of where drug dealing among ethnic minorities was growing fast.*
>
> (Fieldworker 3, 25th March, 2003)

The following quote exemplifies that while there was evidence of drug dealing among Africans, it probably involves small numbers compared to Irish dealers.

> *Crack has always been around. It is very clear now that there are African sellers in street areas. What it probably is, is a minority of these people doing it along with the Irish but because they are Africans they stand out more.*
>
> (Focus Group 1 – drug service provider)

African dealers are also likely to experience racism from their Irish peers.

> *I visited a drugs worker in a local community drug team. He told me there were a lot of racist feelings amongst Irish drug users and dealers in the area. There was an incident of drug dealing among Africans in the area which led to the stabbing of an African living in the area because he was selling cocaine and the Irish drug dealers saw him as a threat.*
>
> (Fieldworker 3, 29th April, 2003)

There were also reports that "mules",[25] in particular South African and Nigerian women, have been recruited in their home countries to smuggle drugs into Ireland.

> *We've had quite a few women who have come through the prison but they would be South African women. They would be more involved in drug trafficking* [...] *They would bring in cannabis and cocaine. They bring it in, in suitcases but they bring them in internally also. It would be mainly South African women. We've had a few Nigerians as well for importation but not actually using.*
>
> (Focus group 1 – individual working in prison system)

As a result of being involved in crime, individuals can come in contact with the criminal justice system. The following quote illustrates that a prison sentence can put inmates at risk of drug use as heroin is available and it offers inmates a way of coping with imprisonment (Dillon, 2001). Conversely, inmates might avoid drug use because of "concerns about personal health and family well-being and attempts to comply with the condition of a judicial review" (Dillon, 2001: 87).

> *I asked him if he met other Romanians inside who were drug users and he said that in the prison he is in, there are no Romanians but that he knows that in* [another prison], *where he started his sentence for a year, there were a few Romanians who used to deal drugs and smoke drugs, but that he was afraid and stayed away from them. I asked him what he meant about the Romanians, where did they get drugs from, and he said that they mix with Irish dealers and sell the drugs for them* [...] *He said sure it was easier inside to access drugs and tempting but that he had remained very quiet inside as he did not want to get a bad reputation. He wanted to stay in the Governor's good books.*
>
> (Fieldworker 2, 8th – 10th April, 2003)

6.6 Factors influencing drug use

Reasons for using drugs are extremely complex. The interviewees and drug users met during the fieldwork offered a range of motives for becoming involved in drug use.

6.6.1 Escapism

Respondents repeatedly cited their current situation as a reason for either continuing or initiating drug use. Therefore drug use was perceived as a means of escape which helped drug users forget about their worries, temporarily.

25 People who transport (sometimes unknowingly) quantities of drugs into a country.

Interviewer: So why do you smoke?
To forget my problems because I've many problems.

(Congolese male, 25 years, smokes heroin)

You think by just snorting, by just taking drugs everything will be over – your problems will go away, you know what I mean.

(Kenyan woman, 24 years, snorts cocaine)

I take drugs to take me away from the pains and stresses worrying me and disturbing me at the moment.

(25-year-old male from Republic of Congo, smokes cocaine)

6.6.2 Exclusion and isolation

Drug users also wanted to escape from experiencing exclusion and isolation. For instance, although chewing the stimulant khat in Africa is generally a harmless, recreational activity (Prasad, 2002); in Ireland it is symptomatic of the social isolation of the Somali community, as explained by one worker:

But most of the Africans I know who started it [khat use] *here did so mainly from pure isolation. They have no job.*

(Focus group 2 – individual working with new communities)

6.6.3 Post traumatic stress

This research found that post-traumatic stress can lead to the development of licit or illicit drug use for the purposes of self-medication, as in the following case.

My friend said that this Moldovian guy started to use heroin here in Ireland. His wife is ill (problems with mental health) because they left an 8 month-old baby in Moldova with his sister and she can't cope with it. They are here 4 years and there is no answer from the Minister on their application. Their baby daughter is now nearly 5 years old. They haven't seen her all this time. I think this is the reason he started using drugs.

(Fieldworker 1, 10th April, 2003)

A factor new to Irish literature is that some members of new communities became involved in drug use because of traumatic incidences, such as the experience of war and torture prior to arriving in Ireland.

I feel really bad as I saw too many people dying during the war. I saw bodies like two hundred bodies you know it makes me sick. I don't want to remember [...] *When I remember back I see pictures of war, war, war. I remember like home you know what I mean. This war is not good like sometimes you know what I mean. It makes me weak.*

(Somali male, 29 years, injects heroin)

The same respondent continued to describe experiences of torture as well:

When I was in Somalia they caught me in the forest as I worked for the United Nations. The soldiers put nails in my hands like Jesus on the cross. One soldier said I'm gonna shoot this guy another soldier told him don't shoot him as he said he must work for us not the United Nations.

(Somali male, 29 years, injects heroin)

6.6.4 Gaining acceptance

Younger members of new communities were reported to engage in drug use in order to gain acceptance from, or to "fit in" with their Irish peers.

I rang a friend who is in an Irish secondary school (he is Romanian who has gone back to do the Leaving Certificate. I asked him if there were other Romanian immigrants in the school. He said there were quite a few in the school. I asked if there is a drug culture in the school – he said that yes almost all students smoke hash and many use stranger drugs. I asked if it seemed that Romanians or other immigrants were also using. He said he presumed that like himself, the other foreign students would smoke hash when they went out with their Irish friends. He doesn't hang out with many

of the Romanians who are all younger than him, but he would assume that Romanian teenagers would take or use whatever their Irish friends use – they want to fit in!!

(Fieldworker 2 25th March, 2003)

6.6.5 Curiosity & boredom

This study found that in addition to the reasons outlined above, new communities in Ireland engage in drug use for similar reasons to Irish drug users. Initiation into drug use was often associated with peer influence (see pgs. 35-36) and curiosity.

When I first started drugs it was just for curiosity. I saw it as escapism because my job was so stressful and I used to see it as a moral escape, but all the curiosity is gone.

(Moldovan male, 30 years, injects heroin)

My brother was smoking and I was curious to know what it was like to take drugs. I wanted to know for myself.

(Congolese male, 25 years, smokes heroin)

As well as curiosity, boredom also acted as a motivating factor for initiating drug use:

I started using drugs because I had nothing to do at the time. I got involved with friends that I shouldn't have got involved with.

(Nigerian male, 25 years, smokes cocaine)

I was 21 when I went back home and I continued to use then but didn't inject. You know what the situation was like at the time. It was very difficult to find a job. I was spending all my free time with guys like me. Nobody was bothered about you.

(Lithuanian male, 34 years, injecting heroin)

6.6.6 Personal problems

Drugs also provided users with a release from personal problems, such as relationship breakdown. This was the case for two drug users:

I would like to have my own family, children and house but I am not lucky with women. My last girlfriend got pregnant and I was so happy that at last I had met a person to build my family life with. I was crazy about the idea of being a father. I was working to save money for the baby for 2 weeks. I phoned her a few times and as soon as I got a chance to go round to her house I realised that she left England two weeks ago and got an abortion. I was crushed as she had stabbed me in the back. I started to drink a lot; there were lots of wild parties, friends using drugs. I started to smoke just to relax and forget about my nightmare.

(Ukrainian male, 25 years, injects heroin)

Mr. B became involved in heroin because he went to prison and the Irish girl he was living with, who also had a baby with him, left the house with his baby. Now he doesn't know where she is living. He was very unhappy about this and one day a friend of his called and told him if he took heroin he would forget his worries.

(Fieldworker 3, 27th February, 2003)

6.6.7 Availability of drugs

Increased availability of drugs often influences why people start to use them and may account for increases in drug use (Bashford *et al*., 2003). The accessibility of drugs in Dublin facilitated continuation or initiation into drug use.

You know it's easier to buy drugs in Ireland than back home.

Interviewer: Why?

Nobody bothers about it, I mean the police. They are selling drugs everywhere and I am buying drugs from the Nigerians as it is better than from the Irish. You have everything you need except money.

(Lithuanian male, 34 years, injecting heroin)

However, drug users met in Galway had to travel to Dublin to buy drugs. As already stated, drugs were usually accessed through Irish friends (see pg. 36) through acquaintances in hostels (see pg. 40), dealers (see pg. 42-43) or other immigrants.

> *I met someone who I used to smoke with in the Congo. I saw him on the street. He already knew how to get drugs here in Ireland so he introduced me to people and where I could buy it. Do you understand me?*
> Interviewer: Did he buy drugs for you or did you buy them yourself?
> *Once he showed me where to buy drugs I bought them for myself.*
>
> (Congolese male, 25 years, smokes heroin)

6.7 Summary

Research has consistently found that problematic drug use and social exclusion are inextricably linked. The results of this study show that drug use, social exclusion and ethnicity are connected. This link has also been established among Black and minority ethnic groups in England (Fountain *et al*., 2003) and Europe (EMCDDA, 2000). The foregoing evidence shows that the social situation (i.e. poor housing, unemployment, insecure legal status etc.) of new communities in Ireland constitutes a risk for engagement in problematic drug use. While the presence of a single or even multiple risk factors do not automatically predict drug use, Fountain (2004: 2) concluded that the greater number of risk factors present, the greater the likelihood of drug use and subsequent problematic use. Furthermore, individuals from new communities, accommodated in areas of social exclusion, were concerned that their children would become exposed to heroin and other drugs.

New communities are also at risk of problematic drug use as they have other stresses such as displacement, seeking asylum and no family and social support. Consistent with international research (Reid *et al*., 2001) this study showed that lack of family and community support can lead to immersion into a "street culture" and illicit drug use.

Similar to research in other EU countries (Fountain *et al*., 2002) some drug users from new communities turned to drug dealing and other criminal activities to finance their habit. However, the situation in Ireland is probably similar to other European countries in that, in absolute terms, the number of dealers from Black and minority ethnic communities is relatively small in comparison to dealers from the national country (Fountain *et al*., 2002).

Factors influencing drug use among new communities were often associated with their background and current legal status. These included worries linked to the asylum process, exclusion and isolation. Similarly, in England, Sangster *et al*. (2002: 35) concluded that problematic drug use amongst Black and minority ethnic communities "may be seen as a way of escaping painful experiences associated with disadvantage and marginalisation". The use of khat among the Somali community in Ireland is particularly concerning as they might be facing similar problems to those in Britain where Bashford *et al*. (2003: 23) attributed their khat use to the "cultural dislocation within the Somali refugee community and racism within the wider community, which may lead individuals to seek khat as a refuge either as an escape or as a means of boosting self-esteem". Experiences of war, torture and trauma were also cited as reasons for involvement in drug use. Similar results have been found among recently established communities in England (Bashford *et al*., 2003; Sangster *et al*., 2002).

The results of this study concur with British research (Fountain *et al*., 2003; Khan *et al*., 1998), in that members of new communities in Ireland engage in drug use for similar reasons to Irish drug users. These include peer influence, curiosity, boredom, relationship breakdown and accessibility. Furthermore, younger members of new communities were reported to engage in drug use in order to gain acceptance from, or to "fit in" with their Irish peers. Khan and Ditton (1999) would regard young people's drug use as a coping mechanism to deal with the tensions of being non-Irish in a predominantly Irish society.

These results are consistent with Reid *et al.'s* (2001) research in Australia in that new communities are not at heightened risk of involvement with illicit drugs because of their ethnicity or minority status but because of a range of economic and social disadvantages. Furthermore, these factors render new communities less likely or willing to access drug services and this issue is addressed in the following chapter.

Chapter 7 – Service Provision

7.1 Introduction

This chapter will examine the barriers to seeking help for drug use and discuss ways in which drug services[26] in Ireland could be made more accessible for individuals from new communities.

7.2 Barriers to accessing drug services

The majority of those interviewed (n = 7) reported that they were interested in drug treatment as they felt that their drug use had become problematic. However they cited numerous barriers that prevented them from accessing drug services and these are outlined below.

7.2.1 Lack of knowledge

The most significant barrier to seeking help was the lack of knowledge about existing drug services and what these services have to offer. As one interviewee stated:

> *If somebody is prepared to help me or if there is a place they can help me, I am prepared to go there to see if the place suits me. But I don't know where to go or who I need to talk to. I don't know how to receive any kind of treatment.*
>
> (Kenyan woman, 24 years, snorts cocaine)

Very few of the drug users met during the fieldwork knew about needle exchange programmes and only two interviewees were linked in with a needle exchange programme. Many of the users associated drug treatment with abstinence and were generally unaware of services promoting harm reduction.

Similarly drug users had little knowledge of methadone maintenance programmes, and the information they did have, they obtained from Irish users. Often drug users seemed sceptical about methadone maintenance as they had heard from Irish drug users that methadone was as addictive as heroin:

> *He* [Somali male, smoking heroin] *said he wasn't interested in methadone as it is as addictive as heroin but he would be interested in a detox.*
>
> (Fieldworker 3, 27th February, 2003)

> Interviewer: What kind of drug services would you like?
> *I would like help. I would like methadone although some of my friends were saying methadone is more addictive than heroin. I don't know if it is true.*
>
> (Somali male, 30 years, smokes heroin)

> *I'm afraid about the side effects of methadone. I heard it is bad for men, it makes you impotent. I heard this somewhere. I'm scared that it is also addictive.*
>
> (Moldovan male, 30 years, injects heroin)

This respondent went on to explain that people are unaware of methadone maintenance as similar services are not available in their countries of origin:

> *I didn't know about the methadone programme because in the Republic of Moldova there is nothing like that and I never heard of such a thing. Here in* [a needle exchange] *I heard about it and later on the street I heard people talk about it.*
>
> (Moldovan male, 30 years, injects heroin)

One respondent pointed out that some users fear contacting drug services in case they would have to enroll in a rehabilitation programme.

26 This includes the whole range of drug services offered in Ireland from low threshold (outreach and needle exchange) to methadone maintenance, detox and rehabilitation.

People are afraid of being forced into rehabilitation programmes. They don't know about the legal part here.

(Focus group 2 – individual working with new communities)

7.2.2 Language barriers

Lack of knowledge is often related to language difficulties as promotional material on drug services is not available in someone's preferred language (Reid *et al*., 2001). The following quotes illustrate that language difficulties are a significant barrier for new communities in accessing drug services.

I asked him [Moldovan male, injects heroin] *if he knew about drug services and he replied he didn't know exactly what kind of services they are providing, because his English was very poor.*

(Fieldworker 2, 14th February, 2003)

I don't know but there is not much information about it. I've seen lots of leaflets about drug treatment services at the health centres. But all of them are in English. I can speak and read English but some people can't speak English.

(Ukrainian male, 25 years, injects heroin)

During the focus group with service providers, it was highlighted that language barriers also posed a problem for staff in drug services.

That would be a big thing when a client who is a non-national comes into a service. It is quite hard when you are trying to converse with somebody and get information of any description if you don't have somebody who can speak the language or even a common language.

(Focus Group 1 – drug service provider)

7.2.3 Waiting lists

Long waiting lists also acted as a deterrent in accessing drug services, especially in relation to methadone maintenance programmes.

He was told that he had to wait one year to get on a programme which discouraged him.

(Fieldworker 3, 22nd February, 2003)

When I came to the country I went to [a drugs service] *for help and they told me it would take three years before they could help me.*

(Georgian male, 44 years, injects heroin)

7.2.4 Bureaucracy

Drug users from new communities were also discouraged from accessing drug services, in particular methadone programmes, because of the assessment procedure (i.e. urinalysis; referral procedure etc.)

He complained about methadone treatment. He said that his doctor told him that he needed someone to recommend him to a clinic or alternatively he could go with his project worker.

(Fieldworker 3, 12th May, 2003)

Some of them want methadone very, very quickly and are not prepared to go through the normal way of giving urines. I don't know whether that reflects what was happening in their home countries or whether they were nervous about what happens with the results.

(Focus group 1 – drug service provider)

The frustration with the Irish system was summed up by the following interviewee:

Their system is very slow and very bureaucratic.

(Ukrainian male, 25 years, injects heroin)

Even though many of the drug users met were deterred by the bureaucracy of the Irish system, there were reports of African Caribbeans, Romanians, Russians, Georgians and Somalis on different methadone maintenance programmes in Dublin.

7.2.5 Group work

Group work usually plays an integral part in drug treatment in Ireland. This therapy was seen to alienate drug users from new communities as they feel uncomfortable attending groups where the majority of participants are Irish.

> *One woman was very keen on going to a support group or something like this. She was trying to find somewhere to go and she found a group and she came in. In this particular case it was all Irish women with a drug-using background. She didn't want to go in and talk about personal issues in front of them* [...] *If there are complex issues such as drug use or domestic violence they cannot join in the support groups that are there for the Irish people because they don't fit in and they are scared because in Africa if you told somebody something it would be just kept in the community and would not go to a bad person but I am not sure if that is what they are dealing with here.*
>
> (Focus group 2 – individual working with new communities)

7.2.6 Stigma

Many of the interviewees in this study did not want to admit to a drugs worker that they were drug users as they were ashamed of their drug use and were concerned about being stigmatised as a drug user.

> *I don't trust anybody because I am afraid of the stigma that I am a drug user in a foreign country.*
>
> (Kenyan female, 24 years, snorts cocaine)

> *They* [other drug users] *are also ashamed and worried people will judge them. That's what I think.*
>
> (Moldovan male, 30 years, injects heroin)

> *If you are a member of a new community you are already stigmatised by being here whether you are from Romania or from Africa. Now if you come up with a drug problem then it's like they brought AIDS to Ireland now they are bringing drugs. So the best thing is to stay in the house – keep yourself isolated.*
>
> (Focus group 1 – individual working with new communities)

Stigma, and the fear of losing his social welfare, also prevented the following interviewee from enrolling in a detox programme:

> *When I asked him* [Moldovan male, injects heroin] *if he would like to go to a detox clinic, he said that he wouldn't, because he was afraid that he's going to lose his Social Welfare money and his friends might wonder where he was.*
>
> (Fieldworker 2, 14th February, 2003)

7.2.7 Confidentiality

Fear of breaches of confidentiality was identified as a serious barrier in the present study. Many respondents reported that they distrusted drug agencies and were doubtful about the confidentiality of information kept on clients. Furthermore, many of them were worried that drug services had connections with the Department of Justice or the Gardai. Therefore drug users were often scared of the consequences of contacting drug services in case they lost their work permits or failed their asylum process:

> *I don't believe and don't trust their confidentiality and anonymity. I think it's only words not reality.*
>
> (Ukrainian male, 25 years, injects heroin)

> *I am scared if I speak to somebody they might call the police or arrest my boyfriend you know.*
>
> (Kenyan woman, 24 years, snorts cocaine)

> *I am worried about confidentiality. As an asylum seeker you know, you don't have any rights, no freedom to live, you know, so I am a bit worried for people to know what I am doing and what I am up to as a drug user. Sometimes I find it hard to trust because I am afraid of maybe saying something and then seeing it on the television or reading it in the newspapers. That's why I am a bit worried.*
>
> (25-year-old male from Republic of Niger, snorts cocaine)

7.2.8 Racism[27]

Several interviewees in this study were also concerned that they would encounter racism if they accessed drug services, either from the clients and/or workers.

> *I would go* [to a drugs service] *if you think they would help me. Many of my friends complain that you don't get help through these Irish people because they are racist and don't like Black people.*
>
> (Somali male, 30 years, smokes heroin)

> *It is so difficult to ask for help if you are a normal person. I think it is more difficult if you are a drug user and mostly Irish people are nationalists and racists and I don't believe they can overcome it even doing their job.*
>
> (Lithuanian male, 34 years, injects heroin)

There is a possibility that potential clients from new communities could encounter racism from other clients in drug services as the fieldworkers did during the research:

> *From there we went to A&E at a local hospital. We saw some drug users waiting for treatment. We tried to talk to them and they ignored us. One shouted at us with verbal assaults saying "fuck you, fuckin' refugee". We left.*
>
> (Fieldworker 3, 19th April, 2003)

7.2.9 Suspicious of help

Often drug users from new communities, in particular Russians and Georgians, were suspicious of offers of help from drug services and did not believe that drug workers were going to help them.

> Interviewer: Why do you think people from the former U.S.S.R. don't attend drug services?
> *I think they don't believe that somebody is going to help them.*
>
> (Lithuanian male, 34 years, injects heroin)

> *In his opinion* [Russian shopkeeper], *they* [drug users] *don't attend our services because they are scared. In the former U.S.S.R. it is a crime to use drugs. People do it illegally. They don't believe somebody is going to help them.*
>
> (Fieldworker 1, 3rd February, 2003)

7.2.10 Unsuitable services

All the barriers outlined above refer to the current provision of drug services in Ireland. Another significant barrier, however, is that services are basically inappropriate for many drug users from new communities. Drug services in Ireland developed in the late 1980s mainly as a response to the emergence of HIV and AIDS. As a result the focus of drug service provision is on injecting opiate use. However many of the drug users from new communities smoked heroin, smoked cocaine and snorted cocaine.

> *Respondent 1: If they are not using heroin, if they are smoking cocaine or snorting cocaine or using crack, hash or alcohol, they are not going to come into a needle exchange. Culturally, it seems in Ireland everything seems to be injected.*
> *Respondent 2: There are people who smoke heroin who would never think of going to services. Why, there is nothing for them.*
> *Respondent 1: If they see us as a needle exchange and they don't inject they are not going to come here.*
>
> (Focus group 1 – drug service providers)

7.2.11 Self-sufficiency

Several of the interviewees in this study reported that they did not want help and would be able to deal with their drug problem themselves.

27 There are many forms of racism. In generic terms it is broadly defined as "any beliefs or practices which attribute negative characteristics of any group of persons either intentionally or unintentionally on the basis of supposed "race" or ethnicity, within the context of differential relations of power" (Fanning *et al.,* 2000: 18).

Interviewer: But are you interested in drug treatment?
No, I am not. I can stop when I want.

(Lithuanian male, 34 years, injects heroin)

I am not really interested in drug treatment at the moment. It seems to me that I can give up drugs myself without help.
(Ukrainian male, 25 years, injects heroin).

I can come off drugs on my own. I am lucky because I am very strong and determined. I don't want to go and receive treatment [...] *I think it is all about willpower and determination because if you say to yourself I don't want to use drugs you won't.*

(Nigerian male, 36 years, smokes cocaine)

7.2.12 Ethnic monitoring

Drug service providers highlighted during the focus groups that it was difficult to plan a strategy around services for drug users from new communities because there was sparse information on the nature and extent of the problem.

We don't have that many and we don't even have statistics on how many we have.

(Focus group 1 – drug service provider)

7.3 Service development

This final section presents the findings from the in-depth interviews, focus groups and informal conversations on how drug services could be made more accessible for drug users from new communities.

7.3.1 Outreach

It is clear from the above results that drug users from new communities are not going to access drug services for a range of different reasons. Therefore, drug service providers proposed that they should go out on the streets to meet these drug users, in their own social milieu.

Outreach is the best way to meet them. If they know there is a needle exchange programme there, they will come. We are able to talk to people much easier. It is different on the streets from having to sit and wait. On the streets it is a whole different thing [...] *On the streets you are on their territory – you are very much out there and it is a good way for clients to build up a rapport with you. It is relatively safe for them* [...] *I think you have to bring the service to the client rather than expect them to try and come to you. It is very important.*

(Focus group 1 – drug service provider)

Drug service providers felt that the most effective type of outreach work would be peer outreach where influential drug users from new communities and the Irish drug scene would be recruited to contact hidden groups of drug users.

Respondent 2: I think peer outreach would be much better. I think our role would be to train the peers outside. It is completely by chance that we have come across people even though we have actively started to go into areas where we thought they might be. I think it is a whole different ball game if you have peers doing it.
Interviewer: What do you mean by peers?
Respondent 2: People from that community who speak the language, people who know about the culture or whatever. It would make a big difference – we could do training and support the people who would do this.
Respondent 3: Even failing that – peers could be fellow drug users even if they were Irish they would have a better chance as they are running in the same circles. Ideally, it would be great if they were non-national drug users themselves.

(Focus group 2 – drug service providers)

7.3.2 Specialist services?

There was much discussion during the fieldwork on whether specialist services or generic drug services are the most appropriate way of providing drug services to new communities. Generally specialist services were considered impractical given the range of new communities living in Ireland. Key informants wondered which communities, which languages, which religions would specialist services target?

> *Would you separate the Romas, from the Georgians, and from the Nigerians? I think that is where the difficulties would arise.*
>
> (Focus group 1 – drug service provider)

While there was much discussion in the focus groups around this topic, specialist services were generally considered unrealistic although it was pointed out that generic services needed to be made more flexible and responsive.

> *The system that is set up at the moment is just not flexible. It's not flexible for travellers. If the system we have is not capable of dealing with our own ethnic minority – how can we stretch it to deal with Africans, Chinese and East Europeans?*
>
> (Focus group 1 – drug service provider)

As well as being unfeasible, individuals were also concerned that specialist drug services would encourage more racism.

> *I would be more inclined not to have specialist services because for example if you have a specialist team for Nigerian people it intensifies feelings of racism – the drug problem is* [seen to be] *located in the Nigerian community.*
>
> (Focus group 1 – drug service provider)

7.3.3 Recruiting staff from new communities

While none of the drug users from new communities showed a preference for specialist services, several of them stated that services would be more accessible if there were workers from new communities. Interestingly none of the interviewees claimed that they would feel shame if confronted by a worker with a shared cultural understanding. Instead, they explained that they would be able to build rapport better with someone who understood their situation and the presence of staff from new communities would also address language barriers and cultural differences.

> *It* [drug service] *doesn't have to be separate for the Black community. it can be any community but it would be good if Black people got involved in this. I'd like to see Black people around as it gives me lots of hope.*
>
> (25-year-old male from Republic of Niger, smokes cocaine)

> *I think it is really hard for Irish people to understand us and what we've been through and I don't really want to explain to them. I would feel more comfortable with people around me who can honestly relate to me. That's why they should hire people who can speak my language. I mean non-nationals themselves. That's what I need. A place where you can come and have a cup of tea and chat to someone in your own language. Sometimes you need some information or advice and need people who won't ask questions and teach you how to live and what to do. I am just wondering why there are so many organisations supposedly helping non-nationals but there are no non-nationals working there. Only people who know what it's like to be a non-national can do this job really well.*
>
> (Lithuanian male, 34 years, injects heroin)

However, several respondents said that they would deal with any worker who related to and understood their problems in a non-judgmental way, as explained by the following interviewee:

> *I will talk with anybody who is prepared to listen to me and to help me. Anybody. I don't care who it is whether it is a white or black person, Irish, Scottish or African. I don't care. As long as the person is prepared to help me fine.*
>
> (Kenyan woman, 24 years, snorts cocaine)

7.3.4 Drug awareness training

Many individuals from new communities appeared very keen to participate in such training given their lack of knowledge in relation to drugs and their effects.

> *Respondent 1: Most community groups and service providers are not trained in relation to this issue. They have no idea even how to define this issue. Maybe one of first needs to be addressed is an induction or introduction which equips us with the tools to deal with this.*
> *Respondent 2: So it's probably a question of training people well who can relate to people from different communities.*
>
> (Focus group 2 – individuals working with new communities)

> *I went to an English school and spoke to some teachers. I asked them their opinion of drug use among ethnic minorities. They were teaching people mostly from Africa. There were also some others from the former USSR, Moldova, Ukraine, Baltic countries, Turkmenistan (Russians)* [...] *They think that all of them need support and information around drug use.*
>
> (Fieldworker 1, 12th March, 2003)

7.3.5 Symbols of accessibility

During the fieldwork it was deemed important that information advertising services, especially the confidentiality of services, is distributed to drug users who are not accessing services. Leaflets that were translated into Romanian and Russian for the purpose of this research were successful in reaching drug users not in contact with services as illustrated by the following extract:

> *In the evening my phone rang. The person said that he saw our leaflets. He was asking about MQI, the address and how to find it. I explained and gave him the address. He saw the leaflet in a shop. He was interested in the needle exchange.*
>
> (Fieldworker 1, 9th May, 2003)

7.3.6 Help-line

Drug help-lines are another means of addressing stigma and confidentiality. One of the interviewees proposed that a help-line be set up for non-nationals.

> *I don't really know but I've seen somewhere the phone number of a helpline for drug users which might be to do with something like this one for non-nationals. People could call and get information they need in their native language.*
>
> (Ukrainian male, 25 years, injects heroin)

7.3.7 More appropriate services

This research has shown that drug use among new communities in Ireland is not homogeneous. There are different patterns and levels of drug use. Different communities are injecting heroin, smoking heroin, smoking cocaine and snorting cocaine. If drug services from Ireland continue to focus on injecting opiate use the needs of drug users from new communities will be marginalised. Therefore, it was suggested during the focus groups that drug services should be set up to target stimulant users.

> *Maybe we should start with holistic stuff like relaxation, massage and acupuncture, things like that* [...] *We say there is nothing you can do for people on cocaine but in fact there is a lot you can do. It is just that all our interventions in the past have been for heroin use.*
>
> (Focus group 1 – drug service provider)

As well as holistic interventions, a one-to-one approach was considered the most appropriate method of dealing with drug users from new communities.

I am not expecting any treatment the only thing I am expecting is to talk to somebody. Sometimes talking to somebody will help you and reduce your stress.

(25-year-old male from Republic of Niger, smokes cocaine)

I think the best approach to the whole issue of confidentiality would be one-to-one, you know. I know it is difficult when you don't have enough staff but I think that would be the best and from there you would build their trust and then ask them then, what they would like.

(Focus group 2 – individual working with new communities)

7.4 Summary

The majority of those interviewed (n = 7) reported that they were interested in drug treatment. However the respondents cited numerous barriers which prevented them from accessing drug services. Consistent with international research (Butt, 1992; Patel, 2000; Reid *et al*., 2001), the most significant barrier to seeking help for drug use was the lack of knowledge of existing services and what these services had to offer. Many of the users associated drug treatment with abstinence and were generally unaware of services promoting harm reduction. The poor uptake of needle exchange programmes is a cause for concern as those not in contact with needle exchanges are more likely to be involved in risky behaviour. Lack of knowledge was related to language difficulties and similar to research carried out in Australia (Reid *et al*., 2001) respondents reported being unable to access information in their own language.

Many drug users from new communities did not want to admit to a drugs workers that they were drug users as they were concerned about being stigmatised as a drug user and they were afraid of breaches of confidentiality. In Britain, Sangster *et al*. (2002) noted that the shame associated with drug use is often grounded in a range of religious and cultural influences and drug services have been criticised for failing to develop practices to address these feelings. These criticisms have "focused on issues of trust and confidentiality which, are seen to be particularly, although not exclusively important in relation to Black and minority ethnic communities" (Sangster *et al*., 2002: 23). As a result, similar to findings in Britain (Awiah *et al*., 1992; Fountain *et al*., 2003), Black and minority ethnic groups in Ireland seem to be depending on self-sufficiency rather than approaching drug services for help.

Several respondents were also concerned that they would encounter racism if they accessed drug services. Similarly, in Britain, drug users reported that they did not use drug services because they anticipated and/or experienced racism (Awiah *et al*., 1992; Khan and Ditton, 1998; Pererea *et al*., 1993). These fears of encountering racism are reasonable as many immigrants in Ireland, especially refugees and asylum seekers, have experienced some form of racism (Fanning *et al*., 2000). For instance, in a survey of 622 individuals from Black and minority ethnic groups in Ireland, 78% reported that they had experienced racism (FAQS Research, 2001).

Outreach work, in particular peer outreach, was deemed the most appropriate way of contacting drug users from new communities. Conversely, specialist drug services, targeted at Black and minority ethnic groups were considered impractical and unrealistic and drug service providers were concerned that this would encourage racism. The advantages of specialist drug service are that there is cultural ownership and an understanding of cultural needs. However, they are often expensive, impractical and have limited opportunities for sharing expertise (Sangster *et al*., 2002). Similarly in Scotland, Khan and Ditton (1998) found that "dedicated ethnic minority services [...] could be seen as shaming the general ethnic minority community" (7).

Several drug users from new communities stated that drug services would become more accessible if there were workers from new communities. While this issue should be addressed, drug services need to be attentive to the fact that it is not seen as a "quick fix" type of response in that agencies recruit staff from new communities in order to feel safe against any allegations of racist practice. Secondly drug services need to be wary that it does not lead to the "ghettoising" of the ethnic worker in that if a non-national accesses a service that client is "automatically ushered in the direction of the ethnic worker" (Coomber, 1992: 12-13). Furthermore, a client may not necessarily want to see a worker from their own ethnic background (Sangster *et al*., 2002). The recruitment of workers from new communities is most successful if it is grounded in broader issues relating to cultural competence and diversity (Sangster *et al*., 2002). However, several respondents claimed that they would deal with any worker who related to and understood their problems in a non-judgmental way. This

emphasises the need for anti-racist training in drug services for staff and clients as this would enable them to become more aware of issues surrounding race and ethnicity.

Furthermore, given the lack of knowledge among new communities in relation to drugs and their effects, there is a need for drug awareness training targeted at new communities. According, to Fountain *et al*. (2003: 5) "cultural appropriateness – including community consultation and drug awareness training – is at the centre of policy and planning initiatives to provide drug services to Black and minority ethnic groups". Drug awareness training carried out with new communities should provide capacity building benefits so that communities can recruit, train and support members from the community to address the drugs issue in their own communities (Sheikh, 2001).

During the fieldwork, it was deemed important that information advertising drug services is distributed to drug users who are not accessing services. Sangster *et al*., (2002: 26) feel that symbols of accessibility (i.e. posters, leaflets, culturally-specific newspapers and magazines) are important for communicating "the message that an agency is there to meet the needs of a diverse community".

Finally it was suggested that for drug services to become more appropriate they need to target stimulant users. Services which have a stimulant focus or generic services which act directly with stimulant users are more likely to increase the number of clients presenting for treatment. In these services, preference should be given to holistic therapies, such as acupuncture, and therapeutic interventions which are considered more culturally appropriate for drug users from new communities (Sangster *et al*., 2002). Furthermore, a one-to-one approach, rather than group work and counselling was seen to be more appropriate for drug users from new communities. This is because many Black and minority ethnic groups do not have a tradition of counselling or therapy outside family structure and friendship networks (Sangster *et al*., 2002). Sangster *et al*. (2002: 31) emphasise that these approaches should be centred "on notions of culture and cultural differences and focused on identity, intergenerational working and religion".

Some of the barriers cited above could be attributed to cultural influences such as shame, apprehension of residential treatment, aversion to group work and fear of breaches of confidentiality. Other barriers are more specific to the situation of new communities in Ireland including racism, language difficulties and the lack of knowledge of existing services. Several barriers cited in this research are significant for all drug users, regardless of culture or ethnicity. These include problems with waiting lists for methadone maintenance and the bureaucracy of the Irish system. Furthermore the focus of drug services on injecting opiate use not only affects drug users from new communities but also Irish drug users who smoke their drug of choice or use cocaine.

The numerous barriers that prevent drug users from new communities from accessing drug services in Ireland are a challenge to these services to implement equality policies. Currently Irish drug services, wittingly or unwittingly, may be guilty of institutional racism[28] and are not effectively meeting the needs of drug users from new communities.

28 Institutional racism can be defined as "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwilling prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people" (McPherson Report, 1999 – quoted in Fanning *et al.,* 2000).

Chapter 8 – Recommendations

The following is a list of recommendations based on the results of the research and international best practice guidelines. The existence of problematic drug use among drug users from new communities means that drug services in Ireland must now work within an intercultural remit. Therefore the nature and shape of their work needs to change. It is hoped that these recommendations will assist drug services to respond to the needs of this client group. Similar action research projects carried out in Britain successfully and dramatically increased the numbers of Black and minority ethnic users accessing drug services from a handful a year to several hundred (Patel, 2000). If these recommendations are taken on board, drug services should become more accessible to drug users from new communities and respond better to their needs. It is also expected that this project will encourage liaison between community groups representing new communities and drug agency representatives.

8.1 Developing drug services

The following are a list of recommendations on drug service development. It is advised, however, that drug services do not develop in an *ad hoc* manner to meet the needs of new communities (Fountain *et al*., 2003; Patel, 2000). Instead service development needs to be undertaken as part of a well-planned and well thought out long-term strategy (SDF, 1999).

- **Drug services need to produce culturally-sensitive material in different languages, including English.**
  Drug users from new communities were generally unaware of drug service provision in Ireland, and were suspicious of the confidentiality of information held. Any material produced needs to highlight the range of services provided in Ireland and their confidential nature. This information should be translated into appropriate languages and distributed in places where drug users are likely to frequent.

- **Images and posters should be displayed in drug services which promote diversity.**
  It is important to create an ethos of welcome within drug services (SDF, 1999). This can be done by displaying images and posters which promote diversity and clearly show that an agency is there to meet the needs of a wide range of users (Sangster *et al*., 2002).

  While raising awareness of drug services is important, the main emphasis should be on providing accessible and culturally appropriate services (Coomber, 1992). In this regard drug services should work towards implementing the following recommendations.

- **A drugs outreach team should be set up in Dublin specifically targeting drug users from new communities.**
  Many drug users from new communities often remain hidden from drug services and are particularly difficult to reach. Therefore outreach work would be the most effective way of targeting these groups. According to Butt (1992) this work should not only involve contacting drug users but should also target community-based organisations to win the trust of local communities.

- **Any outreach work should use peer-based approaches.**
  Peer based approaches to outreach are most appropriate when groups are particularly difficult to reach (Rhodes, 1997), as is the case here. Therefore, any outreach team should incorporate a peer element and recruit drug users from new communities who would be in a position to contact hidden groups of drug users and distribute information in their social networks.

- **Outreach teams and peer workers should target female drug users from new communities at general health, maternity and health promotion agencies.**
  Female drug users from new communities remained particularly hidden as during the 280 hours of fieldwork, only a handful of female drug users were met. Drug use is increasingly being reported amongst young Black and minority ethnic women in England (Fountain *et al*., 2003; Sangster *et al*., 2002). Therefore there may be a possibility of it increasing in Ireland. Health services are the most appropriate place to target female drug users from new communities as they are more likely to use these types of services (Fountain *et al*., 2003).

- **Drug services should be set up specifically targeting stimulant users.**
  This research has shown that there are different patterns and levels of drug use among new communities in Ireland. Different communities are injecting heroin, smoking heroin, smoking cocaine and snorting cocaine. Therefore there is a need for drug services to break away from their focus on injecting heroin use and begin to address cocaine/crack use as well as khat which may become problematic for members of the Somali community.[29] Therapeutic interventions in such services should be culturally appropriate and focus on holistic therapies (such as acupuncture) and give preference to one-to-one support over group work and counselling.

- **Drug help-lines in Ireland should advertise their services in several languages.**
  Given the fears around breaches of confidentiality and stigma, members of new communities may be more likely to use drug help-lines. Patel (2000) found that this also helps to raise awareness of drug-related issues and allows discussion amongst the wider community.

- **Information on drug services should be posted in different languages on websites in Ireland.**
  Many drug users in this study were met in Internet cafes. Therefore information could be posted on websites such as Merchants Quay Ireland's website – www.mqi.ie. These could be based on some of the better drug-related websites in Britain which are targeted at Black and minority ethnic groups, such as www.adibop.co.uk (drugs information targeted at Asian communities), www.orexis.co.uk (website of a voluntary organisation in London which offers a multi-cultural approach to service provision) and www.nafas.org (targeted at the Muslim and Bangladeshi communities).

- **Drug services should recruit staff from new communities.**
  According to Fanning (2003) promoting employment among new communities is necessary to address social exclusion among these groups. This would also address cultural barriers and communication difficulties as staff would be able to translate and interpret relevant information. This would also enhance the cultural competence of Irish workers (Sangster *et al*., 2002). However an ethnic worker should not solely be responsible for clients from new communities as this creates a ghetto mentality. Programmes could be piloted similar to the 2-year apprenticeship pilot for Black and minority ethnic trainees developed in Britain by the Community Justice National Training Organisation (CJNTO) in partnership with the National Treatment Agency (NTA) and with the support from the Federation of Black and Asian Drug and Alcohol Workers.[30]

- **Anti-racist training must be provided for staff and clients in drug services.**
  Given the fears drug users from new communities have in encountering racism in drug services, anti-racist training should be provided to staff and clients to enable them to become more aware of issues surrounding race and ethnicity. This would also enable the staff to be better prepared and better trained when carrying out interventions with clients from new communities. This is crucial to the delivery of drug services as research has found that when interventions are sensitive to cultural issues utilisation of services increases dramatically (Reid *et al*., 2001).

- **Young people from new communities need to be targeted through drug prevention programmes.**
  Given the concern that second generations of new communities will become exposed to drug use, there is a need for culturally appropriate drug prevention programmes to equip young people from new communities with the skills to make informed choices in relation to drug use. Young people need to be targeted through schools and youth clubs while drug-specific interventions should be linked to employment, education and training initiatives for those outside mainstream education.

29 While heroin is still the dominant drug of choice among attendees at low threshold services in Dublin, cocaine and crack use are becoming more popular (Corr and Lawless, 2003). Therefore any development in services targeted at stimulant users will also benefit Irish clients.

30 The apprenticeship pilots are planned to last over a period of 2 years offering the potential for progression into higher education and a key skills programme. The programme is aimed at trainees in substance misuse treatment, aged 20 – 23 years on commencement, from Black and minority backgrounds. For more information see www.nta.nhs.uk/programme/workapprentice.htm.

- **There is a need to raise awareness about drugs and drug services among new communities by providing culturally-specific drug awareness training.**
  As this research found a lack of knowledge among new communities in relation to drugs and their effects, drug awareness training needs to be provided to these groups. This would also ensure that this research is not guilty of "parachuting" into a community and undertaking the research, without offering anything in return (Patel, 2000). Drug awareness training needs to be targeted at all members of new communities including young people, parents and local community groups.

- **Community engagement should be promoted in the design and delivery of drug services in Ireland.**
  In their review of drug service provision for Black and minority ethnic communities in England, Fountain *et al*. (2003) found that the most significant way forward in terms of drug service development was community engagement. This also leads to "cultural ownership and leadership" within drug services (Sangster *et al*., 2002). People representing new communities should be included in the decision-making process of drug agencies, such as management committees, as well as on local drugs task forces, especially in areas where many immigrants are accommodated.

- **Drug services and the National Drug Treatment Reporting System (NDTRS) of the Health Research Board should introduce ethnic monitoring.**
  Ethnic monitoring is a useful way to measure up-take of services among new communities. This would enable drug services to monitor if their services are accessible for all drug users and would help them observe changes in drug-using patterns among different groups. However, Khan (1999) points out that it is important to use these results in the context of the whole dataset in order to avoid negative stereotyping of Black and minority ethnic drug users.

8.2 Policy development

- **The National Drug Strategy needs to set specific targets in relation to developing drug services for individuals from new communities.**
  These specific targets should be added to the National Drug Strategy's 100 action plans.

- **Anti-poverty polices in Ireland need to address social exclusion among members of new communities.**
  The exclusion of drug users from new communities from drug services is just one example of how they are excluded from Irish society. Other areas of exclusion highlighted in this research include housing and employment. Research carried out in Ireland on new communities has also emphasised training, education and social welfare as other areas of social exclusion (Fanning, 2003). These areas need to be addressed in anti-poverty polices so that the cycle of disadvantage, social exclusion and associated problematic drug use is broken for new communities in Ireland. While the revised National Anti-Poverty Strategy, *Building an Inclusive Society* (2002) addressed poverty among migrants and Black and minority ethnic groups for the first time, "specific targets relating to the goal of ensuring that migrants and ethnic minorities do not face a disproportionate risk of poverty have yet to be set" (Fanning, 2003: 20).

8.3 Further research

- **Further research is needed on the nature and extent of drug use amongst Ireland's new communities.**
  More research and information will assist drug services in becoming more responsive to the needs of drug users from new communities

- **Evaluations of drug services should be on-going to assess that the barriers to drug services for users from new communities are dismantled and prevent further barriers being erected.**

- **More in-depth research should be carried out on the link between ethnicity, social exclusion and drug use.**
  The main aim of this research was to identify barriers to accessing drug services. However, a significant finding was the link between the economic and social situation of new communities and problematic drug use. Therefore there is a need for more information in this area.

Bibliography

Ana Liffey Project. 2001. *Drug Services and Non-European Nationals: A Brief Survey.* Unpublished.

Andersen, M.L. 1993. "Studying across Difference: Race, Class and Gender in Qualitative Research" in Stanfield, J.H. and Dennis, R.M. (eds.) 1993. *Race and Ethnicity in Research Methods.* California: Sage Publications.

Awiah, J., Butt, S. and Dorn, N. 1992. *Race, Gender and Drug Services.* London: Institute for the Study of Drug Dependence.

Babbie, E. 1998. *The Practice of Social Research.* America: Wadsworth Publishing Company.

Bashford, J., Buffin, J. and Patel, K. 2003. *Community Engagement: Report 2: The Findings.* England: Centre for Ethnicity and Health and supported by the Department of Health.

Butt, S. 1992. "Asian Males and Access to Drug Services in Bradford" in Awiah, J., Butt, S. and Dorn, N. 1992. *Race, Gender and Drug Services.* London: Institute for the Study of Drug Dependence.

Coomber, R. 1992. "Agency Change and Orientation: Accessing the Non-White Drug User" in Adebowale, V., Cochrane, R., Ranger, C. and Coomber, R. 1992. *Substance Misuse and Ethnic Minorities: An Agenda for Change.* Northampton: Can Press.

Corr, C. and Lawless, M. 2003. *Patterns of Cocaine Use among 100 Attendees at a Low Threshold Service in Dublin.* Unpublished: Funded by the National Advisory Committee on Drugs.

Coveney, E., Murphy-Lawless, J., Redmond., D. and Sheridan, S. 1999. *Prevalence, Profiles and Policy: A Case Study of Drug Use in North-Inner City Dublin.* Dublin: North Inner City Drugs Task Force.

Cox, G. and Lawless, M. 1999. *Wherever I lay my hat... A Study of Out-of-home Drug Users.* Dublin: Merchants Quay Project.

Cox, G. and Lawless, M. 2000. *Making Contact: Evaluation of a Syringe Exchange Programme.* Dublin: Merchants Quay Project.

Cullen, P. 2000. *Refugees and Asylum-seekers in Ireland.* Cork: Cork University Press.

Daniel, T. 1992. *Drug Agencies, Ethnic Monitoring and Problem Drugs Users. Executive Summary, No.16.* London: The Centre for Research on Drugs and Health Behaviour.

Daniel, T. 1993. "Ethnic Minorities' Use of Drug Services" in *Druglink:* 8: 1: 16-17.

Denis, R.M. 1993. "Participant Observation" in Stanfield, J.H. and Dennis, R.M. (eds.) 1993. *Race and Ethnicity in Research Methods.* California: Sage Publications.

Department of Tourism, Sport and Recreation. 2001. *Building on Experience: National Drugs Strategy 2001-2008.* Dublin: Stationery Office.

Dillon, L. 2001. *Drug Use among Prisoners: An Exploratory Study.* Dublin: The Health Research Board.

Drug Policy Alliance. (DPA). 2002. "Race and the Drug War". *http://drugpolicy.org*.

Education Development Centre. (EDC). 2001. *Racial and Ethnic Differences in Alcohol and Other Drug Use.* USA: US Department of Education.

EMCDDA. 2000. *Mapping Available Information on Social Exclusion and Drugs, Focusing on "Minorities" Across 15 EU Member States.* EMCDDA Scientific Report.

Facio, E. 1993. "Ethnography as Personal Experience" in Stanfield, J.H. and Dennis, R.M. (eds.) 1993. *Race and Ethnicity in Research Methods.* California: Sage Publications.

Fanning, B. 2003. "Social Inclusion and Immigration: Migrants and Ethnic Minorities within the Revised Anti-Poverty Strategy (2002)". Presented at Irish Social Policy Association *Changing Social Policies* Annual Conference, 5 September, 2003, www.ispa.ie.

Fanning, B., Loyal, S., and Staunton, C. 2000. *Asylum Seekers and the Right to Work in Ireland.* Dublin: Irish Refugee Council.

FAQs Research, in association with Loyal, S. and Mulcahy, A. 2001. *Racism in Ireland: The Views of Black and Ethnic Minorities.* Dublin: Amnesty International (Irish Section) with the support of Public Communications Centre.

Feldman, A., Frese, C. and Yousif, T. 2002. *Research, Development and Critical Interculturalism: A Study on the Participation of Refugees and Asylum Seekers in Research and Development-Based Initiatives.* Dublin: Social Science Research Programme, UCD.

Fielding, N. 1993. "Ethnography" in N. Gilbert. (ed.) *Researching Social Life.* London: Sage Publications.

Fountain, J. (ed.) 2004. *Young Refugees and Asylum Seekers in Greater London: Vulnerability to Problematic Drug Use.* London: Greater London Authority.

Fountain, J., Bashford, J. and Winters, M. 2003. *Black and Minority Ethnic Communities in England: A Review of the Literature on Drug Use and Related Service Provision.* London: The National Treatment Agency for Substance Misuse and the Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

Fountain, J., Bashford, J., Underwood, S., Khurana, J., Winters, M., Patel, K. and Carpentier, C. 2002. *EMCDDA Scientific Report: Update and Complete the Analysis of Drug Use, Consequences and Correlates Amongst Minorities.* Lisbon: EMCDDA.

Government of Ireland. 2002. *Building an Inclusive Society: Review of the National Anti-Poverty Strategy.* Dublin: Official Publications.

Great Britain, Cabinet Office. 1998. *Tackling Drugs to Build a Better Britain: The Government's 10-Year Strategy for Tackling Drug Misuse.* London: Stationery Office.

Hammersley, M. 1990. *Reading Ethnographic Research: A Critical Guide.* London: Longmans.

Hammersley, M. 1992. *What's Wrong with Ethnography? Methodological Explorations.* London: Routledge.

Hay, G., Kohli, H. and McKeganey, N. 2001. *Drug and Alcohol Issues affecting Black and Minority Ethnic Communities: Literature Review.* Glasgow: Centre for Drug Misuse Research and Department of Public Health.

Hornsby-Smith, M. 1993. "Gaining Access" in N. Gilbert. (ed.) *Researching Social Life.* London: Sage Publications.

Jay, M. 2002. "Legalisation: The First Hundred Years. What happened when drugs were legal and why they were prohibited?" Lecture presented at a conference in London, July 17th 2002, organised by the Institute for Public Policy Research.

Johnson, M. and Cross, M. 1984. *Surveying Service Users in Multi-Racial Areas: The Methodology of the Urban Institution Project.* Research Papers in Ethnic Relations No. 2., Coventry: Centre for Research in Ethnic Relations, University of Warwick.

Johnson, R.A. and Larison, C. 1998. *Prevalence of Substance Use among Racial and Ethnic Subgroups in the United States.* USA: Substance Abuse and Mental Health Services Administration.

Johnson, T., Freels, S. A., Parsons, J.A. and Vangeest, J.B. 1997. "Substance Abuse and Homelessness: Social Selection of Social Adaptation?" *Addiction:* 1997: 92: 4: 437-445.

Khan, F., Ditton, J., Hammersley, R., Philips, S. and Short, E. 1998. *Ethnic Minority Drug Use in Glasgow. Part One: Comparative Attitudes and Behaviour of Young White and Asian Males.* Glasgow: Glasgow Drugs Prevention Team.

Khan, F. and Ditton, J. 1998. *Ethnic Minority Drug Use in Glasgow. Part Two: Special Problems Experienced and Possible Gaps in Service Provision.* Glasgow: Glasgow Drugs Prevention Team.

Khan, F., Ditton, J. and Hammersley, R. 2000. "Ethnic Minority Use of Illegal Drugs in Glasgow, Scotland: Potential Difficulties for Service Provision". *Addiction:* 2000: 8: 1: 27-49.

Korf, D. 2000. "Drug Use among Ethnic Minorities". Paper presented at 11th ESSD conference, Dublin, September 21-23, 2000.

Krueger, R.A. 1994. *Focus Groups: A Practical Guide to Applied Research.* London: Sage Publications.

MacEinri, P. 2001. "Immigration into Ireland: Trends, Policy Responses, Outlook". *http://www.migration.ucc.ie*.

Marlow, A. 1999. "Youths, Minorities, Drugs and Policing: A study of Stop and Search" in Marlow, A. and Pearson, G. 1999. *Young People, Drugs and Community Safety.* London: Russell House Publishing.

May, T. 1997. *Social Research: Issues, Methods and Process.* Buckingham: Open University Press.

Max Planck Institute for Foreign and International Criminal Law. (MPI). 2000. *Illegal Drug Trade in Russia.* Germany: Freiburg.

McNiff, J., Lomax, P. and Whitehead, J. 2003. *You and Your Action Research Project.* Second Edition. London: Routledge.

Meares, T.L. 2001. "Race and Crime (including Ethnicity)" in Smelser, N.J. and Baltes, P. (eds). *2001 International Encyclopedia of the Social & Behavioral Sciences.* Pergamon: Oxford.

Mulligan, C. 2002. "What if Jim Crow sold Drugs? An analysis of Race and Drug Policy in America. Unpublished.

National Advisory Committee on Drugs. (NACD). 2003. *Drug Use in Ireland and Northern Ireland: First Results from the 2002/2003 Drug Prevalence Study.* Dublin: National Advisory Committee on Drugs.

National Treatment Agency (NTA). 2001. *NTA Business Plan, December 2001.* London: NTA.

National Institute on Drug Abuse. (NIDA). 1998. *Drug Abuse among Racial/Ethnic Minorities.* USA: NIDA.

North Inner City Drugs Task Force. (NICDTF). 2002. *Strategic Development Plan 2001.* Dublin: North Inner City Task Force.

O'Brien, M., Kelleher, T., Cahill, P., Kelly, F. and Long, J. 2003. *Occasional Paper No. 9. Trends in Treated Drug Misuse in the Republic of Ireland, 1996-2000.* Dublin: Health Research Board.

Patel, K. 2000. "Using qualitative research to examine the nature of drug use among minority ethnic communities in the UK" in EMCDDA. 2000. *Understanding and Responding to Drug Use: The Role of Qualitative Research.* Belgium: EMCDDA Scientific Monograph Series, No. 4.

Perera, J., Power, R. and Gibson, N. 1993. *Assessing the Needs of Black Drug Users in North Westminster.* Hungerford Drug Project/The Centre for Research and Planning Unit Paper No. 89, Home Office, London.

Prasad, R. 2002. "Bitter Harvest". *The Guardian.* Wednesday, September 4, 2002.

Reid, G., Aitken, C., Beyer, L. and Crofts, N. 2001. "Ethnic Communities' Vulnerability to Involvement with Illicit Drugs". *Drugs: Education, Prevention and Policy:* 8: 4: 359-374.

Rhodes, T. 1997. "How to reach injecting drug users: What models of outreach work are being used? And which are the most effective? *Addiction Counselling World:* 9: 49: 10-12.

Ritter, A.J., Fry, C. L. and Swan, A. 2003. "The Ethics of Reimbursing Injecting Drug Users for Public Health Research Interviews: What price are we prepared to pay? *The International Journal of Drug Policy:* 2003: 14: 1-3.

Rubin, H. and Rubin, R. 1995. *Qualitative Interviewing: The Art of Haring Data.* Thousand Oaks, CA, Sage.

Sangster, D., Shiner, M., Patel, K. and Sheikh, N. 2002. *Delivering Drug Services to Black and Minority Ethnic Communities.* DPAS Paper 16: Public Policy Research Unit, Goldsmiths College, University of London and Ethnicity and Health Unit, University of Central Lancashire.

Schneider, J. 2001. *Drug Treatment and Ethnicity. A Comparative Study in the Metropolitan Areas of Frankfurt, Tel Aviv and San Francisco.* Germany: Psychosozial – Verlag.

Scottish Drugs Forum. (SDF). 1999. *Drug Services and Black and Minority Ethnic Communities in Scotland: Guidance on Positive Action.* Glasgow: Scottish Drugs Forum.

Shaffir, W.B. 1991. "Managing a convincing self-presentation: some personal reflections on entering the field" in W.B. Shaffir and R.A. Stebbins (eds). *Experiencing the Fieldwork: an Inside View of Qualitative Research.* Sage Publications.

Sheikh, N. 2001. "Making Things Equal: Delivering Drug Services to South Asian Communities in the UK". Paper presented at 13th International Conference on the Reduction of Drug Related Harm, Ljubljana, Slovenia, 5th March, 2002

Silverman, D. 2000. *Doing Qualitative Research: A Practical Handbook.* London: Sage.

Singleton, R., Straits, B., Straits, M. and McAllister, R. 1988. *Approaches to Social Research.* Oxford: Oxford University Press.

Singh, G. and Passi, P. 1997. *Drug Use in the South Asian Community.* Lancashire: North West Lancashire Health Promotion Unit.

Soros Foundation Network. (SFN). 2002. *Drug Use & HIV in Eastern Europe and the Former Soviet Union.* www.soros.org.

Stanfield, J.H. 1993. "Methodological Reflections: An Introduction" in Stanfield, J.H. and Dennis, R.M. (eds.) 1993. *Race and Ethnicity in Research Methods.* California: Sage Publications.

Stringer, E. 1999. *Action Research.* London: Sage.

Trimble, J. E. 1990. "Ethnic Specification, Validation Prospects, and the Future of Drug Use Research". *The International Journal of the Addictions:* 25: 2A: 149-170.

Walton, H. 1986. *White Researchers and Racism: Working Papers in Applied Social Research.* No. 10. Manchester: University of Manchester.

Wanigaratne, S., Dar, K., Abdulrahim, D. and Strang, J. 2003. "Ethnicity and Drug Use: Exploring the nature of particular relationships among diverse populations in the United Kingdom". *Drugs: Education, Prevention and Policy:* 10: 1: 39-54.

Winters, M. and Patel, K. 2003. *Community Engagement: Report 1: The Process.* England: Centre for Ethnicity and Health and supported by the Department of Health.

Yates, R. and Gilman, N. 1990. *Seeing More Drug Users: Outreach Work and Beyond.* Manchester: Lifeline Project.

Drug use among new communities in Ireland:

an exploratory study

By

Caroline Corr

Merchants Quay Ireland (MQI)

Merchants Quay Ireland is a leading Irish charity established by the Franciscan Friars to provide services aimed at reducing harm related to drug use and homelessness and at providing pathways towards rehabilitation and settlement. To this end, MQI provides a wide range of services for drug users and homeless people including a health promotion and needle exchange service, a day centre for homeless people, stabilisation services, residential programmes and settlement and integration services.

Merchants Quay Ireland, 4 Merchants Quay, Dublin 8.
Tel: 01 679 0044
Email: info@mqi.ie

National Advisory
Committee on Drugs

Shelbourne House (3rd Floor),
Shelbourne Road,
Dublin 4,
Ireland

Tel: + 353 (1) 667 0760
email: info@nacd.ie