Stigma First: Pakistani-Heritage Male Community Leaders on Addiction in Rochdale

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THE SALIK PROJECT UK

FIGHTING ADDICTION TOGETHER

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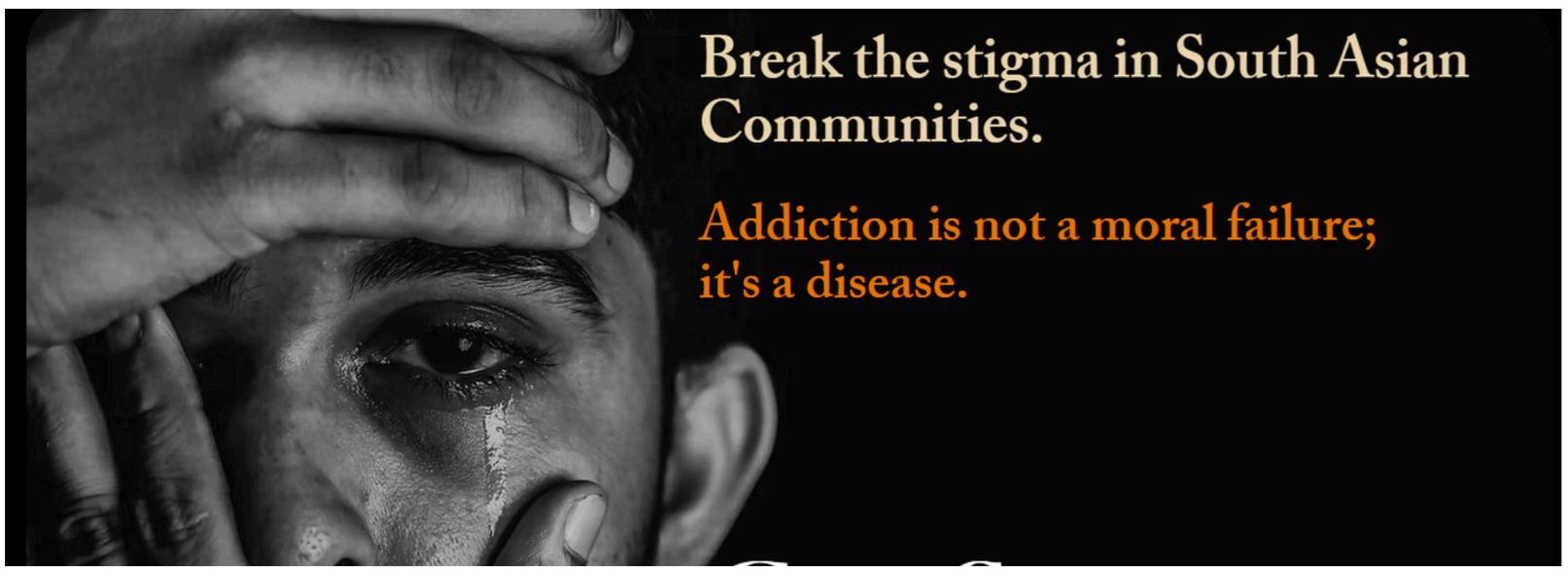
INTRODUCTION

This brief shares what six Pakistani-heritage male community leaders in Rochdale told us about addiction. We met for two hours at Deeplish Community Centre. Participants described addiction as dependency tied to mental distress and social pressures—not simply "bad choices." They highlighted stigma and silence, early exposure and easy access for young people, a high-risk window at 16–24, and why mainstream services can feel hard to approach. Contributions are anonymised; quotations are verbatim.



KEY FINDINGS

- **Stigma:** Participants said fear of "what people will say" keeps problems hidden and delays help until crisis. This was the primary barrier for them.
- **Education:** It isn't vocabulary that's lacking; it's open, regular conversations—they want sustained, bilingual, age-appropriate education, not one-offs.
- **Changing Realities of Traditional South Asian Family Life:** Long work hours (mums now as well as dads) and high educational expectations reduce parent–child talk; young people feel "pushed to the corner", straining family bonds.
- **Mainstream Services Lack Cultural Sensitivity:** Services felt generic and culturally misaligned; language/trust gaps and misunderstandings of faith/culture deter engagement.
- **Earlier Exposure & Accessibility:** Reports of vapes among 9–11s, peer drop-offs, adult proxy buying, and doorstep delivery normalise use before families notice.
- **Gender shift:** Leaders saw rising visibility of South Asian girls/young women using substances post-COVID, linked to mobility and social hotspots.
- **Youth window:** First use concentrates at 16–24, where belonging pressure, comparison culture and "quick money" cues meet easy supply.
- **Realistic Role of Mosques:** Mosques raise awareness and signpost and can educate families/wider community, but imams aren't clinicians and many in active use don't attend mosque regularly. Often preaching to the converted.

METHODOLOGY

A two-hour, in-person focus group was convened at Deeplish Community Centre with six Pakistani-heritage male community leaders (two Labour councillors, a community-centre manager, a charity lead running a weekly soup kitchen, a religious youth project lead, and an outreach worker in recovery; ages 22–70). Following five short video stimuli, discussion proceeded openly. With participants' consent, the session was audio-recorded. The Salik Project UK reviewed the full recording in detail, identifying recurring and divergent themes and extracting brief verbatim quotations to illustrate them. Attributions were deliberately anonymised to encourage frank contributions. The analysis is qualitative and presents participants' views; it is not intended to be statistically representative.

WHAT WE HEARD — AND WHAT THAT MEANS

Taken together, the leaders' accounts trace a clear pattern: stigma around both addiction and mental health keeps problems out of sight; it isn't vocabulary that's missing but everyday conversations. Long work hours and high expectations squeeze space to talk at home, while early exposure and easy access lower the bar to first use—most often in 16–24s, with rising visibility among girls/young women and nitrous increasingly normalised. Services often feel generic and culturally off-key. Mosques help equip families, but they're not where most users will be reached. The way forward is simple: normalise talk, back families, meet people where they are, and make support culturally right.

HOW PARTICIPANTS UNDERSTAND ADDICTION

Participants did not frame addiction as "bad choices." They described a dependency under pressure—a "state of your mind" where isolation, anxiety, family tension and bullying push people to use something to "take your mind off" what hurts. Several said dependency can attach to "good things and bad things," not only illicit drugs. For many, it starts socially—"from fun and laugh… in social circles"—then becomes "very powerful… it doesn't go away easily." First steps were linked to who you spend time with, whether anyone notices distress early, and if support is available when life hits hard.

STIGMA AND CULTURAL SILENCE

Stigma was called "the killer" because it attaches to both addiction and mental health. Families fear a lasting "scar on our family background," so problems are hidden and help is sought late. People stressed it isn't a translation problem—the words exist in Urdu/Punjabi—but "we don't have the conversations." That is the core barrier: everyday talk about addiction, anxiety, depression or psychosis is avoided for fear of judgment, gossip, and damage to reputation or marriage prospects. The change participants want is a cultural shift that makes these topics ordinary at home and in community spaces, with work done in mosques, schools and local venues designed to spill into family life rather than stay at the podium.

FAMILIES AND CARERS (WHY TALK IS HARD AT HOME)

Families are the first line of support, but practical pressures make openness difficult. Men described long work hours (e.g., 12-hour shifts in taxis/takeaways) linked to cost-of-living strain; parents also try to meet high expectations (tutors, branded clothes), which adds stress. In that reality, the time and energy for careful conversations are thin. At home, some young people become "quiet" or "a certain person" around fathers—respectful but closed—so worries stay unsaid. Participants want simple prompts to start hard chats and clear, supported routes into help so carers aren't left carrying this alone. One line captured the potential: once someone discloses, "the most caring you get is from the family."

EXPOSURE AND ACCESS (WHAT CHILDREN ACTUALLY FACE)

Leaders described early exposure: vapes in schoolbags among 9–11-year-olds, peer-arranged drop-offs, and occasional adult proxy buying—all of which normalise use before families or services notice. Access is close and easy: social content connects people to supply, and "you can just order it from home… they'll come to your house." Some schools were said to be hesitant to challenge vaping near gates, letting a new normal bed in. The net effect: low-friction access meets low conversation at home. Since patterns of usage are becoming earlier, intervention needs to start earlier too.

GROWING USE OF NITROUS OXIDE

Leaders told us nitrous use is now "in plain sight"—one even saw a driver "casually… with a balloon in his face." They're worried social media makes it look harmless. Hospital teams have also reported serious nerve damage linked to nitrous: in a large UK study across London, Birmingham and Manchester, Asian/Asian British patients made up a high share of these hospital cases (57% overall; 73% in East London; 54% in Birmingham; 29% in Manchester). Important: these figures show who turned up at hospital with serious harm, not how many people use nitrous in the community. They're a warning signal about who is being most hurt, not a measure of overall use.

YOUTH RISK WINDOW (16–24) AND A GENDER SHIFT

First use is most likely at 16–24, where belonging pressure, comparison culture and "quick-money" talk collide with easy supply—"they want to be a millionaire by 24." Participants also noticed rising visibility among girls/young women after COVID, tied to increased mobility (more driving) and access to hotspots (parks, car parks, shisha venues). Their message: reach this age range early and repeatedly, with content that speaks to identity, status and belonging.

MAINSTREAM AND RECOVERY SERVICES (CULTURAL AWARENESS)

Participants often experienced services as generic and not sensitive to our needs. Language and trust gaps deter engagement, and tone/content can miss younger audiences. Convenor recalled incident of sister in care—continuous prayer (salawat) during a psychotic episode misread as "speaking in tongues"—showed how misreading religious expression derails support. The ask is practical: bilingual, culturally literate professional clinical help that is easy to approach, and someone who stays with the family through the first steps instead of handing over them to a service that feels culturally alienating and isolating.

FAITH AND MOSQUES (VALUE AND LIMITS)

Leaders praised mosques' "magnetic unity" for awareness and signposting, especially to equip families. They also drew a clear line: imams aren't clinicians, and many people in active use don't attend regularly beyond Friday prayers. The balance they proposed: use mosques for awareness, relevant reminders that flow into home conversations, practical tips for congregation, signposting, while outreach in neutral/social settings (and online) meets those in recovery where they are and connects them to professional help. Healthy disagreements over the role and scope of mosques and imams. Are we asking too much from them? Are they qualified enough? Should all Imams have a basic level of training in mental health and addiction issues? Some leaders said that conversations over faith in recovery organisations with a secular ethos was shut down but said that they did not want support to be faith-centred but rather have support that considered faith as a source of healing. Participants also recognised the challenges that came with introducing faith into recovery because sometimes it could exacerbate rather than improve the situation depending on the mental state of the one in recovery.

About The Salik Project UK

The Salik Project UK is a Rochdale-based organisation focused on supporting people in recovery from addiction—and the families who stand with them. We work to reduce stigma and raise awareness in South Asian communities through education and signposting to existing services, acting as a cultural bridge between families and mainstream support.

Recommendations

1. Tackle The Stigma

Drive a community-wide conversation via social media and community/faith events including focus groups. Use lived-experience clips featuring South Asian young people to spark open talk.

2. Support Families

Give carers simple “how to start” guides and clear next steps. Provide supported, person-to-person referrals—we help contact the service, book the first appointment (with consent), and check it happened.

3. Go to where people are.

Run by-appointment drop-ins in safe, neutral places (centres, schools, youth clubs, GP/pharmacies), in pairs with safeguarding; use phone/online where needed. Keep focus groups/pulse surveys going. Intervention centred ethos.

4. Use Faith Spaces Within Limits

Share brief, practical messages and signposting in mosques to equip community; meet people in active use via non-mosque settings and link them to culturally competent care. Imams support/signpost—not clinical roles. Awareness raising too.

5. Help mainstream services close cultural gaps.

Offer short, practical training (culture, faith-literacy, tone/language) to mainstream service, co-design brief bilingual materials, and share anonymised feedback/focus groups. Ensure first contact feels “for us” and people stay engaged.