“We Carry It Quietly”: Stigma, Survival, and the Family Cost of Addiction

Womens Focus Group

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Venue: Kashmir Youth Project

THE SALIK PROJECT UK

FIGHTING ADDICTION TOGETHER

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INTRODUCTION

This report presents findings from a women’s focus group on addiction in Rochdale delivered in partnership with The Salik Project UK, Kashmir Youth Project (KYP) and High Level Northern Trust. The discussion explored women’s understandings and lived experiences of addiction, alongside awareness of emerging risks such as nitrous oxide, to inform future community support and engagement. The focus group raised themes around family impact, stigma and *izzat* (honour), the gendered burden on mothers, social media pressures, and participants’ low confidence in government and police to tackle drugs in community.

KEY FINDINGS

Women defined addiction as “fixation,” coping (“to relax”), and weak willpower.

Addiction was described as hidden family harm, with children and partners carrying the impact.

Trying to help family can turn you into **“the biggest enemy”** during active addiction.

Women were expected to hold things together and were often blamed

Stigma and izzat (“what will people say?”) drove silence and delayed intervention.

Culturally shaped responses iincluding marriage were criticised as harmful “solutions.”

Risk was linked to online exposure and visible dealing in local spaces.

Low trust in police, prisons, and government reinforced self-reliance until crisis point.

CONTINUE FOR DETAILED ANALYSIS

METHOD(OLOGY)

We held a qualitative, community-centred focus group to understand women’s lived experiences of addiction and identify knowledge gaps to shape future education and support. Ten women took part (7 Pakistani, 2 Bengali, 1 English; ages 20–65) and, with consent, we audio recorded the session to capture people’s words accurately and respectfully. We opened with an image-based activity to explore awareness of different substances, with particular attention to nitrous oxide due to growing local concern, before Asma facilitated the main women-only discussion to support comfort and openness. We focused on listening rather than training, handled emotional moments sensitively, and then reviewed the recording to identify key themes in preparation for the write up where we used direct quotes to keep it grounded in participants’ voices, experiences, and community realities throughout

DETAILED ANALYSIS: THEMATIC FINDINGS

1) How Focus Group Understood Addiction

Women described addiction in everyday terms shaped by observation and lived experience rather than clinical language. Addiction was described as something that takes hold and becomes difficult to stop: one participant called it "*a fixation*," while another said, "*you just can't control yourself*." Several women distinguished addiction from habit by emphasising loss of control, suggesting that habits can be managed whereas addiction cannot.

Participants also framed addiction more broadly than drugs, citing shopping and gambling as examples. Women then offered different explanations for why addiction happens. Some emphasised inner strength and willpower—"if you're weak inside, you're gonna carry on doing it"—which places the emphasis on the person's ability to stop. Others linked addiction to emotional coping, describing it as something people do "to relax themselves," and connecting harmful behaviours to distress, self-harm, and suicide when support or attention is missing. Women located addiction in different places: in loss of control, in emotional distress, and in personal strength, often holding these explanations side by side.

2) Addiction as a Family Experience, Not Just an Individual One

Women rarely spoke about addiction as something that affects *only* the individual using substances. Instead, it was consistently described as a *family experience*, with consequences that extends harmfully across relationships, households, and even generations. One participant captured this plainly, saying, "*They (the addict) don't realise what the family is going through… like their partners and their kids and everything*."

Several women spoke about how addiction strains family dynamics and creates ongoing stress within the home. Attempts to intervene or raise concerns were often described as leading to conflict rather than resolution. As one woman explained, when someone is in the throes of addiction, "*you're the biggest enemy for them at that time*." This sense of opposition made family members feel caught between concern and confrontation, often unsure how to act without worsening the situation.

Accounts of domestic upheaval were common. Women spoke about frequent arguments, shouting, and, in some cases, physical aggression such as punching walls. Theft within the household was also raised, particularly the taking of parents' gold jewellery to fund substance use. These experiences were described not as isolated incidents, but as patterns women had witnessed or heard accounts of within in South Asian communities.

The impact of addiction on families was also described in fatally tragic terms. One participant shared a story of a young man whose drug use caused prolonged distress within his family and ultimately ended in suicide. This account underscored the sense that addiction can have irreversible consequences for families, leaving long-lasting emotional scars.

Another woman spoke of her decades struggle of helping a partner through addiction with heroin. She said she was ostracized (within the South Asian community) through association, had to raise children on her own, had to attend court hearings and even nearly had a her children taken from her by social services. Her story showed how South Asian women can be stigmatised within the community and unsupported outside it, because seeking help risks making the issue public. Traces of cultural shame (*izzat*) still surfaced as she spoke, but they sat alongside a clear, critical frustration at how addicts and their families are made to feel by their communities.

Taken together, these accounts show that women experience addiction as a collective problem, one that disrupts family life, strains relationships, and places emotional and practical pressure on those closest to the person affected while being amplified by cultural stigma.

CONTINUE FOR DETAILED ANALYSIS ››› ››› ››› ›››

DETAILED ANALYSIS: CONTINUED

3) Stigma, Izzat, and Silence

Stigma emerged as a central theme shaping how addiction is understood and managed within families and the wider community. Women spoke about *izzat* (honour) as a powerful force that discourages openness and delays action, even when harm is visible. One participant explained, "*Us Asian parents, right, if our child is doing something, instead of helping them, they stay quiet. Why? Because they're too ashamed.*"

Fear of judgement was described as ever-present. Women spoke about worrying what relatives, neighbours, or the wider community might say if addiction was disclosed. This fear often led families to deny problems or keep them hidden. Participants described situations where parents were confronted about their children's behaviour but responded defensively or refused to acknowledge what was happening, even when signs were clear.

Several women noted that silence extended beyond immediate families. Faith leaders and respected community figures were perceived as being wilfully unaware of drug-related issues choosing not to speak about them openly. This reinforced a perception that addiction is something to be managed privately in the absence of the collective will of the communities to address it openly.

Stigma was also described as operating within families themselves. One woman said she would rather speak to a stranger than a relative, adding that "*family can destroy you*." Others spoke about how disclosure can lead to gossip, blame, and long-lasting damage to reputation. As a result, women often felt isolated, carrying concerns alone while maintaining outward appearances.

These accounts show how shame and silence function as social mechanisms that shape responses to addiction. Rather than stemming from lack of awareness, they reflect fear of judgement and loss of standing within the community, contributing to delayed intervention.

4) Culturally Shaped Responses to Addiction

Women described a number of culturally specific responses that South Asian families sometimes use when addiction becomes visible. These responses were spoken about as familiar and widely recognised within communities, particularly when families feel under pressure to protect their reputation or prevent wider scrutiny in order to protect their *izzat* (honour). Sending a child abroad, removing them from their usual environment, or arranging marriage were described as strategies designed to contain the problem of addiction rather than confront it directly.

Marriage, in particular, was said to be used in the hope that responsibility, stability, or a change in the individual would resolve the underlying issue of addiction. Participants were clear that this approach was driven by honour and concealment. One woman challenged this approach by asking, "*Why should another person's life [from Pakistan] be destroyed*?" Another stated firmly, "*You should not get your child married off until they are of stable mind*."

These practices were understood as attempts to manage risk and avoid public exposure, but women widely viewed them as ineffective and harmful in the long-term. Several participants noted that addiction does not simply disappear when circumstances change, and that such responses can transfer the burden onto another family or individual who is unprepared to deal with it.

Women from both Pakistani and Bangladeshi backgrounds confirmed that these responses are not isolated incidents but part of a shared cultural approach for dealing with addiction. Their reflections highlighted a tension between maintaining family honour and addressing addiction in a way that recognises its complexity and long-term impact.

Taken together, these accounts illustrate how cultural expectations shape responses to addiction, often prioritising reputation and containment over understanding and support. It also highlights reactionary and damaging practices rooted in a lack of awareness of mainstream services that could help and a more general deficit of understanding with regards to other possible ways to deal with someone suffering with addiction.

DETAILED ANALYSIS: CONTINUED

5) Knowledge Gaps and Emerging Drug Risks (Nitrous Oxide)

Women demonstrated a high level of awareness that drugs are present in their communities, but their accounts revealed clear gaps in understanding about newer substances and the risks associated with them. Cannabis was the norm while nitrous oxide was a key example of substance they had little knowledge of. While Participants recognised discarded canisters in their neighbourhoods and public spaces, most did not know, how and what they were being used for nor associated them with serious harm.

When presented with a case study of a young woman left paralysed, none of the participants identified nitrous oxide as the cause. The reaction was one of surprise and shock. This moment exposed a disconnect between what is visible in the local environment and what is understood about risk. Women were familiar with the presence of the substance but not with its effects or potential for long-term damage.

These discussions highlighted how rapidly changing drug trends can outpace community awareness. While women expressed strong concern about drug use in general, their accounts showed that emerging substances can be grossly underestimated thereby increasing risk before awareness catches up.

All of this points to not so much as a lack of awareness regarding the presence of drugs in the community - the women clearly acknowledged this as a tragic fact of the areas in which they lived. Rather, it was more of a lack of awareness of specific types of drugs. Cannabis was conspicuous because of its pungent smell but other substances such as nitrous oxide just would not appear on their radar. This clearly pointed to the need for bespoke educational outreach work in the future.

6) Rochdale as an Environment: Visibility, Normalisation, and Fear

Women spoke in concrete and often vivid terms about the local environments in which they live, describing drug use and dealing as highly visible and, in some cases, normalised. Several participants said that drug activity is seen "*in broad daylight*," particularly around transport hubs such as Rochdale Interchange, and in areas close to their homes, mosques, and garages.

One woman described feeling frightened when she first moved into a certain area because of the level of visible drug activity. Others spoke about becoming accustomed to what they saw over time, even though it continued to cause concern. One participant summarised this sense of saturation by saying, "*It's everywhere.*" Cannabis use in public spaces was also mentioned as common, with one woman describing an encounter where someone younger she knew openly smoking before greeting her, leaving her lamenting the loss of respect that youngsters once showed elders.

Participants also spoke about rumours and observations involving taxi drivers and shopkeepers, suggesting that some may have knowledge of, or involvement in, local drug activity. While women were careful to say this did not apply to everyone, these perceptions contributed to a broader sense of the social environment essentially being stacked against them and corrupted.

These accounts show how addiction is seen as being part of a wider deteriorating social landscape which for them it could not be divorced from. The visibility of drugs being dealt in everyday settings heightened their anxieties as parents, partners and individual citizens of a community and reinforced the feeling that the risk is not only constant and ubiquitous but also difficult to escape, shaping how families think about safety, security, and trust in their surroundings. Such social degradation was laid at the doors of not only the authorities (police, government and community leaders) but also at the South Asian communities at large whom they felt needed to be more forthright in discussing issues like drugs and addiction.

CONTINUE FOR DETAILED ANALYSIS

DETAILED ANALYSIS: CONTINUED

7) Trust, Mistrust, and Experiences of Authorities

Women's descriptions of addiction and drug activity were closely tied to questions of authority, safety, and whether institutions are seen as effective or trustworthy. Several participants expressed scepticism about policing and enforcement, shaped by what they felt they had witnessed in their local areas. Some questioned whether police action matched the scale of visible dealing, while others voiced more direct suspicions. One participant even said, "*The police are in it*." Even where such claims were anecdotal, the intensity with which they were expressed reflected a deeper sense of frustration and loss of confidence.

Prison was also discussed as an ineffective deterrent for drug dealers whom they believed had blighted certain areas in Rochdale. Some believed that prison does not reform people and instead made things worse, with one remarking that "*everything outside of prison happens inside of prison*," referring to drugs and violence. Others spoke about the belief that drugs can be smuggled in, sometimes with the involvement of staff, reinforcing the view that the system is corrupt.

Women also expressed little confidence that government would provide the resources needed to address addiction in a way that felt accessible to their communities. When discussing the idea of walk-in centres, some participants responded pessimistically, saying it was unlikely because "*the government just isn't going to help*" and "*hasn't got enough funds*." Wider pressures on health services were also raised, with references to strain within the NHS and concerns about services deteriorating. This fed into a mood of resignation in which formal systems were viewed as either overstretched or unwilling to act.

This scepticism contributed to a strong theme of self-reliance. One participant captured this starkly: "*You are not safe anyway these days. Until you save yourself, nobody can save you*." These accounts show how experiences of visible drug activity, combined with low confidence in institutions, can leave South Asian families feeling they must manage problems privately, even when the risks are severe, contributing to delayed early interventions.

8) Social Media and Shifting Influence

Women's comments about social media and the internet arose when participants tried to explain why they felt substance use and related risks have "*got much worse than it was before*." In response, a younger participant said, "*As a youth myself, I think it's because of the exposure from the internet. It's easy to find anything on there*." Other women agreed, describing children as being on phones "*24 hours*" and noting the limits of parental oversight: "*You can't keep an eye on them all the time*." One participant contrasted this with earlier family routines, recalling a time when families sat together and talked, whereas now "*everyone is in their own corner… the mother's on their mobile, the father's on their mobile and the children on theirs*," making it harder to know "*who the child is talking to, who is he texting*."

Taken together, these accounts point to a wider social shift rather than a single cause: exposure and influence are experienced as more constant, more diffuse, and less visible to adults, which contributes to parental anxiety and a sense that traditional forms of supervision and guidance are harder to maintain. While participants did not describe online spaces as a direct route into drugs, they did frame them as amplifying what young people encounter and normalising risks more quickly than families can respond.

This also points to a practical prevention opportunity. If online spaces are where attention and influence now sit, then trusted, culturally relevant messages can be placed there too—reaching young people, families, and others affected by addiction who may be navigating these issues quietly. As The Salik Project UK's online presence grows, we see social media as a useful, even powerful, tool for timely education and for encouraging earlier engagement with mainstream support, without relying solely on one-off, offline interventions.

Concluding Summary

This focus group shows that for many South Asian women in Rochdale, addiction is not experienced as a private or isolated issue. It is encountered through family life, community judgement, and the local environment—where risk can feel both visible and unavoidable. Women described addiction in lived terms: as loss of control, as coping, and sometimes as a matter of personal strength, reflecting the complex ways families make sense of why addiction happens and what can be done about it.

Across the discussion, the heaviest consequences were repeatedly located in the home. Women spoke about children's futures, disrupted relationships, and the emotional labour that mothers and wives often carry—sometimes quietly, sometimes at breaking point. Stigma and izzat shaped what could be said, to whom, and when, contributing to silence, denial, and crisis responses that women themselves questioned. Participants also linked rising pressures to the digital age and to what they see on the streets, while expressing low confidence that systems respond early enough to prevent escalation.

Taken together, these insights underline a simple reality: families are already living with the impact of addiction, often before services ever see it. Any effective response must therefore be culturally informed, locally rooted, and built on trusted community engagement that reaches people early—before harm becomes irreversible.

NITROUS OXIDE ABUSE: WE MUST DO MORE

UK clinical research led by Queen Mary University of London (2023) found that **young Asian men were over-represented** among **hospital admissions** with **nitrous oxide–related neurological harm**, reinforcing the need for targeted prevention and messaging. We believe this messaging must extend to parents, faith-based and cultural institutions, and youth centres with bilingual campaigns, something which we have already started doing via social media.

ROCHDALE NITROUS OXIDE

Nos has been the most frequent topic raised by Rochdale residents. From stories about how individuals have become addicted, hospitalisations, driving while "ballooning" (inhaling nitrous oxide through balloons) and streets littered with used and discarded nitrous oxide cannisters. It's clear that Rochdale has a big issue with nitrous oxide abuse among youngsters and young South Asian men in particular.

Recommendations

1) Deliver community parent/carer sessions that reflect women's realities

Deliver community parent/carer sessions that reflect women's realities. Run regular, facilitated sessions—co-delivered by trained staff and safely supported lived-experience speakers—covering how addiction is understood in families, how it affects children and relationships, and how parents can recognise risk early.

2) Produce consistent, multilingual information that tackles silence and stigma

Develop simple, culturally sensitive messaging in relevant languages (including Urdu, Bengali, Arabic) for posters, leaflets, and social media, designed to reduce shame, normalise early help-seeking, and clarify the message: you're not alone.

3) Prioritise emerging drug awareness, with nitrous oxide as a named focus

Create targeted materials and short workshops on nitrous oxide and other changing drug trends, addressing why these substances are often seen as "harmless," and linking messages to real local visibility and harm.

4) Rolling focus groups as an early-warning system

Continue regular focus groups with South Asian (not exclusively) women, men, and young people—led by trained facilitators and supported by lived experience where appropriate—to surface changing drug trends and emerging risks early, recognising communities often see shifts before official health authorities.

5) Create a culturally safe route into mainstream support

Offer a simple pathway where families can speak to a trained community worker who can guide them toward appropriate professional help, without judgement, and without waiting for crisis. This also means mainstream services needs to learn about the cultural dynamics within South Asian communities.

6) Sharing the Parental Responsibility and Communal Responsibility

Actively counter the pattern of mothers being held solely responsible by emphasising shared family responsibility and encouraging involvement of fathers and wider family where appropriate. This requires a cultural shift that must begin with messaging from established cultural institutions (e.g. mosques, youth centres...etc)

7) Co-deliver cultural competence training for frontline services in Rochdale

Work with local health and support services to deliver training—co-designed and co-led by community organisations and lived-experience educators—on izzat, stigma, silence, gendered caregiving burdens, and culturally patterned crisis responses (including concealment and marriage).

8) Rebuild trust through visible, two-way local engagement

Partner with local authorities to host regular listening sessions in community venues, facilitated by trusted community organisations, acknowledging residents' concerns about visible dealing, enforcement, and service access. Sessions should give careful consideration to confidentiality since many live in fear of reprisals.

9) Fund community-led delivery, not just consultation

Ensure community organisations are resourced to provide sustained education and engagement, recognising that trusted access to "gated" communities is specialist work that cannot be delivered through one-off campaigns.

ABOUT THE SALIK PROJECT UK (ROCHDALE)

THE SALIK PROJECT UK
FIGHTING ADDICTION TOGETHER

The Salik Project UK was formed in response to lived realities within our own communities in Rochdale, where addiction is often experienced privately, shaped by stigma, and addressed only once situations reach crisis point. Our work grew from recognising that many families—particularly within South Asian communities—are navigating complex challenges without culturally informed support, clear information, or trusted spaces to talk openly.

Our mission is to reduce harm, challenge stigma, and strengthen pathways into support by working alongside communities rather than speaking on their behalf. We do this through community-led engagement, education, focus groups, outreach, and partnership working that centres lived experience as a form of expertise. We believe that understanding addiction requires listening to families, carers, and young people, and taking seriously the social, cultural, and emotional contexts in which their lives unfold.

At the heart of our approach is the belief that tackling addiction is a collective responsibility. Effective responses cannot sit solely within statutory systems or rely on one-off interventions. They must be collaborative, preventative, and rooted in trust—bringing together communities, health services, and local partners in ways that are consistent, culturally informed, and responsive to change.

We are committed to ensuring that our work remains up to date with the fast-changing realities on the ground, from emerging drug trends to shifting social and digital environments. The Salik Project UK aims to contribute to more effective, earlier, and more inclusive responses to addiction—responses that recognise both the harms caused and the strengths that already exist within communities.

WITH THANKS TO...

We would like to thank High Level Northern Trust, Kashmir Youth Project and Action Together for their help and support. We look forward to continued collaboration with them and others in the recovery space. If you would like to collaborate with The Salik Project UK, please feel free to reach out to us here: **contact@salikprojectuk.org**

High Level — www.hlnt.org.uk/

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