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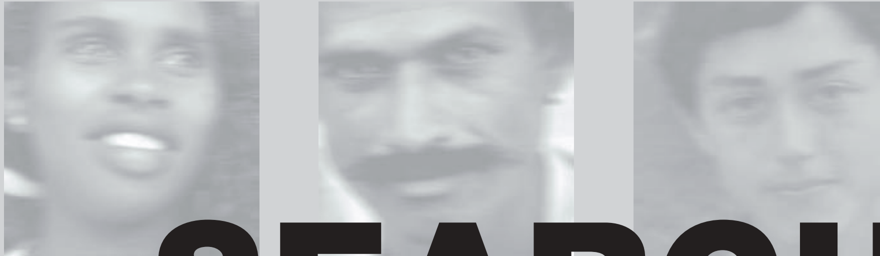
SEARCH II
Suchtprävention
für Flüchtlinge und Asylbewerber



SEARCH II

Materialien zur Suchtprävention für Flüchtlinge, Asylbewerber und illegale Einwanderer

Materials for Drug Prevention for Asylum Seekers, Refugees and Illegal Immigrants

Landschaftsverband Westfalen-Lippe
www.lwl.org

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Note:
The enclosed CD includes the texts from this collection of materials, the text of the RAR Manual, the text of the Prevention Manual from 'SEARCH' and some examples of material in PDF format that were produced within the framework of the 'SEARCH' and 'SEARCH II' projects.You can open the PDF files using 'ACROBAT READER' from Adobe. Should you not have ACROBAT READER, you can download it free of charge at:

http://www.adobe.de/products/acrobat/

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Materials

for Drug Prevention for Asylum Seekers, Refugees and Illegal Immigrants

Findings of the European Project 'SEARCH II'

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Dear reader,

the foreword for the final volume of the first phase of the 'SEARCH' project was written by Dr. Pittrich, who, as the head of the LWL Health Department, was in overall charge of the Coordination Office for Drug-related Issues and thus the 'SEARCH' project.

In the meantime, Dr. Pittrich has retired and the organisational responsibility for the Coordination Office for Drug-related issues has changed to the Landesjugendamt (Federal State Youth Department) at LWL.

As a local authority for one of the most populated regions in Germany, the LWL is confronted with a multitude of migrants, and in recent years my department has found itself confronted with a multitude of problem areas that these people bring with them. These include health problems, which in turn are sometimes due to existing drug-related problems.

The groups that are most difficult to access or to estimate for the purposes of official health reporting are the asylum seekers and refugees. Officially, around 7,400 asylum seekers and 100,000 refugees were registered in Westfalen-Lippe in 2001.

The Landesjugendamt at the LWL is responsible for the large area of youth care and naturally collects all the reports on the development of youths and young adults – in particular, of course, on the specific problems of young foreigners.

In recent years we have observed – and this is a national trend that not only applies to Westfalen-Lippe – problematic developments particularly among young people living in Germany who come from the second (and perhaps third) generation of so-called ‘guest workers’ and among the young ‘Russian Germans’ from the former Soviet Union.

Increasing drug and alcohol misuse, the propensity for violence and forming gangs – which can sometimes be attributed to ghettoisation – are indicative of the considerable difficulties that these young people face in coping with what is for them an alien country and in developing realistic prospects for a satisfied life.

In this context, the following questions keep being raised:

- Are the measures, methods and concepts developed for the German population for health care and drug prevention also adequate for this group of people? Can they be transferred, so-to-speak, ‘1 to 1’ to people from other cultural groups?
- How should ‘culturally sensitive’ drug prevention be developed and which resources should provide the competence necessary to approach this task in an ‘interculturally competent’ way?

These are all questions that we have seized upon with the 'SEARCH' project, and which have been further developed and for which the first answers have been found.

As a local authority, however, we must also answer the following questions:

What have we gained from this project in the local communities, i.e. in the towns, regions and districts?

A first answer has already been given here:

- Approaches and methods for drug prevention were tested for groups who live in the local communities remote from any statistics but not ‘far away’ in an abstract country.
- All approaches that were tested in the 'SEARCH' project are communal measures that help local planners of youth, social and health policies to recognise risks and to develop effective solutions.

As far as the European dimension of the project is concerned, this already becomes clear not just through the commitment of all the project partners but also through the partly concurrent questions raised: although each country certainly has its own specific ways of addressing the problem of migration, these are, however, the same in terms of their basic structure and initial situation, since all European countries have become target countries for migration and almost everywhere shows the same problems.

Here, the respective concrete developments are taking place not at an ‘abstractly national’ level but in the regions, which need to find solutions and must carry out what is necessary at the local level.

It seems to me that the essential point here is that we speak of a Europe of regions.

Thus with the ‘SEARCH’ project we have experienced in concrete terms that proposed solutions must always be initially developed and tested at a regional level in all the countries before being passed on to the national level. In this Europe of regions we are learning from one another: All are teachers and students; each region contributes its own specific approaches, experiences, traditions and questions.Thus it becomes clear that European projects and trials are the working method of the future. This appears to me to be extremely important at a time when a certain weariness of Europe has apparently set in.

There is one other aspect of the project that should be highlighted: the ‘Rapid Assessment and Response’ (RAR) research method that was used by the project to determine the basis for the practical projects.

- It is precisely this method that has enabled project participants to set into motion a series of aspects that are of immense importance for the politicians and those responsible in the local authorities. For instance, it was proved that it is possible to have scientifically sound project and intervention planning in the social and health care area with comparatively little financial expenditure and with rapidly available but nevertheless sound results. This is an advantage that should not be underestimated at a time when the funding available for research is become ever more scarce.
- It has also been shown that with such a procedure, the research does not, so-to-speak, ‘withdraw’ itself from the ensuing process of implementing the results but continues to support it with specific monitoring and evaluation instruments, as have just been tested in 'SEARCH II’.

It is precisely this latter aspect that should also be emphasised for other reasons:

The 'SEARCH' projects have also proved that the almost traditional distance that can be determined between research and practice, or to be more precise, between researchers and practitioners – with their respectively different methods and instruments that can be found in almost all social areas of responsibility -– can be superseded by other methods, roles and ways of sharing responsibilities.

„Rapid Assessment and Response" continues to be consultative, reflective, supportive and communicative where traditional research approaches have long taken leave after providing the desired 'hard data'. It is precisely this special approach that enables research to be used in many more problem areas, e. g. in the area of local youth care or health planning.

Last but not least, one more personal comment: the atmosphere in the workshops, the friendliness towards one another and the respect for the achievements and professional approach of others while remaining in friendly contact have ensured that the work together has been pleasant, fruitful and forward-looking. All the project partners have reported that they have ensured that the project results do not vanish behind book covers but will remain effective in communal and regional networks and in practical measures.

I would like to expressly thank all project participants for their enormous professional commitment, combined with the hope that the participants will find a way to continue the work that has been begun at the European level in the field of drug prevention and addiction care for migrants.

Landesrat Hans Meyer
Head of the Landesjugendamt und Westfälische Schulen in theLWL

1. A quick overview:

Short abstract of the project results:

A. Products

1. The RAR research method (= Rapid Assessment and Response)[1] has proved itself as an instrument for practical research and intervention planning in the area of drug prevention with refugees, asylum seekers and illegal migrants. The handbook produced as a result of the project is used by the drug prevention practitioners in the SEARCH project locations in Europe as a basis both for realistic training and efficient planning for (further) projects.

2. 'SEARCH II' has proved that conducting a monitored assessment of the results of earlier RAR surveys is an essential component of the practical process. The RAR handbook was therefore supplemented with the 'Monitoring' chapter.

3. The 'SEARCH' results have been successfully transferred to another six European countries (Ireland, England, Sweden, Greece, Portugal and Luxembourg). The new project partners were given detailed training in the RAR research method. Corresponding investigations on the 'prevalence of drug addiction among refugees, asylum seekers and illegal migrants' were conducted in these countries and initial conclusions and procedural recommendations developed.

4. The 'SEARCH' project products can be divided into four groups:

- **Materials** for drug prevention with the target groups (cf. for example the 'children's book' in Belgium, 'Dopeheads' in the Netherlands);

- **Curricula** for training multiplicators (key persons, mediators, other multiplicators) in the fields of addiction and intercultural competence (handbook in Barcelona);

- **Concepts** for coaching and supervising professionals working in refugee and asylum facilities (Austria, Germany).

- The **'Guidelines** for Drug Prevention with Refugees, Asylum Seekers and Illegal Migrants'[2] provides a guide for similar projects.

B. Experiences, Results

5. In the investigated group of asylum seekers, refugees and illegal migrants there was no uniform picture on the prevalence of addiction and the associated problem areas[3]. Diverse influencing factors encourage or impede the misuse of psychoactive substances in the project's target populations.

6. It is not just fleeing, which in itself is a traumatic experience, it is also the living situation and conditions of the asylum seekers, refugees and illegal migrants in their host countries that makes them vulnerable to drug misuse.

For many asylum seekers, a stressful everyday existence is created through fear of the future, prolonged legal procedures and an uncertain residence status (frequently for years), isolation, work prohibition as well as other restrictions preventing them from being accepted as equals into the social community of the host countries. This they try to make more bearable through using psychoactive drugs.

7. The influential factors that they ‘bring’ with them and which can encourage drug use include the traumatic events before or when fleeing/migrating, insufficient care services for these severe mental disorders in the host countries, consumption habits that have been acquired early on in the countries of origin and which, as a result of other legal and living conditions in the host countries, have ‘shifted’ into dangerous use patterns, and drug problems that already existed before fleeing.

8. Furthermore, the easy availability of drugs in the host countries encourages access to drugs: alcohol and tobacco are a part of everyday life in Europe, illegal drugs can be acquired easily and frequently without entailing any recognisable legal risks.

9. At almost all the project locations, single men were identified as a particularly vulnerable group in regard to both illegal drugs and alcohol. In addition to the general migration stresses mentioned above, the lack of families seems to also encourage the use of drugs (loneliness, isolation). Furthermore, asylum seekers from Islamic countries seem to find it particularly difficult to deal with alcohol. Forbidden and scorned in their homelands, alcohol is ubiquitous in Europe. As these people mostly lack the rituals and experience of using alcohol, alcohol use frequently takes on risky forms very rapidly while at the same time producing pangs of conscience and feelings of guilt, which in turn can increase the addiction.

10. In most of the regions investigated, it is predominantly young people from the target groups who find access to illegal drugs. Nevertheless, the overall rather low prevalence of addiction among the AMAs[4] in the Netherlands shows, for example, that the tabloid press claims of mass illegal drug use in this target group are not born out in reality.
In all the regions there is information suggesting that asylum seekers and illegal migrants are frequently involved in drug dealing. Although the extent of it is frequently overestimated, our investigations confirm that this phenomenon is obviously in response to the lack of money and the unsatisfactory living conditions. The misuse of the asylum system to migrate to a European country with the aim of earning money through drug dealing was not a subject of investigation in this project. Nevertheless, there were indications at several locations that local criminal organisations were exploiting the situation of asylum seekers and illegal migrants to involve them in their illegal activities.

11. The misuse of psychoactive medicines was described in all the groups investigated as the second most frequent drug risk after alcohol use. Women are frequently mentioned here, who use or misuse these medicines.

12. Drug prevention for the ‘SEARCH’ project’s target groups is generally based on the standards known throughout Europe under the terms ‘intercultural competence’ and ‘intercultural addiction care’.

According to this, drug prevention must:

- *start as soon as possible after arrival in the reception country and be conceived on a long-term basis;*
- *strengthen the educational competence of the parents and firmly establish specific approaches for drug prevention for migrants in the schools (assuming that children from the target group are allowed to attend school);*
- *use precise knowledge of the target group's native culture and ensure a culturally respectful and sensitive approach in terms of teaching aims and methods. Here, the emphasis on strengthening the culturally specific protection factors is what provides the methodical guideline;*
- *carry out integration work with the target groups as well, whereby integration is participative-oriented and does not force the adoption of the cultural norms of the host country. Existing facilities in the local communities should be used; access to existing resources can be achieved through local networking (e.g. language courses, computer facilities, facilities provided as part of youth work);*
- *involve the target groups, where possible, in planning and conducting drug prevention schemes (events, materials);*
- *derive the methods used from the cultural background of the target groups, not (just) from the standards of the host countries. Many refugees come from regions where a 'programme' counts less than the person who conveys it, i.e. the relational level is more important than the subject or methodological level. Here it should be noted that drug problems are a taboo theme in a double sense, in terms of being treated as taboo in the countries of origin and in terms of the fear that, through drug problems, the residence status in the host country could be negatively influenced.*

13. At all locations the project work was integrated in local and regional networks. This ensures that the work can be continued after the end of the project and that the project approaches can be further developed.

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1 See R. BRAAM, F. TRAUTMANN, H. VERBRAECK, Rapid Assessment and Response, 2nd expanded edition, Münster 2004
2. In this volume
3. It was only possible to work on an exemplary basis in the projects 'SEARCH' and 'SEARCH II'. The results cannot be transferred on a 1:1 basis to provide an overall estimate of the drug problem with refugees and asylum seekers in Europe. Furthermore it should be noted that although the RAR method is able to reliably portray trends, indicators etc, it is not a replacement for an empirical, quantitative survey of specific problems.
4. **A**lleinreisende **m**inderjährige **A**sylbewerber (= unaccompanied juvenile asylum seekers)

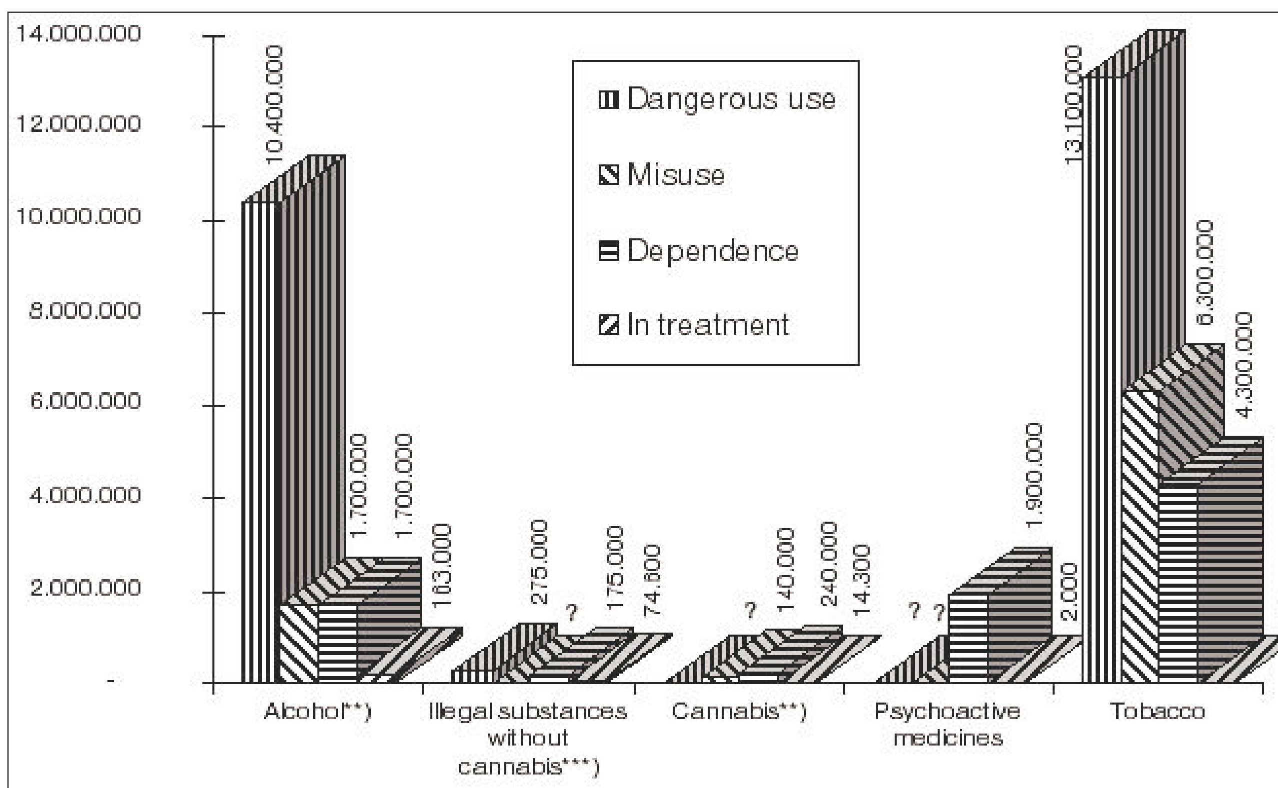
2. The initial situation for the 'SEARCH' and "SEARCH II" projects[1]

2.1. Asylum, flight and drug risks

2.1.1. Drug use in Europe

There are people with drug problems in almost all countries in the world: different substances, consumption rituals, characteristics and trends exist in the various societies, ethnic groups and regions, and the respective care services and systems (insofar as they exist at all) are very differently structured and accentuated. The shelves are full with scientific studies not only on diverse aspects of substance and use risks, but also on the effectiveness and development of the care systems. Almost every drug-related aspect has in the meantime been investigated and can be accordingly described.

In Europe there is an overriding tendency for the public to perceive the drug problem in terms of using illegal drugs. The following graph shows the ratio between the different drugs used in Germany (2002), differentiated according to the various levels of user risk.



*) Independent classification categories; both are sub-groups for risk use
**) Reference group: 18-69 year-olds (57.2 million.),
***) Reference group: entire population (82.2 million.)

It clearly shows that alcohol and tobacco are by far the most-consumed drugs; at the same time they are also the substances that are most frequently consumed in a risky fashion and show the highest number of addicts. This general trend applies not just to Germany but also to Europe – with a different stress in each country.

This is not the place to discuss Europe's drug and addiction statistics in detail. Therefore, for comparison purposes, only two exemplary estimates from the EMCDDA shall be shown here for the use of hard drugs and alcohol in several European countries:

Statistics 1: Alcohol consumption in selected countries in 2000
(Deutscher Bundestag, printed material 15/2057 from 20. 11. 2003)

Country	Litres of pure alcohol per capita
Belgium	8.4
Denmark	9.5
Germany	11
Finland	7.1
France	11
Greece	8
Ireland	11
Italy	7.5
Latvia	7.4
Luxembourg	12
The Netherlands	8.2
Norway	4.3
Austria	9.4
Poland	6.9
Portugal	11
Romania	12
Sweden	4.9

Statistics 2: Estimate of the number of problematic drug users in the 15 - 64 year-old age group
(Deutscher Bundestag, printed material 15/2057 from 20. 11. 2003)

per 1000

Country	From	to
Denmark	3.6	4.3
Germany	2.7	3.5
Finland	3.2	4.1
France	3.9	4.8
Greece	3.1	4.2
Ireland	5.9	5.9
Italy	6	7.2
Luxembourg	6.2	13.6
The Netherlands	2.4	2.8
Austria	3	3.5
Portugal	6	8.5
Sweden	4.2	4.8
Spain	5.3	5.3
United Kingdom	6.6	7.3

However, there are no specific figures on drug risks for migrants. There is only one study funded by the EU[2] that has investigated the EU countries to find out what is known about the prevalence of drugs among various ethnic minorities, and which has collated together the respective information available from the different countries.

If health risks, particularly drug risks among migrants, are generally insufficiently investigated, then this applies even more to asylum seekers, refugees and illegal migrants. When conducting research for the 'SEARCH' project we were able to find indications, reports and assumptions on the use patterns, but no (hard) facts and data. This applies even more to studies on specific prevention and care programmes that are specifically oriented to various cultural backgrounds. To a large extent 'SEARCH' was entering uncharted territory.

What is certain, however, is that regardless of whether and which addictive substance were, or are, available in the ethnic societies of these groups, or whether they already had contact with legal or illegal substances (there): the figures shown above document that when fleeing and migrating to Europe, they arrive in societies with a large range of legal and illegal substances that seem to be practically ubiquitous, and their use is reflected in the life of the general population. This particularly applies to the most used drugs, alcohol and tobacco, but also to illegal drugs as well – as the EMCDDA estimates have exemplarily shown for cannabis.

2.1.2. Flight and asylum

The conflicts in Afghanistan and Iraq clearly show that our world is a long way from being 'one world'. Wars, political, ethnic and religious persecution, but also poverty, hunger and a lack of perspective in life are, as ever, at home in this world. Many people throughout the world decide everyday to leave their ancestral homes to seek protection from persecution, terror and torture in foreign parts, but also to try and live in a socially and economically dignified manner to ensure their own survival. Many of these refugees, exiles and asylum seekers seek refuge, a new home and asylum in Europe, with its economic prosperity and its democratic states.

However, according to the global estimates from the UNHCR, only a relatively small proportion of the international flow of refugees makes its way to Europe.

„Developing countries produced 86 percent of the world's refugees over the past decade, but also provided asylum for seven out of ten of those fleeing. [...]
Although rich countries are voicing increasing concern over the numbers of asylum seekers arriving on their borders, it is mainly poor nations that provide asylum to the world's refugees - 72 percent over the past 10 years. [...]
The number of refugees has hovered around 12 million for the past five years (1997-2001) after dropping by nearly a quarter compared to the previous five-year period (1992-1996). Although the total number of refugees has remained relatively-stable recently, their geographic distribution has shifted. Asia has both produced and hosted a larger share of the world's refugees since the mid-1990s, while the number of refugees both originating from and hosted by African countries has fallen.
In 2001, Afghans made up one-third of the world refugee population and were also the major nationality of origin of asylum seekers in industrialized countries. [...]
In 2001, asylum applications in industrialized countries rose by eight percent. While the six non-European industrialized countries (Canada, United States, Australia, New Zealand, Republic of Korea, Japan) received 31 percent more applications and Central Europe recorded a 33 percent increase, the 15 European Union member countries together saw a one percent decrease in applications."[3]

	Refugees	Asylum seekers	Repatriated refugees	Internally displaced persons Returned IDPs and others	Total
Asia and the Pacific region	4.252.200,0	36.200	1.995.500	3.166.300	9.450.200
Europe	2.165.600,0	385.400	77.000	1.816.900	4.444.800
Africa	3.284.500,0	158.500	341.300	679.500	4.463.900
America	652.200,0	455.200		1.000.100	2.107.400
Total	10.354.400,0	1.035.400	2.413.800	6.662.600	20.466.300

Statistics 3: UNHCR, 20/0172003. See: http://unhcr.de

According to an American study, in the year 2000 around 14 million of the 130 to 150 million global migrants were refugees in accordance with the Geneva Convention[4].

In 2002, most of the worldwide refugees came from the following countries[5]:

Homeland	Main asylum countries	No. of refugees
Afghanistan	Pakistan/Iran	2.481.000
Burundi	Tanzania /Dem. Rep. Congo	574.000
Sudan	Uganda/Ethiopia / Dem. Rep. Congo Kenya /Central African Republic	505.200
Angola	Zambia /Dem. Rep. Congo/Namibia/Congo	433.000
Somalia	Kenya /Yemen /Ethiopia /Great Britain /USA/ Djibouti	429.000
Dem. Rep. Congo	Tanzania /Congo /Zambia/ Burundi / Ruanda	415.000
Iraq	Iran/Germany/Netherlands/Sweden	401.000
Bosnia and Herzegovina	Serbia and Montenegro/USA/Sweden	372.000
Vietnam	China/USA	348.000
Eritrea	Sudan/Ethiopia	316.000

Statistics 4: http://unhcr.de

2.1.3. Asylum in Europe

Immigration – for whatever reason – occurs in all European countries. Let’s take a look at the statistics for the last two years (see next page: Statistics 5):

From these statistics is can also be seen that the absolute figures are only meaningful to a limited extent since they must be compared in relation to the population of the reception countries. For instance, if they are compared in terms of applications per 1000 inhabitants, this completely changes the ranking order of the asylum countries in Europe.

However, by no means are all the migrants in a country ‘counted’. A not inconsiderable proportion live illegally in the respective countries. "The phenomenon of illegal migration clearly shows that national attempts to control migration are only effective to a limited extent.”[6] This has serious consequences for those affected, since in most European countries they have no access to the social and health care systems, are without legal rights and are unprotected. Whereas, for example, Spain and Italy have, so-to speak, faced up to the fact that there are numerous North African illegal migrants and have therefore provided corresponding care and legalisation programmes, it is very difficult or impossible to provide care for illegal migrants in other countries because this is not deemed advantageous politically[7]. Slowly, however, there is growing recognition here that "illegal migration and residence cannot be completely prevented despite all the preventive and repressive measures. Therefore this begs the question as to how one can ensure the social and human standards that also apply to people without a right to abode.”[8]

State	Applications in absolute numbers 2001	2002	Applications in % 2001	2000	Applications per 1000 inhabitants 2001	2000
Belgium	24.550	18.810	5.2	4.1	2.4	1.8
Bulgaris	2.430	2.890	0.5	0.6	0.3	0.4
Denmark (1)	12.510	5.950	2.7	1.3	2.4	1.1
Germany (2)	88.290	71.130	18.8	15.5	1.1	0.9
Finland	1.650	3.440	0.4	0.7	0.3	0.7
France	47.290	50.800	10.1	11.1	0.8	0.9
Greece	5.500	5.660	1.2	1.2	0.5	0.5
Great Britain	92.000	110.700	19.6	24.1	1.5	1.9
Ireland	10.330	11.630	2.2	2.5	2.7	3.1
Italy	9.620	7.280	2	1.6	0.2	0.1
Liechtenstein	110	90	0	0	3.4	2.8
Luxenbourg	690	1.040	0.1	0.2	1.6	2.4
The Netherlands	32.580	18.670	6.9	4.1	2.1	1.2
Norway	14,78	17.480	3.1	3.8	3.3	3.9
Austria (3)	30.140	37.070	6.4	8.1	3.7	4.6
Poland	4.510	5.150	1	1.1	0.1	0.1
Portugal	230	250	0.1	0.1	0	0
Romania	2.430	1.110	0.5	0.2	0.1	0
Sweden	23.520	33.020	5	7.2	2.7	3.7
Swiss	20.630	26.220	4.4	5.7	2.9	3.7
Slovak Republik	8.150	9.740	1.7	2.1	1.5	1.8
Slovenia	1.510	700	0.3	0.2	0.8	0.4
Spain	9.490	6.180	2	1.3	0.2	0.2
Czech Republik	18.090	8.480	3.8	1.8	1.8	0.8
Hungary	9.550	6.410	2	1.4	1	0.6
Total	**470.580**	**459.900**	**100**	**100**		
EU	**388.390**	**381.630**	**82.5**	**83**		

Statistics 5: Number of asylum applications in Europe 2001/2002 / applications per 1000 inhabitants
The figures refer to persons; all information for 2002 is provisional.
(1) *Including asylum seekers who have been brought to a safe third country or whose applications are being processed under the Dublin Convention.*
(2) *First applications only*
(3) *The figures for 2001 include 5,622 persons who have applied for asylum in Austrian embassies. Only a few of them – mostly Afghanis – were able to travel to Austria.*
(From: Bundesamt für die Anerkennung ausländischer Flüchtlinge (www.bafl.de), Germany)

In particular, there is very little research into their health problems, and certainly not into the problem of drug addiction at all[9]. On the other hand, the Landschaftsverband Westfalen-Lippe (LWL), Coordination Office for Drug-related Issues, constantly receives reports from addiction care practice that asylum seekers addicted, or at risk of addiction, make contact with the facilities, and that it is very difficult to help them (with the means available to the 'domestic' addiction care). The idea of addiction prevention with these people seems completely unfeasible, such is the lack of knowledge about them, the extent of the language problems but also the considerable mutual reservations.

One of the main reasons for the 'SEARCH' project[10] was to gain greater knowledge and to find the first answers to these questions:

- How prevalent is substance abuse among the various groups?
- What is the nature of this substance abuse? How can one determine not just the risk factors but also the protective factors?
- How could target group-oriented addiction prevention for and with asylum seekers and refugees look like/be developed?
- What should be the first steps?

At the same time, almost all European countries have similar experiences and questions; as the addiction care bodies from many countries have confirmed in response to our enquiries. In an age in which Europe is coming closer together, it therefore seemed appropriate to instigate a project throughout the EU in order to research these questions.

Together with 6 (national) supporting bodies for drug care and prevention facilities in 6 European countries[11], LWL applied to the European Commission (SANCO G2) for funding from which the 'SEARCH' project grew.

In the first preparatory conference it rapidly became clear: in Spain and Italy there are very few people seeking asylum, and in terms of refugees, these countries only occasionally and temporarily act as reception countries with refugee figures worth mentioning. However, there are many immigrants in both countries who come from the north-western regions of North Africa (Maghreb region). Most of them are illegal and many of them live under conditions that are similar to those of asylum seekers and refugees in the aforementioned countries.
We decided to investigate these groups and extended our project name to include the term 'illegal migrant'. The initial project aims can be described as follows:

- to examine the prevalence of addiction among the target groups,
- to develop customised drug prevention for them.

2.1.4. The 'political dimension'
We don't deny that there is a 'political dimension' to this project:
Much as this project deals with specific aspects of health protection with refugees, asylum seekers and illegal immigrants, and is bound up in the debate on the causes, background and effects of migration and migration polices, we nevertheless wish to avoid going into this subject in any great detail here and refer instead to the extensive specialist literature[12]. We are much more interested in the lives and living situations of the specific people who have found their way to Europe, in order to be able to offer them active health protection regardless of their legally defined right to abode, the political climate, stated aims and the ideological, xenophobic and not infrequently racist attitudes. Nevertheless, we fully appreciate that these factors have a decisive impact on the everyday lives of the target groups in terms of the risk and protection factors that play a decisive role in drug prevention. Poor social and health care provision for the refugees and asylum seekers; an insecure living situation that often lasts for years and which isolates them and frequently denies them any possibility of working and earning their own living; restrictive asylum laws that often place the burden of proof – and in a frequently disgraceful

manner – on people seeking protection and support who are already traumatised; the often inhuman accommodation in camps and hostels, but also the aspects of fear and xenophobia that hamper or prevent human coexistence: all these are serious risk factors that lead to the development of mental and physical illnesses and are stress factors that also encourage the misuse of addictive substances.

We have already emphasised in the prevention manual for the first 'SEARCH' project phase[13] that we are more than aware that drug prevention must always maintain the balance between behaviour and relation-based approaches if it wishes to be successful and credible. If 'relation-based' is used to refer not just to the micro-social sphere (family, home, etc), but also to the aforementioned macro-social factors affecting the conditions under which our target groups live, it becomes clear as to where our limits lie.

2.2. Practice-oriented research: Rapid Assessment and Response (RAR)

Many problems in the field of public health demand rapid answers that, however, are difficult to find. How do you proceed when you only wish to 'speculate' on the extent of the problem: How do you plan when there is no reliable data basis? On the other hand, how do you achieve this when there is no or very little time available?

Therefore, with the application to the EU Commission we decided to combine the mentioned aims in the field of drug prevention for refugees, asylum seekers (and illegal migrants) with a further aim, namely to test the 'RAR' (Rapid Assessment and Response). We shall dispense with a detailed description of the method here since there is also a RAR handbook for the project, and shall instead limit ourselves to summarising the main points of RAR:

The RAR method aims to determine, in a tenably short period of time – and by accordingly tenable means – the type, genesis and extent of an (assumed) social and/or health problem. It makes use of various estimation and interview techniques and promises to provide results that are sufficiently precise and reliable to be able to plan interventions. In concrete terms this means, for example, that when establishing prevention services for refugee groups it is irrelevant whether 13.5 or 15.4 % of a certain subpopulation treat alcohol in a risky way. Important is that such a group occurs in a relevant part (the results of the RAR are 'indicators'). For the RAR method, the adequacy for a problem is more important than 'scientific preciseness'.

Particularly with the use of addictive substances (and in turn especially with illegal drugs), the rapid change in trends in consumption patterns and risk behaviour represents, as far as the speed of research is concerned, an enormous challenge when planning care services. Care should be given when necessary, without waiting until prolonged research work has been completed from which the transfer part is often missing. And it should always be up-to-date, i.e. changes and shifts in the basis behind the drug prevention interventions must be monitored and 'an eye kept on them'. This monitoring was a substantial task of ''SEARCH II" and will be gone into more detail elsewhere.

As with most empirical research, RAR makes use of interviews, and to be precise with so-called 'key persons', i.e. people who have extensive knowledge of the problem being researched. This process is described in detail in the RAR Handbook. Greatly significant in terms of the origins of the 'SEARCH' project was the fact that the Co-ordination Office for Drug-related Issues at the LWL had established a working group of addiction researchers and addiction care practitioners to focus on the frequently very problematic transfer of knowledge and competence from one area to another.

Practice-oriented and relevant addiction research: the RAR method appeared to us to be a suitable and interesting research method for investigating the extent, type and genesis of a social or health problem while at the same time depicting the intervention needs. The idea was born to research the described task – addiction prevention among refugees, asylum seekers and illegal migrants – with the RAR instrument. Our second project aim was:

- to test the effectiveness and practical relevance of the "Rapid Assessment and Response (RAR)" method on the subject area of drug prevalence and drug prevention among refugees, asylum seekers and illegal immigrants in Europe.

It can already be said in summarising the results that the method does what it promises: in a relatively short period of time it provides a wealth of reliable data which provides not only information on the scale, extent and origins of substance abuse but also on promising addiction prevention for this target group. At the same time it provides us with instruments and tools to monitor the process and to evaluate it[14].

2.3. Why a European project?

We have already mentioned that the subject of 'migration and addiction' has constantly been raised during our numerous contacts with Europe addiction care organisations, with whom we have often worked together for years[15]. In all European countries this area is increasingly presenting addiction care with (new) challenges – which differ according to the country. The problem of refugees, asylum seekers and illegal migrants is recognised by everybody as a problem area, without there having been any studies or established practice. It therefore seemed appropriate to carry out research and test out the interventions developed not at national level but at EU level. Of course, we were only able to research and carry out trials in an exemplary manner. In this respect our results, as far as their quantitative dimension is concerned, are not entirely 'representative' for any one country[16]. The 'added value' of this project in European terms, however, could be found in comparing processes, results, experience and methods, learning from one another and looking beyond the 'confines' of national experience. 'Nationally', the results are certainly very different, but nevertheless there are 'common denominators' that make our results interesting at EU level. This applies not only to drug prevention work with select groups of migrants, but in particular to the RAR method that, as a planning and research method in the field of public health and addiction care, represents a considerable advance in planning interventions. It also applies to the conclusions and procedural recommendations that we have collated together in the 'Guidelines for Drug Prevention with Refugees, Asylum Seekers and Illegal Imigrants" included in the Annex.

3. The work involved in the 'SEARCH' project

The first project phase lasted from October 2000 until March 2002 – 18 months, which in many ways turned out to be too short. Many prevention projects were only able to be conceived or just started, but not completed. On the other hand, an abundance of results was achieved that was processed during the course of the various project phases:

In Phase 1
the RAR was prepared and carried out. This included the assessment of existing 'good practice', collecting information concerned with the subject area, etc, as well as an RAR training for the project workers, which was held on the occasion of the first workshop in Münster, Germany, in December 2000. Our research institute provided not just basic material for this training but special questionnaires ('grids') and other materials[17]. It was confirmed that none of the participating project countries were able to report on any notable research on the subject of 'asylum, migration and addiction'. We were therefore entering 'uncharted territory'.

In Phase 2
the RAR was implemented in the various countries (see below). The limitation to one or a maximum of two target groups amongst the asylum seekers and refugees proved to be very difficult (there were so many other target groups in the regions!), and dealing with the questionnaires did not always prove to be very simple (as is documented by the various country reports). It also proved difficult and time consuming to find the respondents ('key informants'), and in various cases the wrong course was pursued[18]. During this time, the project supervisors and co-ordinators visited the partners ('supporting visits') to provide assistance with the sometimes complex and difficult implementation of the RAR.

In Phase 3
the results were collated, the respective reports sent to the research institutes, evaluated, and conclusions reached at the second workshop in Turin/Italy in June 2001. At the same time the prevention conclusions from the RAR were discussed in detail and concrete working plans adopted for implementing the prevention activities.

The concrete implementation of the prevention activities began in this phase, whereby it soon became very clear that the activities with the numerous key informants within the framework of the RAR survey already represented a significant step in the direction of practical work. Particularly in the focus groups, working alliances, local networks, joint activities, etc, soon began to be established.

These activities were presented and discussed at the third workshop in October 2001, where it was possible to present the first practical projects. However, it was also painfully clear here that a long-term and sustainable implementation of such prevention activities would require very much more time in order to show any effect. Besides their concrete products, all the project partners very much valued the establishment of local working alliances and networks in the field of migration and addiction in general, but also in the field of 'asylum, refuge', etc. as a central task for the future. It was therefore decided that the LWL would apply for a follow-up project with the EU.

In Phase 4;
beginning in October 2001, the prevention activities continued to be implemented in the regions while work was started on the country reports. Both the Trimbos and CVO institutes completed their RAR Manual during this phase. Stock was then taken at the final workshop in Barcelona/Spain in March 2002 and steps agreed upon for the further work on this theme.

4. The 'SEARCH II' project

The second project phase ('SEARCH II': 10/2002 – 03/2004) provided a smooth transition from 'SEARCH' and supplemented the basic tasks with the following aspects:

- With the help of the RAR Monitoring Module to be developed, the changes in the target groups were to be recorded and interpreted (research aspect)
- The projects that had been started were to be further developed, consolidated and firmly established at a regional level on a sustainable basis (practice development),
- Six new European regions (countries) were to be added to further disseminate 'SEARCH' throughout Europe (European dimension) and
- the results of the projects in terms of procedural recommendations were to be published (guidelines).

4.1. RAR monitoring

The six month period between 'SEARCH' and ''SEARCH II" held the risk, of course, that before starting the 'second round' of the project in October 2002 there might have been substantial changes to the target groups that would make it impossible to smoothly pick up on the prevention work started in 'SEARCH'. It was also important to check the previous work in the first project phase and, when necessary, make corrections for its continuation and consolidation.

The RAR method does not just offer rapid and sufficiently secure data collection for intervention planning, it also offers monitoring and evaluation tools. That is exactly where its strength lies: it does not 'sign off' after the data material has been surveyed but monitors the further process. We have already noted in the RAR manual from the first project phase that[19]:

> *„During the implementation phase of an intervention, the RAR can be used to evaluate the process and to control and analyse the project development. RAR makes it easier to decide whether specific aims, target groups or interventions require changing, and helps to recognise changes that can occur during the course of time without those involved noticing this. During the control, it is also possible to take into consideration information concerning the reaction of third parties (partner organisations, decision makers, public opinion and the media) to the interventions conducted or information on the development of local or regional networks, etc.*
> *Last but not least, the RAR method is also suitable as an instrument for the initial evaluation of effects in that it provides information on the effect of an intervention."*[20]

At the beginning of ''SEARCH II", therefore, the project partners were trained in the monitoring techniques and in the corresponding RAR-based monitoring in the regions.
At most of the project locations, the conditions, groups and their composition, etc. had clearly changed, which required corrections and re-orientation. These are discussed in more detail in the regional reports included within this report[21].

4.2. The prevention projects

There were differences in the further development of the prevention projects. Whereas some locations were able to directly continue developing the prevention measures that they had begun in 'SEARCH' (Barcelona, Ghent, Turin), other locations had to begin from scratch (Detmold, Vienna) or modify their approach (Enschede).

It proved to be a great advantage that considerable networking was carried out in the regions during the first project phase: already existing information often only needed to be up-dated, existing networks were able to be continued and proven cooperation was able to be consolidated. As the project aims are known and are generally supported by the professional and political bodies in the regions, we are optimistic that we have succeeded in coming substantially closer to our aim of firmly establishing the project ideas and results on a sustained basis. At many locations (Barcelona, Ghent, Enschede), nationwide enquiries testify to the fact that 'SEARCH' is also becoming known at the national level and the project results are being picked up on.

4.3. New project partners

As has already been described, ''SEARCH II" also aimed to further disseminate its results and methods in Europe by, for example, including new project partners in 6 further countries. This process turned out to be more laborious than had at first been expected. The reasons for this are numerous and range from the requested organisations being overburdened with their own problems, massive financial difficulties through cutbacks in funding, or only having secondary interest in the subject area of the project. The latter reason, however, tended to be the exception. Generally there was considerable interest in the subject area, especially as the requested countries confirmed that our project objectives – drug prevention with refugees, asylum seekers and, above all, illegal imigrants – was of current interest…

Nevertheless, we succeeded in finding six new partners[22], a good selection with experienced professional bodies and considerable interest in carrying out long-term cooperation in the subject area and on the complex issue of 'migration and addiction'.

The first step with the new partners was to train them in the RAR methods during a five-day workshop[23]. The rest of the work was determined by their rather late entry into the ''SEARCH II" project. The remaining project time only permitted the first RAR steps to be undertaken: collecting existing information, determining access routes, random sampling and defining key respondents. We agreed on the global aims: to produce a regional and/or national overview on the subject 'our target groups and addiction', and to reach initial conclusions concerning 'urgent needs'. In some cases interviews were conducted and/or focus groups organised to support the data collection.

5. A selection of results from 'SEARCH' and 'SEARCH II'[24]

5.1. Stress through migration

Today, when researching the health problems of migrants, it is presumed that a series of stress and risk factors lie behind general health risks, including that of addiction.
Which factors can be named today? How is this knowledge reflected in our specific results?

Intercultural communication
Owing to the often short period of time in which they have been living in the country, their specific living situation and the reasons for their migration, our target groups in particular have clearly more communication difficulties with the people of the host country than, for example, the second or even third generation of economic migrants who live there. In turn, the people from the host country have more difficulties in developing contact and in overcoming their reservations. This process, which must be learnt by both sides in order to achieve intercultural communication, presupposes the acquisition of intercultural competence. The experiences had in both project phases concerning this central area are described in the 'Guidelines ...'[25]

Linguistic problems
Not being able to express yourself in the language of the host country means to be cut off from lively everyday communication, opportunities for contact, etc, and having to rely on communicating with people who speak the same native language. This encourages isolation and segregation, and even when the language has been learnt, considerable cultural differences are expressed in the content of the language (i.e. at semantic level), which can make it very difficult to "understand" connections within health and medical areas. This is of essential importance for prevention activities.
All our respondents confirm that the inability to speak the language of the host country contributes to the isolation (and even to the 'ghettoisation') of asylum seekers, refugees and illegal migrants. On the other hand, if addiction prevention is to be successful then it is essential that they are explained the risks and means of avoiding them in their language and in terms of their cultural background.

Living conditions
Immigrants generally live in conditions that are restrictive and oppressive (at least in the first generation, but frequently in the second generation, too). Often the division of the apartment does not conform with the norms of the country of origin[26]. This of course applies even more so with refugees, asylum seekers and illegal migrants who, in all European countries, live under restrictive and oppressive living conditions (in homes, in prison-like hostels, on the street, etc.). It was for all of us an extremely depressing experience to see how unfit for human habitation much of the accommodation was!

Working conditions
Several studies in German-speaking countries (and we assume that this also applies to other European countries!) indicate that immigrants generally have not just worse working conditions than the native population but fewer possibilities to receive training in the host country. Furthermore, the high technological demands of the host countries place many of them, as far as their work experience in their homelands is concerned, in a very difficult situation.
Of course other aspects also apply to the groups of refugees, asylum seekers and illegal migrants investigated by 'SEARCH': most of them are not allowed to work, or only to a very limited extent (owing to state legislation), and are therefore frequently doomed to idleness and degraded to becoming 'charity cases'. This promotes isolation, 'ghettoisation' and – according to our studies – has considerable

impact on their self-esteem, courage to face life and health.
In many countries the refugees and asylum seekers hardly ever escape from their isolated living conditions, not least because the financial means available to them are generally and structurally very restricted. This leads to the risk that they begin selling drugs as dealers.

Ignorance of care structures
Migrants frequently live in considerable ignorance of the care structures within the social and health sectors of the host countries. When problems arise they do not seek suitable help but discuss solutions within the family, who are often, however, overtaxed and react with helplessness. Whilst for working migrants this tends to improve over the course of the years, for our target groups this applies to a considerable extent: These people very often do not know how and where to receive help for problems which occur, and sometimes access to this help is blocked by state legislation (there is no financing of certain health services for asylum seekers and refugees such as, for example, through the Asylum Seekers Benefits Act in Germany[27]).A further important aspect occurs in the various project locations: Often, the people in our target groups come from areas of the world where violence, lack of rights, state despotism and political and religious persecution prevail. They do not understand the care systems in the western democratic world, mistrust their institutions and their intentions. Here it is also important to search for sensitive possibilities for providing access to the people that are adapted to their initial experiences.

Family structures
The tendency of (traditional) family structures to break up in the host country generally plays a considerable role in the psychosocial stress of migrant families. This happens on the one hand through the tearing apart of the family groups in the course of the migration itself, but also on the other hand through the gradual adoption of cultural norms by the family members (generally in the second generation), which can lead to internal family conflicts, increasing 'cultural antagonism' and the associated severe health and mental problems[28].
These observations that apply to immigrants in general are even more dramatically experienced by the target groups we investigated as a result of further stress factors: often the families are torn apart in the course of fleeing and, due to state restrictions in the reception countries, are unable to meet up again, or only to a limited extent. The family as a 'protective factor', as a shield against the dangers of the host country (which are still largely unknown to them), is frequently torn apart. This applies for both asylum seekers as well as the Maghreb migrants in Turin and Barcelona. The loss of the family leads to a singularisation of relations and opportunities in life, and becomes a clear risk factor in terms of general health but also substance abuse[29].

Migration as trauma
The loss of the home, familiar surroundings, cultural certainty and confidence, in short: the fundamental certainties in life play a considerable role within every migration process. Foreign cultures are experienced as something extremely incomprehensible, even threatening, while the loss of all that is familiar is mourned. Meanwhile, this general process of 'uprooting' has begun to be taken seriously in all European countries, and no longer just responded to with the knee-jerk call for 'integration'. Integration presupposes openness, trust, confidence and respect on both sides. This must be first earned and the demand for integration must not be linked to the 'demand for cultural identity'. Otherwise it will have the effect of creating fear and segregation, which in turn can lead to mental stress and health reactions.
According to our investigations, what has been said applies even more to the groups investigated by us: the reasons for leaving the home country are dramatic and often traumatising, whereby persecution, fear, humiliation, torture and the threat of death play a role, but also – as with the Maghreb

people – squalor, poverty, impoverishment and hopelessness in the homeland. Such severe wounds heal slowly, and the less secure status as an asylum seeker, refugee or illegal migrant, characterised by many new stresses, fear of the future and insecurity, is an additional complication in this process. Traumata (and the associated post-traumatic stress syndrome) play a significant role in our RAR in establishing the reasons for vulnerability to substance use and abuse.

All in all, with the help of the RAR we have gained an impressive 'database' on the background of addiction risks, the spread of substance use and abuse as well as appropriate means and methods for addiction prevention. Many of our 'assumptions' had to be revised, some were confirmed.

Prevalence of addiction
The actual prevalence of substance abuse among the examined groups is, in quantitative terms, generally very small. However, where addiction problems do occur they tend to have a more detrimental effect when compared to control groups from the native population. In all countries it was also noticeable that due to the national laws, it is almost impossible for our target groups to receive therapeutic treatment for addiction (since it is not financed!). However, this deficiency was not pursued any further in the project, especially since we had to restrict ourselves to looking at preventive activities. Nevertheless, we are mentioning this factor here as an indication of the health and social policies of the various countries.

5.2. The country reports[30] and products

On the following pages the various results of our project in the different countries are described. These also speak for themselves and do not require any preceding 'interpretation'. The reports come from practice and are written for practice. They summarise processes, experiences and results, and they describe a process that has not reached its conclusion at any point, but continues in its diverse forms. The reports from the six 'new' countries also highlight situations, trends and developments, and in particular various needs for further development.

The 'SEARCH' project products can be divided into three groups:

- Concrete materials that can be implemented flexibly in drug prevention with people from other cultures. (Examples that can be named here include the cards and figures from Enschede, which are very suitable for addressing young asylum seekers whose communication, linguistic and perception forms tend to be based more on images and visually- and affective-based learning than on the rational-cognitive forms that prevail in our cultures);

- Curricula and training guidelines for people working voluntarily or professionally with our target groups. (For example, in updating their 'guide'[31], the project partners in Barcelona have developed a training concept that is currently being used successfully not only in Barcelona but also in the meantime in several Spanish cities);

- Implementation of the work with asylum seekers, refugees and illegal migrants in regional and national structures and institutions (such as, for example, in Vienna), with the help of sustainable training and coaching concepts.

With our project we opened doors in all countries, brought people and institutes together and discovered, or rather 'identified', a need for specific prevention which admittedly already existed 'somehow', and which many people were consciously aware of, but had never actually been tackled. Local

working alliances have often been established – networks which set themselves tasks that extend far beyond the individual projects, the end of the overall project, and what 'SEARCH' set out to achieve.

All those who have already conducted European projects are aware that there is a risk that the project results remain ‘unfulfilled’, that there are often very interesting and important results that are neither ‘implemented’ nor contribute to a change in practice, but lie dormant between the covers of the final reports. For this reason we are even more delighted that ‘SEARCH’ seems to be having an impact. In all our locations our work has had sustainable consequences that very often affect not ‘only’ our target groups but also further aspects and fields in migration-specific addiction and health work. In some countries we were entering uncharted territory, in others we were supplementing existing schemes for integrating migrants with the aspect of asylum seekers, refugees and illegal migrants.

As the project supporting body, LWL has learned not only that the RAR methods provide good instruments for planning interventions in the psycho-social area but that ‘SEARCH’ was only able to touch on many aspects which need to be consolidated. In the area of migration, all countries are experiencing in the mean time a considerable increase in legal and illegal migration:

Regardless of wherever these people may come from who leave their homelands and seek protection and peace – or just social security, a livelihood and survival – they are there, they live among us, and for that reason alone deserve our attention and care!

1. In 2002, the LWL published the 'Manual on Drug Prevention for Refugees, Asylum Seekers and Illegal Immigrants' (as PDF on the enclosed CD rom). At the end of 2002, it was possible to start the second project phase: As with 'SEARCH', 'SEARCH II' was co-financed by the European Commission. This collection of material includes the main results of the 'SEARCH II" project as well as additional materials on the subject. However, in order to make it easier for the reader to gain a complete overview of both project phases, it is also necessary to briefly describe the course of the 'SEARCH' project, including its aims, methods and results.This is provided here with a project description, so-to-speak a 'revised overview', which is then supplemented with the introductory comments on 'SEARCH II'.
2. See: EMCDDA SCIENTIFIC REPORT: Update and complete the analysis of drug use, consequences and correlates amongst minorities, Lisbon 2002
3. UNHCR: http://www.unhcr.ch/cgi-bin/texis/vtx/home?page=statistics
4. Cf. Franz NUSCHELER (1995), Süd-Nord-Migration..., p. 103 f.
5. UNHCR: idid., p. 2
6. Jörg ALT, Norbert CYRUS, in K.J. BADE/R. MÜNZ 2002, p. 141
7. Which in Germany, for example, has led to the charity and refugee organisation campaign: 'Kein Mensch ist illegal!' (no one is illegal!), which is still going on.
8. Jörg ALT, Norbert CYRUS, ebenda, p. 155
9. An exception in Germany is the Ministry for Women, Youth, Family and Health of the federal state of North Rhine-Westphalia (MFJFG) (Ed.); Gesundheit von Zuwanderern in Nordrhein-Westfalen (health of immigrants in North Rhine-Westphalia) Dusseldorf 2000. However, refugees and asylum seekers are only mentioned in passing, and here the area 'addiction risks/illnesses' is only very briefly touched on (p.111 f.).
10. The project received this name after a suggestion from our Belgian project partner: It expresses the idea of research (re-search) by us, but also the 'search' for security, dignity and protection by the asylum seeker and refugees.
11. For the project partners, see the Annex
12. See bibliography in the Annex
13. See LWL (Hg., 2002)
14. However, we must emphasise that this method does not provide secure data that is suitable for planning 'en passant', but only when it is implemented according to plan, expertly and in a disciplined fashion. At the time of writing, we have been giving a lot of thought as to how an 'RAR' training module could be implemented in future.
15. e.g. in the 'euro net ' European network, see the internet home-page:
    http://www.lwl.org/ks/drogen/modellprojekte/frmodellprojekte.html
16. We are also emphasising this to protect our research work from political misuse through parties and opinion leaders!
17. 'Rapid Assessment and Response' (RAR) Handbook on Problematic Substance Use Among Refugees, Asylum Seekers and Illegal Migrants, Edited by LWL, Münster, 2004 (second, revised edition).
18. One project partner, for example, began with great zest to investigate a target group which in actual fact was only present seasonally – of course it was possible to find key informants in the administration and other (social) facilities, but no persons from the target group: it was the wrong season!
19. Cf. BRAAM et al.(2002), loc. cit. p. 20.
20. ibid.
21. A special situation occurred with the German project partner: For SEARCH II, the Drogenberatung Lippe (Lippe Drug Counselling Centre) replaced the district of Soest, which dropped out of the project after SEARCH I. Because there were no data or results available, the basic RAR was conducted instead of the Monitoring RAR. This is explained in more detail in the report from the DROBS Detmold.
22. Compare list of the project partners in the Annex.
23. Turin, September 2003
24. Note: It makes little sense to repeat here in a 'halfway' form the results that are anyway presented in the country reports. The intention is to provide a summary of certain conclusions and insights gained, and to highlight them here in a 'condensed' form.
25. See chapter 18
26. For Germany compare MFJFG (Ed. 2000), Gesundheit von Zuwanderern in NRW, p.16 ff. Also see: Toni FALTERMAIER, Migration und Gesundheit, in: P. MARSCHALCK/K. H. WIEDL (2001), p. 93 ff.

27. Compare critically with PRO ASYL (Hg.): G. CLASSEN, Menschenwürde mit Rabatt. Kommentar mit Dokumentation zum Asylbewerberleistungsgesetz (AsylbLG) und zum Flüchtlingssozialrecht, Berlin 20002
28. 'Imitating' the lifestyles of people in the host countries also plays a role (see the report from Turin): the habitual lifestyle and behaviour patterns in the culture of the country of origin contrast considerably with those of the host country. For those who give up their protective cultural identity (that is in the sense of addiction risk) for a long time only have the possibility of 'simulating' a 'new' cultural identity. The use of alcohol, for example, becomes more risky the less this use belonged to the cultural standard of the country of origin.
29. In some of our studies we were able to establish a clearly higher vulnerability with respect to addictive substances for single men.
30. Here we refer to the previously mentioned 'SEARCH' manual, in which the reports from the first project phase can be drawn upon for comparative purposes. It can be down loaded at www.projekt-search.de
31. This can be found on the enclosed CD-Rom

6. 'SEARCH II' in Austria

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1. Description of the organisation

The Institut für Sozial- und Gesundheitspsychologie (Institute for Social and Health Psychology (ISG)) was founded in 1994 with the aim of conducting various activities in the areas of psychological re-search', counselling and prevention, clinical diagnosis and treatment, as well as psychotherapy. As the only independent institution in Austria, it tries to be active in various psychosocial areas and, in particular, to concentrate on subjects concerned with addiction.
The interdisciplinary group of staff comprises psychologists, educationalists, doctors, sociologists, social workers and psychotherapists.
The work focuses on:

- Psychosocial re'search' on behalf of ministries, regions and local authorities, scientific documentation and publications.
- "Use and misuse of substances by children and youths" (1996-1999).
- "Drug affinity amongst youths in the techno party scene in European metropolises", with SPI-Berlin and VWS Vienna (1999).
- "SONAR": Study on nightlife and substance use in 8 European cities (IREFREA 1999).
- "Re'search' and intervention project for risk reduction among socially excluded individuals, IDUs and people with HIV/AIDS (EURO-EXCLUDE)", cooperation with EASP (Granada).
- "European Healthy Schools and Drugs (EHSD)": Prevention of drug misuse in secondary education establishments (with TRIMBOS, NL).
- "Prevention of drug misuse among refugees and asylum seekers" in cooperation with the LWL.
- Concepts in the field of psychosocial prevention and rehabilitation.
- Training target groups (mediators, peers) in the fields of education, health and youth welfare (in close collaboration with RISIKO - Verein für Prävention und Intervention in Vienna).
- Prevention and rehabilitation in cases of substance misuse and addiction as well as in cases of other forms of psychiatric deviations. (In recent years the ISG has conducted numerous prevention projects in schools and firms in collaboration with the Risiko organisation).
- Clinical-psychiatric diagnostics and treatment.
- Health psychology and psychotherapy work.
- Providing counselling, information and care for persons with psychosocial problems.

The ISG is member of the International Council on Alcohol and Addictions (ICAA), Geneva.

2. The transition from 'SEARCH' to 'SEARCH II'

After completion of 'SEARCH' in March 2002, there was a pause of around six months before beginning 'SEARCH II'. During this period, the RAR team in Vienna maintained contact with the key persons concerned with refugee care (in particular with the Evangelischer Flüchtlingsdienst Österreich – the Austrian Evangelical Church's refugee service (EFDÖ), our partner in the pilot 'SEARCH' prevention project). During the discussions it became clear to the team that there had been changes to the target group of Iranian refugees: (almost) all Armenian-Christian Iranians (the majority of whom had severe alcohol problems during their stay in Austria and were thus particularly vulnerable to addiction) had left Austria, while more restrictive admission requirements in the destination countries (USA, Canada) had stemmed the flux of refugees from this ethnic group to Austria. In addition, our key persons indicated that carrying out prevention work with the Iranian refugees who did not belong to the Christian-Armenian minority, and who therefore remained in much smaller numbers, would be very difficult and

inefficient. Tending to consist of 'older' men, this group showed opium use patterns that were part of their cultural tradition and which would therefore be difficult to change. Here, any prevention measures were very likely to hit upon stony ground. Thus, already before the beginning of 'SEARCH' II, the RAR team again found itself in a 'monitoring' phase that made us consider changing the target group for 'SEARCH II'.

At the same time, key persons involved with the NGO asylkoordination österreich (Asylum Coordination Austria) indicated to us that the problem of drug use had increased among the group of unaccompanied, juvenile refugees (UJRs). We had already considered them a potential target group in 'SEARCH', but had received fewer indications of problems than with the Iranians. Persons from refugee care who work with UJRs could no longer simply standby and watch, and enquired at asylkoordination österreich whether the 'SEARCH' project, which they had already heard about through the ISG, was still running. The ISG learned about this through the asylkoordination and contacted the key persons involved with caring for UJRs.

During the discussions, the RAR team was informed that an increase in the misuse of additive substances had been ascertained in the facilities concerned with UJRs, and that the refugee care workers were keen to do something to prevent this but would require support.

As the beginning of the 'SEARCH II' project had already been fixed at this point, we agreed to enquire at the opening workshop of 'SEARCH II' whether it would be possible to change the target group for Austria for reasons of immediate importance. This was accepted by the project management after we reported on the changes in the situation in Vienna, and we began with a 'light RA' (cf. monitoring chapter in the RAR Handbook for the project) for the UJR group.

3. Course of the 'light RA'

The RAR team began collecting context material on the UJRs in Austria (countries of origin, age, gender relations, accommodation, prevailing legal conditions, etc.) to gain an overview. At the same time we tried, with the help of asylkoordination österreich, to identify key persons involved in refugee care in the UJR area. The starting points were visits to clearing centres for UJRs. These are special facilities for young refugees where they are housed for up to 3 months upon arriving in Austria and where they are provided with initial legal and psychosocial care.
In addition, the ISG attended one of the joint regular meetings of all the Austrian clearing centres where we had the opportunity of getting staff from the various facilities together at one location to concentrate on this theme. This was achieved by means of a clearing centre focus group within the framework of the meeting, whereby we were able to collect a variety of context information and basic facts.
After the clearing centre meeting, at which further interviews were arranged in the individual facilities, we conducted a series of semi-structured interviews with staff not just from the clearing centres but also from the aftercare facilities. These are facilities provided for UJRs after the clearing phase, in which they are housed until they are 18 years old.
We also interviewed staff from the „Kompetenzzentrums für UMF" ('Competence Centre for UJRs', a local department in Vienna) as well as people responsible for the 'Connecting People' sponsorship project[1] for UJRs.

1. Here, individual persons voluntarily sponsor UJRs and, within the time available to them, try to help and support the UJRs with legal, social and other problems.

The concentration on semi-structured interviews was partly due to the positive experience had with this method in 'SEARCH' and partly due to the shortened 'light RA' process.
Apart from the interviews with UJR facilities, working sessions were held with the Institut für Suchtprävention (Institute for Drug Prevention, (ISP)), a local authority establishment in Vienna. Here it was determined to what extent the Vienna addiction care service had been concerned with UJRs. However, we were not able gather much in the way of indications. Although this led to further individual discussions with addiction professionals and social workers involved with youth work, which were partly arranged through the ISP, these also provided very little valuable information. Thus, until 'SEARCH' II, UJRs has previously not been considered in addiction care or youth social work, either in Vienna or Austria as a whole.

4. RAR results

Based on the information from the interview partners, the community of unaccompanied juvenile refugees can be divided into two main ethnic groups with regard to the problem of addiction:

- On the one hand male West Africans;
- On the other male Eastern Europeans.

Based on the statements of the interview partners, two substances in particular came to the fore whose use within the vulnerable groups can be regarded as problematic:

Cannabis use is ascribed in particular to the West African group (especially people from Nigeria, Sierra Leone, Ghana) and, in individual cases, to Afghanis. The interview partners have highlighted the problem not just of using but also of dealing with this substance. The use is considered as an inherent part of their culture and of everyday life, and is therefore somewhat played down. According to the interview partners, the West Africans strictly separate the dealing and use, and only in individual cases do they consider it possible that these are mixed.

At this point it should be noted that, in the group of African UJRs, it is particularly the behaviour patterns linked to drug use that represent a very serious problem. Mafia-like human trafficking and drug rings are carrying out the organised recruitment of African UJRs, who as a consequence are also becoming involved in criminal activities.
The carers of UJRs place particular importance on the problem of preventing crime, as drug searches and raids by the police could harm the reputation of the facilities. This in turn could lead to them losing financial support. For this reason there are usually house rules that are given the highest priority.

The second problematic substance that can be identified is alcohol. Its problematic use seems to be particularly prevalent among eastern Europeans (Georgians, Russians, Kazaks, Ukrainians, Moldavians) as part of a cultural habit that they have brought with them. According to statements made by the interview partners, there is no awareness of the problem among either group. In individual cases, alcohol misuse is also linked to refugees from Guinea and Afghanistan.

In addition, heroin and cocaine were occasionally mentioned in the interviews, which are used as stimulants by African refugees in the street prostitution scene in Vienna, and in the past have also been used by Georgians.

A physical problem that is particularly identified in connection with alcohol use is aggression as a con-

sequence of excessive use. The physical effect of the substance is underestimated by those not used to drinking alcohol as a result of cultural and religious prohibitions in their homelands.
An important psychological factor is considered to be the lack of any awareness of the problem, which according to the respondents is closely connected to the cultural traditions. This can be ascertained with both alcohol and cannabis users. Alcohol is used to suppress worries and fears.
A social problem is considered to be the impairment of daily routines and leisure behaviour due to the effects/results of the drugs. The refugees then spend the entire day in bed and cannot be motivated to take part in any activities.
Apart from the use of specific substances, legal problems also arise as a result of drug dealing and drug-related crime. The drug bans that exist in the refugee facilities are, however, imposed with various degrees of strictness. The consequences range from turning a blind eye and playing down the problem to threats of ejection.

5. Dealing with drug problems in the refugee facilities in Vienna and the surrounding area

In Austrian refugee facilities, it is usually general measures that are applied to counter drug use. Examples that are mentioned in the interviews include house rules, the drug law, announcing drug tests, house searches and their consequences (= ejection). Individual refugee facilities ensure that their carers are trained in aspects of drugs and, in addition, work closely together with the police (e.g. with house 'search'es). Preventive measures include providing information on the legal conditions and activities to bolster self-esteem and self-confidence.
According to the respondents, central elements in the preventive areas are the legal possibility to work (which is only possible for refugees under exceptional circumstances), activities (e.g., German courses), projects (e.g. flood help) and regular leisure activities (e.g., sport, painting, music), i.e. the creation of a structured day programme. However, because of the lack of personnel, time and, above all, financial resources, these are almost impossible to implement.
According to the respondents, a preventive effect is achieved if the juveniles are religiously minded and socially included in peer groups. Although mutual help is offered among the refugees for drug problems, if there are addicts in a residential group or clique they are excluded. Such social exclusion represents a considerable loss for the juvenile refugees and is therefore avoided. Group membership can therefore be regarded as a protective factor.

The focus group that deliberated on the RAR results dealt with open questions and, above all, discussed preventive strategies, confirmed the ascertained 'vulnerable groups' and the problematic substances. There was also agreement that the use patterns are mostly based on cultural tradition and that there is little awareness of the problem either by the UJRs or the carers.

6. Initial considerations for preventive activities in 'SEARCH II'

Based on the results of the semi-structured interviews, we established the following priorities for conceiving preventive measures:

1. Creating structured day programmes through providing activity projects and vocational possibilities
2. Training measures for the carers in refugee facilities
3. Establishing drug behaviour as a standard theme in refugee facility meetings
4. General health care and bolstering self-esteem.

With regard to drug prevention for UJRs, the focus group discussions emphasized the importance of providing structured day programmes that ensure sensible daily routines (and without which there is hardly any basis for providing life skills).
It was also confirmed that the most significant preventive factor would be the legal possibility to work – various possible approaches were discussed in this respect, which, however, all remained unrealistic and would have been impossible to pursue within the framework of 'SEARCH II'.

Overall, participants in the focus group favoured the prevention option of multiplicator training and/or training people from the refugee care services as the most realistic prevention activity. This is not least because there is also the view that, beyond the activities of the ISG within the framework of 'SEARCH' and 'SEARCH II', the ISP could also include 'systematic drug prevention in refugee care' in their working programme. The experts considered that dealing directly with the UJR target group would do little to achieve the aims as this would only be 'paying lip service' and, in contrast to coaching activities, would not be sustainable.

As a result of the RAR findings based on the interviews and the focus group, the ISG began designing coaching programmes for carers of UJRs and, in individual cases, began conducting training in small groups (on location or at the ISG).
When selecting the facilities, we decided for the Vienna clearing centre for UJRs and the Laura-Gatner-Haus for UJRs, which belongs to the EFDÖ. (Here, UJRs can remain until their 18th birthday following the clearing phase). Thus it was possible to provide individual and need-based coaching for employees (leaders, key staff and entire teams) in two different forms of care for UJRs.

7. Provision of coaching as part of the prevention work in 'SEARCH II'

We began the coaching phase in the form of individual coaching sessions with leaders from both the selected care facilities. In particular, these were aimed at:

- further clarifying individual needs to a greater extent than was previously the case during the RAR phase,
- 'monitoring' the changes in the facilities since the last discussions through using first-hand information,
- organising group coaching sessions with the staff.

In the case of the Vienna clearing centre ('Project Caravan'), there was also an additional preliminary discussion on the above-mentioned themes with key persons from the care team, which led to a preliminary coaching session as part of a team meeting of the staff from CARAVAN. This in turn provided the additional information needed for finalising the concrete programme for the team coaching sessions in the Vienna clearing centre. The greater concentration on the Vienna clearing centre was a consequence of the much more complex problems in this facility, which required even more intermediate steps than the EFDÖ's care facility in Hirtenberg (Laura-Gatner-Haus) to the south of Vienna.

The Laura-Gatner-Haus in fact places great emphasis on activities and tries, with considerable success, to find vocational and training possibilities for the refugees. It also conducts its own activity projects (e.g.: designing and renovating the home). For increasing self-esteem, a psychodrama group

is also provided. Led by two psychotherapists, it has been well received by the juveniles. In Hirtenberg there are different prevailing conditions than at the Vienna clearing centre. The geographical position outside of Vienna, the better financial structure through the use of personal donations, the possibility for UJRs to work and be trained, different team dynamics and the fact that there are generally much fewer problems in terms of drug use means that it has a much more positive starting position than Vienna itself. This allows for better implementation of many of the elements that have a preventive effect on addiction and which are theoretically striven for in Vienna (e.g. structured day programmes, activities).

The most important starting point for the coaching was the fact confirmed by the RAR that drug prevention has effectively less to do with individual prevention than with protecting the facilities. The most overriding aspect in this context is: "Which contribution can drug prevention make to the survival of a facility (drug-free facility, keeping house clean, etc)?"
Thus the ISG focussed on drug prevention that was targeted at the staff and the facilities. In the case of the UJRs in Vienna, drug prevention also means taking into account 'delinquency prevention', which is based on similar premises to drug prevention and can work with similar means.

In terms of the carers, it was mostly concerned with reconciling the actual circumstances in the specific facility with their mostly deviating ideals and beliefs. It was not only necessary to increase acceptance of the circumstances, but also improve how they are dealt with. Likewise the phenomenon of suppression needed to be dealt with. The fact that people keep problems to themselves, and each carer pursues their own way or ideas, means that any consistent line taken by the team falls by the wayside. This in turn means that there is a lack of any predictable decision or sanctioning processes. Thus the UJRs cannot recognise any clear and consistent courses of action, or any stability and continuity within the facility.

In terms of the facilities themselves, the emphasis is on improving the structures so as not to encourage addictive behaviour: clear rules and consequences are necessary, and functioning and practical elements for structured day programmes must be developed. The situation in the facilities is severely restricted by the prevailing conditions (the duration of the UJRs is limited and the carers have no influence on the period after the primary care).

Further important elements for the coaching that were able to be identified included teaching basic knowledge on drugs, introducing methods for drug prevention, discussing risk and protective factors, emphasising elements that strengthen self-esteem, improving group and team dynamics and networking elements.

Coaching sessions show that with the help of this technique, which does not follow any strictly ordained guidelines as to content, acute problems can be approached with openness and flexibility. The aims and content of the coaching sessions are thus first developed together during the sessions themselves, whereby the general preventive objective should not be forgotten.
Nevertheless, we have attempted to summarise the most important requirements and contents when coaching carers of UJRs.

Based on our experiences in 'SEARCH II', we believe that coaching programmes for carers of UJRs should include the following elements and models:

- *Basic knowledge on the themes: "Addictive substances – effects and risks"*
  - Development of addiction
  - Recognition of addiction
  - Reaction to recognised addiction risks
  - Dealing with those at risk of addiction
- *Introduction to "methods of drug prevention":*
  - Primary prevention (tools for developing self-esteem + structural elements, life skills, health care, etc.)
  - Secondary prevention (recognising and reacting where there are already problems)
  - Tertiary prevention: treatment
- *Discussing risk and protective factors*
- *Giving particular consideration to changes to the norms and rules (social norms, norms for youth welfare and/or peers) as well as to the structured day programmes or activities for UJRs*
- *Joint development and/or optimisation of elements for structured day programmes, in which drug-related aspects can be incorporated (e.g. German courses)*
- *Emphasising elements for bolstering self-esteem in care beyond the (moral) relation level*
- *Discussing the contentious issue: "combating causes of addiction" vs. "quickly implemented help"*
- *Improving the group dynamic within the team of refugee carers (strong emotions in team with cases causing particular concern)*
- *Networking elements, knowledge transfer (networking with relevant specialist centres at local or regional level)*

8. Extending the training to the 'Connecting People' project:

An innovative project from asylkoordination österreich is called 'Connecting People'. This enables individual juvenile refugees to spend their free time with an Austrian sponsor and be integrated into their family unit (for a limited time), which contributes to the social integration of UJRs and therefore provides drug prevention.
After the focus group for 'SEARCH II', the contacts that were already made with the 'Connecting People' sponsorship project were intensified, those responsible for the project were informed of the coaching idea and, based on these preliminary discussions, the sponsors were offered 10 hours of individual free coaching. The project leader informed the sponsors of this, and they could contact the ISG directly to receive coaching as necessary. Besides the risk of using drugs, a main problem or concern of the sponsors that could be identified was their fear that the UJRs might drift into drug dealing. Thus the coaching sessions mostly dealt with the sponsors' own fears and with developing joint strategies for taboo-free and open communication between the sponsors and the UJRs.

9. Conclusions, Outlook

The use of coaching for carers of UJRs is aimed at supporting the constant factor in refugee care, i.e. the pool of refugee carers, in their daily work. It also provides them with the necessary tools and, in a joint process determined by individual needs, improves the ability of social workers and social educationalists to act in regard to addiction and delinquency prevention.

It has been shown that such coaching must be oriented to the respective, specific needs of the facilities and/or target persons in the different settings (in our case: UJR clearing centre, UJR aftercare facility, sponsors of UJRs). This necessitates an individually determined method of approach that can, however, follow specific guidelines.

The ISG coaching programme met with considerable interest, was well received and shall be continued after the end of the 'SEARCH II' project. Above all, the cooperation and networking in this regard with the Vienna clearing centre is now on a firm footing, even if the concrete longer-term possibilities for coaching are limited by financial aspects.
According to the participants, the coaching was accepted as a 'door opener', as 'something new' that 'did good'. Previous supervision provided for refugee carers beyond 'SEARCH' raised expectations that could not be fulfilled because there was no continuation. In addition, the subject of drugs was only ever a peripheral theme – if it was considered at all.
With the sponsorship project 'Connecting People', a network was also established by the ISG that enabled regular monitoring of the problems and needs of this special group in terms of the RAR.

Imparting the content of the 'SEARCH' activities to the ISP (Institute for Drug Prevention in Vienna) enabled the subject of 'SEARCH' to be shifted to the political level. Currently there are discussions taking place between heads from specialist drug prevention centres and those responsible in refugee care, which gives justifiable hope that a sustainable and longer-term approach to the problem of drug addiction among refugees can be got going. Since 'SEARCH II', there has been better understanding of the various correlations. Whereas during the course of the 'SEARCH' project suppression was still very much a problem, with 'SEARCH II' there was already much more openness regarding our area of concern. The RAR questionnaires and focus groups from 'SEARCH' had already prepared the grandwork for 'SEARCH II', and thus other necessary plans (such as dealing with 2nd generation migrants with regard to drug addiction) can be approached with more confidence of success.

7. 'SEARCH II' in Belgium

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De Sleutel, Gent, Belgien

Peer van der Kreeft
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1. The organization "De Sleutel"

De Sleutel ("The Key") is the largest organisation in Flanders providing counselling services and research into the prevention and avoidance of drug problems. De Sleutel was founded in 1973 and has 230 staff. The organisation has two therapeutic communities, one crisis intervention centre, five day centres, two residential shortterm programs for the under aged, outreach- and streetworkers, methadone supply centres and training centres and a social work centre. De Sleutel works for both the primary and secundary prevention of drug abuse. We thereby combine methods and techniques which are internationally acknowledged and appreciated. De Sleutel has long-term relations with research institutes over the whole of Europe and beyond. Much of our knowledge comes from our own experience on the shop floor. Information, education and a strategy in social and individual handling of drugs converge in an overall preventive treatment in schools or in the community. The life skills and peer-to-peer approach are used in this context.

2. From 'SEARCH' to 'SEARCH II'

2.1. Network

The results of the RAR research in 'SEARCH' led to raised interest from a group of employees within our organisation. This group included people from the different fields: of prevention, outreach, treatment and research. We also found we had learned more about the way how to support asylum seekers. The succession of the first project by 'SEARCHII' assured all the colleagues of the solidity of this project. This also meant that their effort in this action and research could be repeated.

2.2. Objectives and Results

The objectives and expected results for 'SEARCH' were more specificly formulated as follows:

- Further distribution of instruments for prevention. Monotoring the prevention strategy and to change when wanted:
  - in general,
  - with special attention to the integration module in primary schools

- Second RAR-research will have to be carried out in a more differentiated and wider targeted population in compliance with the target population of RAR in 'SEARCH'. RAR consists of a questionnaire and target group of 105 respondents to a local OCMW-initiative.

- To explore instruments for the distribution of the RAR methodology for training modules within our reach.

2.3 Prevention staff involved

Many of the interviewed, target groups or contact persons were connected to people from 'SEARCH'. The positive experiences we had by registrating all documents, granted a good base for the necessary action undertaken in 'SEARCH II'.

3. Concrete results

3.1 Instruments for prevention

We had two publications:

- 1 brochure in six different languages
- 5 stories for children about refugees and about drugs (magic potions)

'SEARCH II' monitored for qualitative distribution and effective use. The distribution became simpler by use of the website (www.desleutel.be) and by adding an audio-version on CD. This material was presented at a press-conference.

3.2. RAR

3.2.1. Monitoring ‚De Brugse Poort', Gent
We held interviews with relevant organisations and individuals from the 'SEARCH' sample as well as with new contacts. This resulted in a detailed report and a formative evaluation of the project. In Chapter 5 you will read lively records of discussions relevant to this subject.

3.2.2. RAR at 105 local OCMW initiatives in Flanders
OCMW's are Public Centres for Social Welfare. Every Community Council in Belgium has such a Public Centre. The RAR methodology was adjusted to incorporate a broader group of contacts by the use of a questionnaire and a regional meeting acting like target groups. The assessment contained 105 respondents. The questionnaire had the same structure as the interviews in 'SEARCH'.
The respondents consisted almost only (96 %) of social workers. The ultimate target group consisted of asylum seekers from almost all parts of the world. Most sensitive for drug problems are, according to the research, asylum seekers from the Middle East and the Balkan. The complete result is published in Dutch and is to be found at www.desleutel.be

3.3 Multiplication of Methodology

3.3.1. Material
We translated the RAR manual and adjusted the manual to the local situation and culture in Belgium. We used examples that were 'close to home'.

3.3.2. Training
We organised a trial of the RAR method in a setting without drug prevention. The theme was "truancy by children". 'De Habbekrats' in Gent cooperated; this is a very active and well known Youth Centre centered towards socially vulnerable teenagers. We use the results of the trial in a one-day training course about RAR. The training is aimed at social workers who coordinate activities in local prevention schemes.
The methodology was also presented in a lecture at the 'Gents Hogeschool', Department of Social Studies. We became even more convinced that the methodology could be transfered to services and organisations which themselves don't have a well developed scientific section.

3.3.3. RAR in 'SEARCH II': General conclusions
Of 105 respondents a large majority (89%) had a job where asylum seekers are the specific target population. 80 % of the respondents indicated they had - a moderate to high - knowledge of drugs.

This research showed no dramatic drug problem with asylum seekers. Still, one in three respondents indicated there were problems with drug abuse in this group.

People working for OCMW's refuge initiatives noticed physical, financial and social problems when drugs were used.

Councillers based their views mainly on what they saw of the asylum seeker or from what the asylum seeker told them. The behaviour of these people is often a source of information. They also got information from colleagues.

The average profile of a problematic user according to the respondent:

- Legal drugs are especially problematic. The three most problematic legal drugs are; alcohol, tobacco and medication. Of illegal drugs, cannabis is the most important, followed by heroin.

- The specific circumstances of the asylum seeker create the most important problem. An insecure future, boredom, waiting and traumatic experiences in their homeland are the main reasons why these people are using and abusing drugs.

- Most problematic users came from regions of the Balkan, Iran and Georgia. These people appeared to be mostly male between the ages of 18 and 35. The majority of them emigrated alone to Belgium.

Most asylum seekers with a drug problem are in contact with an aid worker once a month or less.
Community centers and schools (general aid work) should organize the prevention. Also the centers for asylum seekers would be good places to organize prevention.
The content will have to accent on product -information and difference in culture. The information will also have to accentuate the consequences and dangers involved in drug use. The people best at prevention are health workers, doctors and professional prevention workers. For non-professional aid work it is best to use the target group itself or people representing that target group.

4 'SEARCH II'- Development of material for prevention

Annemie Deloose, De Sleutel, Day Hospital Mechelen, 2004

4.1.1. Recommendation for prevention from 'SEARCH II'
RAR research of 105 local OCMW initiatives shows that the most suitable prevention-channels are: centers for asylum seekers 40%, schools 31 %, community centers 16 %
The content of prevention according to this research will have to be about: drug products 49 %, social context 27 %
The most important causes of drug problems are being defined as: boredom 65%, traumatic experiences 57 %, culture differences 24 %, availability 16 %, social position 16%
The most problematic drugs are: alcohol 80 %, tobacco 60 %, sedatives 24 %, painkillers 24 %, cannabis 15 %, heroin 5 %

4.1.2. Recommendation for prevention from 'SEARCH'
Research of the Kosovanian and Albanian community in a neighbourhood in Gent showed the following conclusions:

- Press the need of good education and the future of the children;
- Give attention to the specific circumstances of asylum seekers without stigmatizing them;
- Give the children and youngsters the same instruments as others in an integrated way;
- Show them the risks of getting involved in a youth-culture of drugs (cannabis and ecstasy) and in truancy;
- Give information about the specific Belgian culture of the use of medicines.

4.1.3. Innovation
We made sure we mentioned in our publications also some recent and common experiences about prevention. We focused in our brochures on physical and mental risks of drug use. But also on the social effects: becoming aggressive after the use of drugs for instance. The publications for this target group give the same information about drugs as other brochures. At the same time we make notes and give information on every page of the brochure of the specific situation of asylum seekers, refugees or illegal immigrants.

4.1.4. Brochures in 6 languages
You will be able to find brochures in 'De Sleutel' in: Russian. Czech, Slowanian, French, English and Dutch.

H.B., streetworker in Gent says about the publications: "*Halfway the nineties streetworkers, who concentrated on drug users and prostitutes, noticed that many different faces appeared. Faces from Kosovo, Albania, Czech Republic, Slowania and very recent Romanies from Prague.*"

„These people speak a different language and have different concerns about their health. They don't always know what they will eat in the evening. They are very reserved. But we managed to gain their trust by working with them in a very intensive and personal way. We realise that these youngsters are not very different from Belgian, Maroccan or Turkish teenagers: puberty, more financial opportunities, experimenting.“

"It is for the first time I see such prevention material and this is already a great effort of 'De Sleutel'. But there are two difficulties for the distribution. One: reaching the people and two: finding people who are able to explain the material and are able to work with it. I hope this will succeed."

4.1.5. Integrated use of material
We conceived material such that various subjects engaged at the same time in the ‘SEARCH’intervention.

- The teacher uses the stories in 'social skills' lessons in primary school;
- The pupil takes the storybook (or audio-cd) home;
- The stories are also to be found on the website www.desleutel.be;
- The social- or healthworker works with the asylum seeker with help of the brochure;
- The parent talks to the child about the stories and the brochure.

4.1.6. Next steps

- A brochure of 8 pages for the social- or health worker, the teacher and coordinators will give guidelines to work with the SEARCH-prevention materials.

- A presentation with powerpoint adds to the brochure. If required De Sleutel will provide a three hour training-session.
- The internet tools of 'De Sleutel' will be used to optimise the distribution of the material.
- Material will be distributed within relevant target groups and presented at different occasions like e.g. when training the VAD for regional and local people responsible for prevention.

5. "Het Gat in de Haag" ("A hole in the hedge") and 'SEARCH II': primary schoolchildren

The information brochures (in 6 languages) are read by teenagers and adults with or without support of a community centre, integration worker, translator, language teacher, aidworker or other professionals. The brochure refers to 'A Hole in the Hedge', a story book of the prevention program 'Contactsleutel'. A lot of primary schools and nursery schools work with this program. The stories in the book concentrate on the basic skills. These are social and emotional skills children learn on their way to adulthood. We give a few examples of basic skills such as making choices, critical thinking, getting a positive image of themselves, dealing with feelings, learning from mistakes, asking for and giving help, thinking about the differences between good and bad. These skills are being learned at a very young age and 'A Hole in the Hedge ' is a good example. The children look 'through a hole in the hedge' to the small vegetables in the garden. Through the stories of Carrot, Mr. Cabbage, Tomato and others they learn about social skills or life-skills. In this way the teacher, parent or any other person who reads the story to a child promotes prevention. The word 'drugs' doesn't exist in the stories, the word 'magic potion' is used.

Five of the nicely illustrated stories are about the situation of asylum seekers ('Brussel sprout has lost his way ' and 'A new vegetable in the garden'). There are three stories about medication and drugs ('The magic potion does not work', 'The magic potion of mushroom' and 'The potato and onion become friends').

De Sleutel wants to work in an integrated manner in Gent and also in other cities; the children read the storybook together with their parents in Dutch and the teacher works with the story in the classroom. The mother and father will read the story in their own language at home or in a waitingroom. This forms the start of a dialogue between teacher, child and parent.

6. RAR Monitoring

We asked Evelien Geldof, student of criminology at the 'Brugse Poort' in Gent, to hold open interviews with some key figures of the RAR sample to improve the process of the prevention project. Some of the interviews are interesting for the process and are an example for people who will have to make prevention more concrete locally. ' How do I make sure that people get our prevention material and that they will actually read it ?' is an often asked question for many prevention workers. In this part of the report we offer you a lively record of some discussions. There is the danger of it becoming an anecdote, because of the use of the 'I' form in the records, but it has the advantage of being 'down to earth'.

6.1. Report of interviews with key figures

Evelien Geldof

"As contact persons for this stage of monitoring we focused on all organizations and people contacted during the RAR research of 'SEARCH' (Brugse Poort, Gent) and 'SEARCH II' (OCMW-initiatives

Flanders). Certain other organizations could also be addressed; the local police, JAC, schools in the area, centers for part time education, GP's etc,...

In the meantime I completed a list of contact persons, and I made a list of schools, childcare centres and youth movements in the Brugse Poort. I started with the following four people: Arafat, Wannes, Veerle and Joris. I decided to contact these people because of their former key-position in 'SEARCH' or because of their relevant experience.

➠ Integration worker Arafat

Arafat gave me the names of some important people: Marc of the City Council Integration Service (In Belgium known as SID). Marc will discuss my proposal at the team meeting. They will make some suggestions.
I received the name of Ferdi, also an employee of the same SID. However, I decided to stay in contact with only Marc, as I thought it better to have only one contact in the service. Anyway, both Marc and Ferdi work with asylum seekers and refugees.
Arafat also mentioned an organization for Romanies (gypsies): Opre Roma. This organization is active in Gent and is engaged with people from the Balkans, Eastern- and Central Europe. Contact person: Wolf). Wolf sent me, after a phone call, an e-mail with the names of important organizations working with Slovenians, people from Kosovo and the Czech Republic as well as social workers in the schools of "De Brugse Poort" ("The Bruges Gate") are also included.

➠ Health worker Veerle

Veerle of the Community Health Centre is very glad that something is happening with 'SEARCH'. She is certainly happy to help me. Together with Veerle I looked at a list of all possible organizations engaged with asylum seekers and refugees of De Brugse Poort. She knows a lot more about the working of the organizations, their target groups and exact activities. She crossed some services off my list and added a few new ones. Veerle advised me to work with a couple of primary schools and a school with special classes for newcomers in Gent who speak a different language. Veerle gives a long list of organisations for me to contact.
Towards the end of our conversation Veerle gave me some important information; there is a community meeting once a month. A few services working with occupants of De Brugse Poort take part in this meeting. The community meeting is organized by the City Council Community Center. I would very much like to be present at such a meeting. I will be able to present the project to most of the services in the community. I decide to ring Kristien (who is responsible for community meetings) and ask her if I can talk to the group about my project.
In the waiting room there were mainly women and children I noticed. I'm not sure, but I think most of the patients are children. I don't think asylum seekers like to ask for help. They feel ashamed, unsure, etc. and they are frightened they will be sent back to their homeland. An exception is when a child is ill. They will then overcome these fears and make sure their child gets medical attention. Therefore it is very important to reach the children via the parents: we could give the brochure to the parents. The storybooks are also suitable for parents and we can ask the parents to read them to the children.

➠ Street worker Wannes

Wannes works for a refugee service and he used to be a street worker for the City Community Centre of the Brugse Poort. At this moment he mediates for newcomers. Wannes knows as no other the

customs of the different nationalities of De Brugse Poort. He also knows what they do with their leisure time; what are they doing, and where do they get together ? Idea is to distribute brochures through informal networks. You hope to reach people who don't have contact in any other way with any form of aid work. I specially thought of local pubs. Wannes can give me a list of the most popular pubs. I planned to visit one of these pubs (possibly with a friend) for a drink and to talk to the barman informally about the brochures. It might not be such a good idea though. Yesterday the project coordinator told me about past experiences when during the first phase of the research she received negative reactions from publicans, barmen and customers. It seems sensible to talk first to Wannes before I take a decision about how to handle this. To be honest, I hadn't thought of these problems.

➠ Social worker Joris

Joris works for OCMW Gent, Brugse Poort. Together with his colleague Annelies and with De Sleutel he works on a project regarding drug use: Perspective, social re-integration through work and education. Joris was very enthousiastic when I introduced him to 'SEARCH'.
Appointment with Joris, social worker in OCMW. Joris was willing to distribute the CD ROM and the brochures within his organization. He said the project is a great initiative. I can always contact him for further information. I had the impression Joris had difficulty in giving me a straight and clear answer to my question. Apparently the network of services is so diverse and obscure, it is difficult to see through it. This was also my experience when working on my task. There are so many different services focused on asylum seekers and often they work alongside each other. Regularly two different services offer help to the same target population without knowing of each other's existence. Joris admitted this; OCMW works with drugs, Medical Social Centre, De Sleutel and the Gent City Coucil do also. There is little consultation. Services should adjust their initiatives and exchange their experiences. This could result in two services sometimes working on the same project whereby if one service had problems setting up a prevention project another service with the knowledge and experience of setting up such a project could share the knowledge.

➠ Reflections and State of the Art

'SEARCH' is a research and prevention project for illegal immigrants and asylum seekers. Such a project is an important initiative. We can't deny it anymore: the multicultural society is a fact. It has a lot of benefits like enrichment of our culture, but sadly there are also negative sides. Unfortunately there is a large risk that people who are different will be excluded from society. This happens with many immigrants. They look different, they speak a different language, they have different customs, food, clothes, religion etc. We notice this exclusion at different levels.

At first I think of economical exclusion, people find it hard to get a job because for the following reasons: they don't speak the language, they don't have the right job qualifications, they are not used to working in a structured environment like ours or they don't have the right knowledge and experience to go for a job interview.

Social exclusion often follows economical exclusion and not just for immigrants. One becomes more and more isolated from ordinary society. A low income makes it difficult to take part in all sorts of social and cultural activities. If you are not working you don't have contact with colleagues and some of your skills will disappear. A normal reaction would be to get in touch with people in the same position as you. You will then spend your free time together. I can imagine people in this circumstances becoming antagonistic towards the Belgian authorities. It might seem as if we don't want to give them

a chance to lead a good life, though I am certain they would take the chance to have a happy life(if it were offered). Unfortunately, it often seems very difficult for us to understand asylum seekers as our cultures are so different.

A third dimension of exclusion is political exclusion. One becomes excluded from taking part in democratic decision making process of a country. One doesn't get the opportunity to vote and to emancipate. You may then imagine: the government has no interest in you at all.

This, of course, paints a very negative picture of immigrants. Surely there are many examples of immigrants who are succesfully integrated in our society. The situation mentioned in the former paragraph is, I think, typical for a certain group; namely refugees, asylum seekers and illegal immigrants. Their existence in a foreign country like Belgium is characterized by great uncertainty. Add to this the problematic and often traumatic experiences which have been the reason for their emigration.

We are happy to have a couple of organizations concentrating on these people. They try to help them as much as possible. Examples are: het Klein Kasteeltje (the small castle), numerous centres for asylum seekers, city and county councils, the Movement for People without Papers, OCMW's, Social Services, Red Cross, etc. There are of course still people who have problems (with themselves and their surroundings). The use of drugs or medication may provide a feeling of relief. Drugs help you to escape from reality and to forget your problems. It is often difficult to reach people in this position and it makes it difficult to talk to them about drug abuse.

Drug abuse by asylum seekers has a few specific problems. Asylum seekers might not know about products in Belgium or alternatively products here might contain more or less psychoactive substances (than the user is used to). Problems could arise because of the law. This needs to be avoided. It is very important to inform asylum seekers, refugees and illegal immigrants in an constructive way about the available products, the effects, the dangers of addiction, the price, the law around drugs, aid organizations, etc.

This is a role for ‘SEARCH’. It is an interesting project with the objective of informing asylum seekers, refugees and illegal immigrants about addictive substances. An inventory of drug abuse within target population is necessary before we can start on prevention. Without this information it is impossible to start effective prevention because it would not be properly aimed at the target population.

‘SEARCH’ examined drug use and drug prevention in Gent's area De Brugse Poort. Mainly Albanians and Kosovo live in this part of the city.

➠ Critical discussion of the method in daily practice

I don't pretend to have a lot of background information about a particular research method. My idea is to look closely at the method and to decide for myself if I can agree with the decisions taken or whether I would have done things differently.

➠ Mapping, access and sampling

It was a good decision to start with aid organizations in the area. They know most of the people, have details about their background, they can tell a lot about life in this community and they might have an idea about drug abuse within the target group. First of all we contacted four organizations. They

mentioned some interesting contact persons, so we could extend the interviews. They specially referred to local people and to people known to use drugs and medication. From them I got more useful information than I would have from aid organizations. Everybody contacted was willing to take part in the interviews. In the end 15 interviews were taken from 11 respondents.

When we realize that former participants pointed out these respondents I do not think this is a lot. The respondents were asked to take part in the semi-structured interviews. This resulted in contacting just a small group. It is thought that people when asked to point someone out, will point to someone similar to themselves rather than to someone very different from themselves . A small group of respondents selected by the 'snowball method' has a good chance of being fairly homogeneous. I noticed the participants originally wanted to start with the aid organizations. These organizations point to someone else, a local or other aid worker. It seems possible for all respondents to be in contact with one or more aid organizations. We have to realize that there are a lot of people who are not known by OCMW, a health center, the city council's integration centre or the asylum policy project. Thus, an important part of the target group has been 'neglected'. This part might be a special group with specific characteristics in relation to use of drugs/medication. It would be a shame to ignore this situation.

➠ Semi-structured interviews

We took 14 interviews from 10 respondents. Of these 10, eight were professionals and two were locals. A pity only two locals were interviewed. I think locals can give more relevant information than for instance social workers, especially when they have a good contact with Albanians and people from Kosovo. Not that I doubt the expertise of social workers, I am a social worker myself, but I would be inclined to think that locals know even more about the customs of certain people and about life in the community. They walk on the streets, live there day in day out, take part in conversations, listen, visit the same shops,.....as a matter of course they will have a better idea of probable drug use in their neighbourhood. I realize some asylum seekers will hide drug abuse at all costs. They are frightened and think it will effect their asylum application. Aid workers will give information based on suspicion. It is difficult to see the difference between Albanians and people from Kosovo. Again I think locals will know the difference better than aid workers.

➠ Report SI

The respondents who also took part in the semi-structured interviews were questioned again. Asylum seekers were questioned as well. The people were referred to via participating aid organizations. Personally I think the interviews could have surplus value for this research. I realise there are some less practical sides to this method. I can imagine it to be very time-consuming when asylum seekers refuse to cooperate. It is only natural for them to be suspicious towards someone asking them questions again and again and asking about the use of drugs; it works against co-operation.

A shame the police didn't want to give information. I am sure they have relevant information about drug abuse. It would be interesting to know why they refused to cooperate.

Although understandable, a weak point is the fact we have interviewed very few asylum seekers. The reasons for this include the following: they don't speak the language, it is too confrontational for them and their friends to talk about drug abuse, they have to answer lots of questions from people anyway, etc. There should be more time and a greater availability of resources, only then interviews will produce more information.

➠ Focus groups

The intermediate report shows the problem of bringing people together in a focus group. They all show an interest but drop out when it matters. Just a few respondents attended the two focus groups. It might be interesting to investigate why.

➠ Methods of prevention

After I read this report I concluded there is a need for prevention, but it will have to be general. I mean it should contain the really basic information and be put forward neutrally. The report considers whether prevention will be better realized via brochures or via an information evening. I think it is better to do this via brochures as it is anonymous. People can pick up a brochure in their own language in the pub or when attending an organisation. This is a lot easier than going to an information evening which may put people off because to do so might cause other people to think they have a drug problem. There is also a language problem. I feel it is too formal to organize an information evening which people would have to make time to go to. I think it was a good choice to produce brochures in different languages.

➠ Contents of the brochure

The brochure looks very attractive, I'll have to say. It looks suitable for youngsters and the drawings in the brochure are of people of different complexion. This is essential when making a brochure for a certain target group; aim everything at the target population.
The use of language is not too scientific. I don't think the text is too complicated for the target group. Whenever a difficult word is used, it is explained in a clear way.
There might be a bit too much emphasis on the 'bad' side of drugs. For every type of drugs there are two considerations: effects and risks. 'Risks' is automatically associated with something negative:e.g. "it is dangerous, we shouldn't use drugs because..."Maybe it makes a difference to give the two categories another name: 'nice effects' and 'not so nice effects' for example. There would then be a positive and a negative text. The brochure mentioned just the negative side effects of the use of drugs but we shouldn't forget the positive effects people experience when using drugs. Some people love to be under the influence of drugs. The brochure rightly points out these positive feelings but the heading of the text doesn't explicitly indicate this.
It is very positive to mention nicotine, alcohol and medication in the brochure. Attention is also paid to cannabis and amphetamines. I feel they could have given information about coke and heroin. I'm sure coke and heroin are being used, though probably less than other drugs. This doesn't mean we shouldn't inform our target group about these drugs.
It is also important to gain knowledge of Belgian drug laws, even if just to ensure they know you are not to be allowed to drive after drinking a certain amount of alcohol.
I can imagine asylum seekers get little information about such things.

➠ Instruments for prevention

- CD-ROM

A CD-ROM with directions of how to use prevention materials is a good initiative. However, it will still be necessary to contact aid workers, schools and community centres personally with regard to the brochures and 'SEARCH' project.

- Brochure

I advise putting the brochure together with other leaflets in different centers in the community: centres for adults and youngsters, pubs, doctor's surgeries, community centres, OCMW's, schools, ... The brochures can be taken voluntary. We could also do it differently, for instance if someone within OCMW has a problem with a certain drug, we could give this person a brochure.
Personally I disagree with this method because it is too obvious.

- Life skill stories selected

Do we talk about the book itself or do we have to make another collection of relevant stories?
The book should be presented personally to the teachers in nursery- and primary schools. We will have to try to encourage them to work with the book in the classroom.

7. Conclusions and prospects

Peer van der Kreeft

'SEARCH' and 'SEARCH II' rejuvenate the Flemish community in the following aspects: the projects financed by the EU delivered an attainable methodology to assess problems effectively in hidden populations. The methodology was usable by field workers, like social workers, on the condition they had access to more scientific services. The method brought a high level of commitment and because of this there was a great sense of 'ownership'.

The project results in a view of drug problems in communities of refugees and asylum seekers. It shows important nuances of the problems. 'SEARCH', as well as in the wider orientated 'SEARCH II', show us we have many unfounded assumptions, some of them based on thin air.
This is an important conclusion which has been and will be given to the media.Other results of our research directed strategies for prevention for asylum-seekers, refugees and illegal immigrants. For example, we became aware of a difference between asylum seekers/refugees who live in an urban community and people who have left such a community or no longer take part in a community. The latter easily get involved with criminals and get trapped easily in drug use and drug trade. A result of the RAR-Assessment Method is the specific context in which the target group approaches our medical and social services. The associated easy availability of tranquillisers and analgesics are particularly concerning.
The 'SEARCH' report revealed a few side effects of alcohol use and smoking with extra risks for children and teenagers. I am alarmed by the reference to the catastrophic consequences of young asylum seekers who are quitting school. The school represents some sort of community or family and tries to educate children in a normal way, even if it is only for a short period of time. It is essential for their social integration and development to send children or adolescents, who are even more at risk, to a school in the neighbourhood.

The somewhat sophisticated formula we use for the usage of prevention material - a combination of brochures in foreign languages for parents and stories in Dutch for children- answers the call to send children and teenagers to school and to keep doing this.

In the future we will take steps to further consolidate our knowledge and expertise in methodology. We will undertake action to realize an integrated strategy of information for parents and children in a coordinated way. We will consolidate the concrete and formative results of this interesting and stimulating method, delivered by the 'SEARCH' team.

8. 'SEARCH II' in the United Kingdom

Drug use amongst refugees and asylum seekers using the Rapid Assessment and Response method (RAR)

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1. About the Organisation

The University of Central Lancashire traces its roots back to the Institution for the Diffusion of Knowledge founded in Preston in 1828. It developed through the Harris Institute and Harris College to become Preston Polytechnic in 1973. It became Lancashire Polytechnic in 1984 and was granted University status in 1992 when it became the University of Central Lancashire (UCLan).

UCLan now has around 30,000 students studying on the main campus in Preston, the Cumbria Campus, partner colleges across North West England and National Health Service sites throughout Lancashire. Students study full time and part time, on taught and research degree programmes. The University employs over 2,000 staff.

The University has five faculties: the Lancashire Business School; Cultural, Legal and Social Studies; Design and Technology; Health; and Science.

It offers a variety of courses, many of which reflect its strong links with industry, commerce and public service. It runs courses at access, HND, degree and post-graduate and research level. Modular study programmes allow students to build their degrees around their own interests and aspirations. Research work is undertaken which supports the teaching and learning programmes, much of it relating to the needs of local industry.

About the Centre for Ethnicity and Health, University of Central Lancashire, Preston

The Centre for Ethnicity and Health was founded in 1998 to address inequity in health and social care for Black and minority ethnic communities in order to improve service access, experience and outcomes. The Centre has four areas of expertise: research, teaching and learning, community engagement and organisational change.

The Centre currently consists of a multi-disciplinary team with a range of bilingual skills and extensive understanding of the UK's multi-cultural and multi-faith communities. The Centre's main activities lie in the fields of drugs and alcohol, mental health, community engagement, racist victimisation, regeneration and health, equality and diversity strategy development, and mental health law. To complement the Centre's research portfolio, teaching and learning activities are in continual development, with the aim of contributing to knowledge, expertise and good practice in the fields of ethnicity and health. The Centre has particular expertise in research and drugs, and trains and supports members of Black and minority ethnic community organisations to undertake their own research.

The Centre's research methods and results have a significant national and international reputation. National research has been commissioned by various government departments and international commissioners have included the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the Department for International Development, and the United Nations Office on Drugs and Crime (UNODC).

2. The national and regional situation of migrants in the United Kingdom

The current climate in the UK is that of an 'asylum clampdown'. The current Home Secretary has vowed that asylum legislation will be 'tough' in response to popular perceptions that the UK is 'a soft touch' for applicants (TRAVIS 2003b). Measures are being taken to make entering the UK more diffi-

cult and to make the removal of those who fail with their asylum application easier and quicker. In addition, the social support that asylum seekers are entitled to is being reduced, and the use of detention and removal centres is being utilised more frequently.

Certain sections of the press media have inflamed the debate about asylum with sensational headlines. Although Britain, in terms of asylum applications in relation to the overall population, was ranked fifth in the EU in 2002 and accepts just 2% of the world's refugees (THE OBSERVER, 2002), the country's best-selling daily newspaper suggests 'Britain the No 1 refugee magnet' (THE SUN, 14 September 2002).

According to a recent Home Office study, asylum seekers made a net fiscal contribution to the UK of approximately £2.5 billion in 1999-2000. A recent report by the Greater London Authority suggests that 23% of doctors and 47% of nurses in the National Health Service (NHS)[1] were born outside the UK (Refugee Council, 2003b). However, there is fear expressed by certain media that asylum seekers are a drain on resources, including that of the National Health Service: 'Bogus asylum seekers are draining millions from the NHS' (DAILY EXPRESS, 26 November 2002).

The Department of Health is expected to confirm in the near future that it will abandon rules that allow anyone who has been in Britain more than twelve months to receive free medical treatment (HINSLIFF, 2003c). Ironically, hundreds of 'failed' asylum seekers were recently found to be working in the NHS, mostly as ancillary workers who are difficult to recruit from within the UK (HINSLIFF, 2003b).

The dispersal of asylum seekers and refugees to various geographical locations across the UK has resulted in local dissatisfaction and numerous attacks on them. The Crown Prosecution Service reports that it dealt with 20% more racially-motivated crimes in the year up to April 2002 than in the previous year, with anecdotal reports suggesting a rise in attacks against asylum seekers and refugees (BBC News Online, 2003). A number of murders of asylum seekers have also been reported in the media. The first to come to national prominence in recent years was that of Firsat Dag, a Kurdish refugee, who was killed on a housing estate in Glasgow in August 2001 (Ibid.). New accommodation centres are being built as an alternative to the current system of dispersing refugees across the country (TRAVIS, 2002). In addition, there is the introduction of induction centres where asylum seekers will be housed when they first arrive in the country, and removal centres where 'failed' asylum seekers will be kept in secure conditions until they are removed from the country. It is proposed that induction centres will provide basic health screening. However it is unclear whether any information given by individuals relating to drug use will be confidential and would not impact on their claim for asylum.

Chronology of UK immigration policies

Over the past decade there have been a number of Acts dealing with immigration.

> **In 1993** the Asylum and Immigration Appeals Act amended the 1971 Immigration Act. This Act placed restrictions on carriers (airlines, lorry drivers, etc.) to demand transit visas from passengers to ensure they do not disembark in the UK in order to claim asylum. The Act withdraws the rights for asylum seekers to apply for local authority housing[2] and to receive child benefit[3].

1. The NHS is funded through taxation and is free at the point of access.
2. State-provided subsidised accommodation / social housing
3. All parents with children are entitled to child benefit of between £10 and £16 per week per child under 18 years of age.

In 1996 the Government attempted to remove all rights to state benefits for asylum seekers applying in-country[4] but the Court of Appeal rejected this. In the same year the Asylum and Immigration Act received Royal Assent. The main provisions of this Act include accelerated procedures for removing asylum seekers from designated 'safe' countries[5] and the removal of the right of appeal against return to a safe third country[6].

In 1999 the Asylum and Immigration Act extended carriers liability including new measures to refuse entry to undocumented passengers, introduced a system of social housing and support centralised under the National Asylum Support Service (NASS) for new asylum seekers. The Act also introduced the dispersal of asylum seekers to designated cluster areas across the UK and a centralised system of benefits in the form of vouchers was introduced.

The Nationality, Immigration and Asylum Act 2002

The most recent major piece of legislation, the Nationality, Immigration and Asylum Act (2002) introduces:

- new criminal sanctions for those who destroy travel documents en route to the UK;
- the withdrawal of state benefits for rejected asylum seekers who repeatedly refuse to leave the UK;
- a single tier of appeal only (asylum seekers are deprived access to the Higher Courts);
- a two-stage plan to 'massively restrict' legal aid (state provided legal assistance);
- electronic tagging (tracking system) of those facing deportation; and
- an extension to the list of designated 'safe' countries.

Since July 2002 asylum applicants are no longer able to work or undertake vocational training until they are given a positive decision on their asylum application, irrespective of how long they wait for a decision.

Under Section 94 of the Act, people may have their asylum application certified as 'clearly unfounded' and be removed to their country of origin prior to appeal. This means that the asylum applicant is denied an in-country right of appeal.

The Nationality, Immigration and Asylum Act 2002 introduces a requirement for refugees to attend citizenship lessons and emphasises the need for asylum seekers to learn a British language. This Act allows for the establishment of accommodation centres where hundreds of asylum seekers will be placed and requires those asylum seekers living in the community to report regularly to the police or immigration authorities. If they do not comply they risk losing any social support and housing the state has provided. The National Asylum Support Service (NASS) will not support those who do not claim asylum 'as soon as reasonably practicable', in effect leaving them destitute. The Act also simplifies the process of removing those who have applications rejected.

4. These are applicants who have already entered the UK - they are not claiming asylum at point of entry.
5. The 'white list' of countries the Government deems to be safe for refugees to return to.
6. Where an asylum seeker has travelled to the UK via another designated 'safe' country.

The new Immigration and Asylum Bill (first announced in October 2003) plans to remove all state benefits and social support from 'failed' asylum seekers, which does not preclude the state from removing children from their families 'for their own welfare'.

Recent Government statistics on asylum

- There were 84,130 applications (excluding dependants) for asylum in 2002. This is a rise of 18% from 2001.
- The main countries of origin were Iraq, Zimbabwe, Afghanistan, Somalia and China.
- Asylum was granted in 10% of cases and exceptional leave to remain[7] awarded to 23% of cases.
- There were 65,405 appeals against refusal of asylum of which 22% were allowed to proceed.
- Following appeal, 10% were granted asylum.
- In 2002, 68% of asylum applications were made in-country

(All figures taken from HEATH, JEFFRIES AND LLOYD, 2003)

It is difficult to estimate the number of 'illegal migrants' in the UK. The Home Secretary recently admitted that he has 'no clue' of illegal immigrant numbers (WOOLF, 2003). MATHER (2002) suggests that asylum seekers going missing while being dispersed to regions across the UK has resulted in 'hundreds of thousands of illegal migrant workers in Britain'.

The Government recently pledged to reduce asylum applications by half and figures released on 27 November 2003 saw the number of applications to the UK fall by 52%. There were 11,955 applications between July and September 2003, down from 22,030 between the same period in 2002. (PRESS ASSOCIATION, 2003).

The Government has also pledged to reduce the cost of legal aid given to asylum seekers (this is state funding for legal appeals). 'The Department of Constitutional Affairs has drawn up a two-stage plan to cut the legal aid bill for asylum and immigration cases which has risen from £83m to £174m in the last two years'. (TRAVIS, 2003c)

3. The situation of refugees and asylum seekers in the UK - *Literature review*

In the UK, asylum seekers only receive 70% of the state benefits usually allowed to those who are unemployed and low-paid. This situation reflects the government's intention that providing a low level of financial support will discourage those who seek asylum because of extreme poverty rather than from fear of persecution (AUDIT COMMISSION, 2000).

This financial deprivation is likely to be exacerbated by a recent decree from the Home Office, where-

7. The replacement of exceptional leave to remain by a 'humanitarian protection' status became effective in November 2002

by asylum seekers applying after 23rd July 2003 are prohibited from working until they are granted a positive decision (ie awarded 'exceptional leave to remain' or refugee status) on their asylum application. This provision does not take into account the length of time an asylum seeker may wait for a decision, which may be many months.

Variations in practice between regional local authorities also affects the financial hardship faced by unaccompanied minors: support for some young people may be provided wholly through meals and accommodation without financial assistance available for costs such as travel and resources for education (STANLEY, 2001).

The high cost of living in some areas such as the South East of England has led to some local authorities dispersing asylum seekers to other parts of the country. Support structures to facilitate asylum seekers' access to services (housing, education, social and health care, etc.) may be lacking in a number of geographic areas. The formal policy of dispersal, applicable to adult asylum seekers and some minors, can, however, place additional restrictions on available support. Unaccompanied minors may be particularly vulnerable to the unavailability or inaccessibility of support when dispersed (KIDANE, 2001) and there may be wide variation between local authorities in the adequacy of the support package a young asylum seeker will receive (BARNADOS, 2001). Asylum seekers may be dispersed to areas that have little experience of providing for these communities and may not have a sufficient infrastructure available to provide adequate support (AUDIT COMMISSION, 2000). Dispersal throughout the UK, to regions where Black and minority ethnic communities are smaller and less well established, may also bring with it the risk of conflict with indigenous communities (DENNIS, 2002).

Young people

Young refugees and asylum seekers may have experienced many or multiple stressors and traumas, 'including physical harm, intimidation or other forms of psychological trauma, loss, deprivation, malnutrition, separation from family members, bereavement, or abuse' (BERMAN, 2001). STANLEY (2001) reports, however, that many services for children are 'accommodation focused'. Further research by the AUDIT COMMISSION (2000) and DENNIS (2002) show that many children are being placed in inappropriate accommodation often aimed at 'single adults'. KIDANE (2001) has noted that 'as most unaccompanied children arrive at a potentially stressful stage in their development, they are vulnerable to trauma and particularly sensitive to insecurity'.

Unsatisfactory care (for example, with inadequate adult support and supervision) arrangements could also endanger the safety of children who, in their search for someone to belong to, could fall prey to inappropriate relationships (attachments) that might exploit their vulnerability. Some local authorities also lack specialist child asylum seeker teams, which appear to be an important factor in children being enabled to form relationships with social workers (Stanley, 2001). Furthermore, Stanley highlights that frequently those children who are accorded 'looked after' status[8], have less contact with a named social worker. Prospects for social interaction, development and support are hampered further by restricted access to appropriate opportunities and resources in education. Consequently, the needs of young asylum seekers, particularly those who arrived unaccompanied, are not always fully met and they may, therefore, be seriously at risk of social exclusion.

8. In England and Wales, Section 17(1) of the Children Act 1989 requires local authorities to 'safeguard and promote the welfare of children within their area who are in need.' Section 20(1) states that 'every local authority should provide accommodation for any child in need, who appears to them to require accommodation as a result of there being no person with parental responsibility for them.'

Government statistics state that 6,200 unaccompanied children applied for asylum in 2002 (HEATH, JEFFRIES and LLOYD, 2003). Main countries of origin for unaccompanied children are Afghanistan, Federal Republic of Yugoslavia (FRY), Somalia and Iraq (HEATH and HILL, 2002). It is estimated that around 40% of refugees in the UK are children (HODES, 2000). The number of unaccompanied minors amongst them is unclear, although there are several estimates, ranging from 3,350 to 10,000 (AUDIT COMMISSION, 2000; HODES, 2000; AYOTTE and WILLIAMSON, 2001; SOMERSET, 2001; UNICEF, 2001; HEATH and HILL, 2002; HEATH, JEFFRIES and LLOYD, 2003).

3.1. Immigration and addiction

3.1.1. The research team and the research process

The RAR team consisted of two researchers supported by colleagues within the Centre for Ethnicity and Health. Before embarking on the study, we obtained ethical approval for the work from the University of Central Lancashire's Faculty of Health Ethics Committee. We began by analysing previous research that had been conducted on substance use amongst asylum seekers and refugees by looking at media reports in this area and conducting a literature review.

A number of key individuals were identified from the literature and contacts within the Centre for Ethnicity and Health. These individuals were approached by telephone or email and asked if they would participate. Then, if they agreed, semi-structured interviews were conducted with key informants. The interviews were a combination of face-to-face and telephone interviews. In a number of interviews, one researcher conducted the interview while the other took notes. A single interviewer conducted some interviews over the telephone if the interviewee was located in another part of the country. The SEARCH RAR schedule for semi-structured interviews was followed, with slight adaptations to fit into the British perspective of drug use. Once the interview was completed, individuals were asked if they knew of other people we could interview and other contacts were followed up.

3.1.2. Literature Review

Introduction to refugee and asylum seeker drug use

Within the UK, little research has been conducted on the extent of drug use amongst refugees and asylum seekers, and there is little published literature in this area. Most recently the Home Office has published a report which aimed to scope the incidence of drug use amongst these communities and the implications for the provision of services (CRAGG ROSS DAWSON, 2003).

The Centre for Ethnicity and Health has recently conducted research looking at drug use amongst young asylum seekers and refugees in London (Patel et al., 2004). The research takes account of the known risk and protective factors for drug use amongst these young people, and examines the relevant national and local policies that should act as protective factors.

The Home Office report (CRAGG ROSS DAWSON, 2003 pp. 20-1) states that

'refugees and asylum seekers are not a homogeneous group and propensity to become involved with drugs depends on many factors. However, the attention of those concerned with this issue tends to focus on four principle areas of concern. In no particular order, these are: khat use by refugees and

asylum seekers from Somalia and other East African countries[9]; unhealthy dependence on prescription drugs, particularly by women from Asia; addictions resulting from coerced use of drugs, either in warfare or as a means of forcing women into prostitution; and the particular vulnerability of some national/ethnic groups, notably from Eastern Europe and Turkey, of being recruited by drug dealers.'

Incidence of use

CRAGG ROSS DAWSON (2003) report that problematic drug use amongst newly-arrived asylum seekers and refugees is a relatively rare occurrence. However, the authors concede that 'very little is known for certain about how many refugees and asylum seekers have drug dependency problems', largely due to a dearth of dependable data from agencies such as drug services, the National Health Service and the police and criminal justice services. Similarly, data from the Centre for Ethnicity and Health also reveals that drug use and problematic substance use is low amongst young people in this group (PATEL et al., 2004)

CRAGG ROSS DAWSON (2003 p. 3) highlight that 'refugees and asylum seekers very rarely access services, but this does not mean they are not in need of them'. Information on the use of substances by asylum seekers and refugees is hampered not only by underreporting and unwillingness to present to services (because of fear and stigma), but also the likelihood that such substance users may not access any statutory or non-statutory groups or services.

Use of substances and amongst different groups

Research suggests that the use of substances and the type of substances used vary according to factors such as: the length of time a community has been in the UK; the cultural acceptability of certain substances; the type of community; age; gender; and the availability of substances. An accurate picture of substance use by asylum seekers and refugees is difficult to determine because the data which are available are often based on anecdotal reports from workers in the drugs and community fields, many of which will have focused on a particular community or geographical area.

SANGSTER et al. (2003) suggest that there is reason to suggest there is drug use, some of which is problematic, in a number of recently established Black and minority ethnic communities with a large number of recent migrants. Amongst the Vietnamese communities involved in their study, opiate and crack cocaine use is reported, while amongst the Somali communities the use of opiates and crack cocaine is also highlighted, but to a lesser extent than in the Vietnamese communities.

There is some evidence to suggest that khat chewing, although a legal substance in the UK, is becoming problematic amongst some communities (GRIFFITHS, 1998; WHITTINGTON and ABDI, 2001). Its use is associated with the Somali community in the UK, but is also used by people from the Yemen, Ethiopia and Eritrea.

Research into the use of khat has highlighted a number of key factors associated with its use. These include a high rate of unemployment in the Somali community, the loss of culture and cultural roles,

9. Khat (quat, qat, chat, qu'at, Catha edulis) is a perennial shrub traditionally cultivated in Ethiopia. The leaves and young shoots of the plant are chewed for their stimulant properties. Traditionally it has been popular in countries where other intoxicants are prohibited because of religious beliefs. Khat chewing sessions are usually social affairs. Khat contains cathine and cathinone which are psycho-active (similar to amphetamine but less strong).

particularly for men who have lost their traditional role as providers for their families, and a removal of cultural restrictions which previously discouraged use by women and young men under the age of 21 years. Khat use has long been associated with religious worship and particularly men still primarily use it in a social context (a khat user's house may have a designated 'khat room'). However, the environment where men often meet carries a number of health risks as ventilation points are sealed to improve the smoking experience and cups are shared which may lead to infection due to the smoke and heat in the khat room (WHITTINGTON and ABDI, 2001 p. 16). The stigma attached to khat chewing for women has led to many women chewing khat in their own homes, which means as invisible users they may be ignored in preventive interventions, services and education. It is also reported that younger khat users have further progressed to other available drugs and some have become involved in dealing and other criminal activities to fund their usage (SANGSTER et al., 2003 p.19).

Young people

In a recent report from the Centre for Ethnicity and Health (PATEL et al., 2004), interviews were conducted with 67 young asylum seekers and refugees aged 16-25 years of age in the London area. These young people were originally from Africa, Nepal, Afghanistan, Turkey and Iraq. Current problematic drug use amongst them was reported to be low. Some had used drugs prior to entry in the UK and current use was largely centred around cannabis, although a small minority used a number of other substances, including alcohol, crack, heroin and ecstasy. A number of interviewees reported that they had discontinued any drug use after their arrival in the UK. In addition, a small number of participants reported involvement in the sale of illicit drugs.

There are reports that the initiation of drug use for recreation purposes has become a 'normal' part of growing up in the UK. McDonald and Marsh state that 'the findings of a range of national and regional social surveys are claimed to show that the use of an illicit drug by early adulthood is becoming a statistical probability' (MCDONALD and MARSH, 2002 p. 29). It is estimated in the British Crime Survey that 47% of 16-24 year olds have used an illicit drug and 17% have used a Class A drug at least once in their lives (CONDON and SMITH, 2003). As young refugees and asylum seekers become integrated into their local communities, their patterns of drug use may reflect those of the indigenous communities. For example, research by Abdi and Whittington (2001), based on interviews with community workers and community members in London, report that Somali young people were using khat but also cannabis, cocaine and heroin. This finding was further substantiated in reports by drug workers in SANGSTER et al. (2003) that young Somali men reported opiate use. Such findings support the suggestion made by the Centre for Ethnicity and Health (PATEL et al., 2004) that patterns of drug use may vary with time spent in the UK.

Reasons for using substances and the associated risk factors

<u>Social circumstances</u>
The small number of studies which exist from both academic and unpublished (grey) literature indicate that asylum seekers and refugees in the UK are not provided with necessary levels of social support. These groups may suffer from social exclusion; a poor physical environment; inadequate housing; lack of access to education, training and health facilities; and financial deprivation (PATEL et al., 2004). FLEMEN (2003) also notes that refugees and asylum seekers are settled in areas of 'high urban deprivation' and are likely to experience high availability of drugs. Furthermore, financial deprivation and restrictions placed on asylum seekers gaining employment may lead to 'engagement in underground economies' (FLEMEN, 2003 p. 14). Consequently, the implications of resettlement in the UK are far-reaching and SANGSTER et al. (2003 p. 19) argue that 'settlement in Britain has presented these com-

munities with new challenges in relation to drugs'. For example, the Bangladeshi Youth Forum, a community organisation that conducted research among the Bangladeshi community in Birmingham as part of the Centre for Ethnicity and Health's Community Engagement project (see WINTERS and PATEL, 2003; BASHFORD, BUFFIN and PATEL, 2003), report that:

'The Bangladeshi community are one of the last groups to come to Britain from the South Asian continent, in addition to being one of the poorest, and as such are having to adapt to cultural transition at a feverish pace. It is well documented that many drug problems are experienced and get a 'foothold' where a culture is in 'transition'.' (AJID et al., 2001 p. 45)

Given that many asylum seekers are living in a poor social environment in the UK, they are vulnerable to many of the risk factors identified as pertinent in problematic drug use, whether these are licit prescription drugs or illicit drugs (HAWKINS, CATALANO and MILLER, 1992; SUSSMAN, DENT and GALAIF, 1997).

Young refugees and asylum seekers interviewed for the Centre for Ethnicity and Health study (PATEL et al., 2004) cited a number of reasons for using drugs. Many of these are related to the social environment in which they have found themselves and include peer pressure; emotional suffering and problems; depression; feelings of isolation from society; loneliness; boredom and excessive free time; family pressures and problems; lack of status (i.e., a decision on asylum application); and the wide availability and use of drugs in local environments. A number of respondents in the study expressed the opinion that having greater access to a number of substances increases the likelihood of them experimenting with them.

Notably, these young people reported that they had no formal drug education. Their knowledge of drugs was gained through personal experience of their own or others' drug use and from various media.

<u>The cultural use of drugs</u>
SANGSTER et al. (2003 p.18) argue that 'drug use within these communities [asylum seekers and refugees] reflects collective cultural experiences which preceded settlement in Britain'. FLEMEN (2003 p.14) also notes that asylum seekers and refugees may arrive from countries that already have 'indigenous substance misuse issues'. He reports that 'many countries across the world have moderate to high levels of substance misuse and these often develop in situations of social breakdown, poverty and deprivation' (ibid.). For example, Sangster et al. (2003) report that amongst the Vietnamese community, an 'older' group of users were described as having started to inject opiates while they were in refugee camps in Hong-Kong. Some refugees and asylum seekers may also have had experiences with drugs due to their experiences of conflict in their homeland where drugs may be used as a method of controlling prisoners and soldiers (BASHFORD, BUFFIN and PATEL, 2003).

Use of traditional substances may serve to maintain cultural identity and provide a means to deal with a range of issues surrounding cultural dislocation. Research by the Somali Health and Mental Health Links group reported in BASHFORD, BUFFIN and PATEL (2003 p. 23) suggests that 'cultural dislocation' within the Somali refugee community may play a role in their involvement with drugs: 'cultural dislocation within the Somali refugee community, and racism within the wider community, which may lead individuals to see khat as a refuge, either as an escape or as a means of boosting self-esteem'.

As noted, above, there is some evidence that asylum seekers and refugees may adopt the cultural drug-using patterns of the UK once they have been living in the country for a period of time (ABDI and WHTTINGTON, 2001; PATEL et al., 2004).

Mental Health Difficulties

It has been suggested that mental health difficulties incurred as a consequence of experiences prior to, and following, migration to the UK may be a contributory factor to drug use. For example, respondents in SANGSTER et al. (2003) reported a link between drug use, PostTraumatic Stress Disorder (PTSD) and mental health difficulties in Somali and Vietnamese groups.

While mental health difficulties may be a common occurrence amongst refugees and asylum seekers due to past and current events, the applicability of western diagnostic frameworks such as PTSD has been questioned by academics such as SUMMERFIELD (2001). Nevertheless, a national study of asylum seekers who have been granted refugee status conducted by Carey-Wood et al. (1995) revealed that two thirds of respondents interviewed stated they were experiencing anxiety or depression. Those who had poor English or were unemployed were particularly likely to say they felt anxious and depressed. The most likely causes for depression were attributable to problems in the country of origin, although a sizeable proportion also reported the inability to find employment in the UK was also a factor. A number of studies also suggest that certain groups of asylum seekers may be at an elevated risk of mental health difficulties. A study by AGER et al. (2002 p.75) with 26 refugee and asylum-seekers in Edinburgh, who were acknowledged by Scottish Refugee Council service staff as being at risk of social exclusion, found that 54% 'scored at a level associated with formal clinical diagnosis of anxiety disorder', while 42% 'scored at a level associated with formal clinical diagnosis of depression'. Those respondents who had been in the UK for over two years were nearly twice as likely to report 'case' levels of depression and anxiety, with higher levels of case depression and anxiety found amongst single people. Furthermore, international research has suggested that young refugees and asylum seekers may be particularly at risk of developing mental health problems, with unaccompanied minors being particularly vulnerable (MCCALLIN,1992; SOURANDER,1998; LOUGHRY and FLOURI, 2001).

It has been suggested that licit and illicit drugs may be used by asylum seekers and refugees as a means of self-medication to alleviate physical and mental health difficulties. A study conducted by the King's Fund (WOODHEAD, 2000 p.2), which consulted a small number of non-governmental and statutory sector organisations providing services for refugees and asylum seekers in London, reports 'unofficial self-medication (e.g. through alcohol and street drugs) often helps victims cope with the psychological effects of torture and war'. Reports by the Health Education Authority Expert Working Group on Refugee Health (1998) and by WHITTINGTON and ABDI (2001) also suggest that substances may be used as a coping strategy. In addition, certain practices in a person's country of origin may allow for the prescription of large doses of drugs to manage negative psychological affect. Substances in this quantity may not be available in the UK legally, which may create the need to obtain prescribed drugs illegally. Drugs obtained through these means will not be accompanied by professional guidance in safely using them.

Barriers to accessing services for problematic drug use

FLEMEN (2003 p.14) outlines a number of barriers that may discourage asylum seekers and refugees from disclosing substance use:

- Substance use may not be considered when assessing the health or other needs of asylum seekers and refugees;
- Fear that disclosure will affect asylum applications or status;

- Fear of imprisonment or punishment due to the heavy penalties attached to substance use and supply in many parts of the world;
- Fear of social stigma attached to substance use and dependence;
- Users may not perceive a drug as problematic due to cultural norms;
- Users are not aware of drug services;
- In many countries outside the UK (and Western Europe), 'treatment is simply not available, and elsewhere may be unaffordable, brutal, basic, or a combination of all three'.

Furthermore, FLEMEN (2003) suggests that once a drug problem develops, this group faces further barriers to accessing help or drug services because of fear of punishment, stigma, demonisation, language barriers and unfamiliarity with services. Drug service providers may not be familiar with particular substances used by refugee and asylum seekers.

3.2. Immigration and addiction: *First results from RAR*

The key individuals

The researchers conducted semi-structured interviews with the following individuals who were involved with asylum seekers or refugees:

1 policy-maker (London-based)
2 managers/workers in drug services (Northern England-based)
2 community group researchers (Northern England-based)
1 education/youth worker (Central England-based)
1 community group worker (London-based)

Each of these individuals either worked directly with asylum seekers and refugees or managed programmes targeted at these groups. Owing to the short period of time the RAR team had to conduct this study, we could only interview 7 individuals but we were fortunate that they possessed a good knowledge about asylum seekers, substance use, and the related issues. We tried to speak to the major voluntary organisations regarding asylum seekers, but were unable to do so in the time and resources allowed for the project.

Initially, it was difficult to get some potential interviewees to participate; many said that they did not know enough about substance use among asylum seekers. Therefore, our initial plan to focus particularly on unaccompanied (separated) children and young people was made very difficult. Following semi-structured interviews, it is difficult to pinpoint the most 'at risk' group. However, the use of khat is mentioned by the majority of interviewees, reflecting current concern in this area amongst policy makers, drug agencies and some refugee groups. It is worth noting that khat is a legal substance in the UK and used by only a small number of refugees.

The interviewees were located across England. Asylum seekers are generally dispersed across the UK, although the greatest numbers are located in London. This report aims to provide an overall view of asylum seekers, refugees and substance use across the UK rather than in just one geographic area.

What agreement was there on the use of substances by this group?

The majority of the interviewees agreed that there was little use of substances among asylum seekers in the UK, and it was unusual for their use to be problematic. A number of interviewees mentioned Class A drug use but these were cited as rare occurrences. One interviewee, who worked in drug services, suggested that around one-third of young asylum seekers were using substances, but again stressed this was not likely to be problematic use. The education/youth worker interviewed suggested that around 50% of Somali young people were using khat, but again, that this use was generally unproblematic.

The two individuals who worked in research suggested that those young people who volunteer to take part in research studies are those who are least likely to be using substances in a problematic way, and therefore the true extent of the problem may be hidden. This highlights the need for asylum seeker and refugee groups to conduct research amongst their own communities, with the training and support such as that offered by the Community Engagement project at the Centre for Ethnicity and Health (WINTERS and PATEL 2003; BASHFORD, BUFFIN and PATEL, 2003). Using this approach, asylum seekers and refugees can 'own' the research, focus on the issues that are most relevant to them, and are less likely to feel further stigmatised by outside 'experts'. The approach also encourages and builds on the capacity of the organisations involved.

What substances were being used?

A number of substances were mentioned by interviewees, the most frequently mentioned were heroin and crack, khat and cannabis. Also mentioned were paan (a mild stimulant which is a mixture of spices used with betel nut), alcohol and a substance that was reported by Nepali young people (a cough mixture unknown in the UK).

Who are using these substances?

- Crack was mentioned in relation to women in the sex industry from Eastern Europe.
- Cannabis was mentioned in relation to young people, and also to adults.
- Khat was mentioned in relation to the Somali community mostly, but also to Yemeni and Ethiopian communities in the UK.
- Alcohol was mentioned in relation to older Afghans.
- Kurdish and Turkish young people were also mentioned in relation to drug use.

What are the psychological, physical, social, financial and law-related effects of using substances?

A number of interviewees spoke specifically about the effects of using khat:

- Interviewees reported that heavy khat use could result in eating and sleeping problems (due to its amphetamine-like qualities).
- Interviewees highlighted that heavy khat users are not likely to be working and they can withdraw from society owing to the large amount of time they dedicate to chewing.

- However, interviewees also said that chewing the plant (which is traditionally consumed in the company of others) gives asylum seekers a cultural identity and is not necessarily seen as problematic by those who use it.

- Interviewees reported that using khat within the context of unemployment was an issue and there may be financial problems for users if they are spending what little money they have on khat. Interviewees said that the use of khat had been linked to domestic violence and the necessity to obtain money to buy the plant could result in involvement in crime.

- One interviewee suggested that, in one area, there were links with prostitution.

Substance use in general

Interviewees also spoke more generally about the effects of substance use, suggesting that asylum seekers might use drugs as a coping mechanism to combat depression, isolation and stress. There was mention of gang related activities amongst Kurdish and Turkish asylum seekers particularly related to drug dealing. However, when interviewees were asked about asylum seekers or refugees being involved in drug-related crime, a number of interviewees stressed that asylum seekers were likely to be the victims of crime, particularly racially motivated attacks and harassment.

What factors influence substance use in the homeland and host country?
Differences in use between the homeland and the host country.

In considering the use of other substances, interviewees mentioned that more substances are available in the UK than in most countries of origin and some interviewees suggested that asylum seekers were not always aware of what substances were illegal in the UK.

In considering khat, a couple of interviewees stated that the use of khat is very different in the homeland than it is in the UK. It is socially acceptable in Somalia (and the Yemen and other African countries where it is used) but its use has been pathologised in the UK. Another interviewee suggested that khat use was problematic in the UK because of the social context within which it is used (for example, unemployment and housing problems).

With regard to young people, interviewees noted that the influence of the family is diminished or non-existent: they may be in the UK without their families and their sudden independence and lack of restrictions that operate in their homeland may make them vulnerable to drug use. Another interviewee added that those asylum seekers who are not integrated with the indigenous population might be more protected than those who are integrated from using drugs.

Function and benefit of using substances

One interviewee suggested that some asylum seekers are experimenting with substances because they were experimenting with integration: using drugs could be part of becoming accepted by the indigenous population. Other interviewees also said that using substances could help to form an identity and can foster a sense of belonging – 'it is what others do'.

Interviewees also mentioned that substances can be used as self-medication, a means to 'turn it all off for a while.' Many asylum seekers have had very traumatic experiences involving torture, death of family members and hazardous journeys to the UK and may use drugs to escape from memories of the

past and the difficulties of their present situation, and the uncertainties of the future. As one interviewee said:

'it is the experiences of asylum seekers that makes them vulnerable to drug use. Young people arrive without their parents and often talk about being isolated and depressed. They are separated from their families who may be dead, and they may have seen them being killed. Some arrive and do not get plugged into services – they get approached by, or latch onto, complete strangers just because they speak the same language.'

What do asylum seekers and refugees know about the risks of substance use?

Overwhelmingly, the interviewees suggested that asylum seekers knew little of the risks associated with substance use. Interviewees suggested that this might be due to unfamiliarity with some of the drugs available in the UK. For example, one interviewee reported that asylum seekers were confused about the legality of cannabis (although this could be due to recent amendments to UK laws surrounding the possession and use of cannabis making it a less serious offence to possess small quantities). A couple of interviewees noted that there was especially a lack of information regarding khat use. One said 'there is no information on khat use. It is not seen as a problem to take action on. Agencies target Class A drugs use. Drug education at school… does not include khat use.'

A couple of interviewees mentioned that for Muslim asylum seekers, their religion prohibited the use of substances and therefore they are taught only that, 'taking substances is wrong and that is all they need to know'.

What are the existing preventive conditions and/or preventive interventions to minimise the involvement of asylum seekers and refugees with substance use?

When this question was asked, most interviewees answered with what should be in place or questioned whether there were any preventive conditions or interventions currently in place for asylum seekers.

One interviewee said that young asylum seekers who go to school would receive drug education at school. Another interviewee said that Drug Action Teams (DATs) conducted needs assessments with newly-arrived asylum communities, and this would look at the needs of the group regarding drug services, although another interviewee suggested that the depth of this intervention may vary between regions.

Other interviewees mentioned that strong links to community groups and religious networks could provide asylum seekers and refugees with support and this might have a preventive effect with regard to using substances.

What prevention is needed?

The responses to the question about what prevention is needed varied from specific drug prevention and education, through to wider social needs. One interviewee felt that there needed to be information available that was interpreted into the required languages. Another interviewee felt that harm reduction interventions were needed.

Most interviewees spoke about the social conditions for asylum seekers and refugees and how these

needed to change if preventing substance use was to be successful.

Interviewees said that asylum seekers and refugees needed better living conditions, good housing, decent employment and to be able to contribute to society.

One interviewee noted that asylum seekers and refugees 'need to learn to speak English in order to participate fully'.

One interviewee said that access to mental health services for asylum seekers and refugees needed to be improved. Another said that many asylum seekers were not registered with a family doctor, who would be able to refer them to mental health services if necessary.

A couple of interviewees discussed the process of claiming asylum. They said that this process needed to be quicker in order to reduce the amount of time that asylum seekers could not work or participate in society while their claim was being dealt with.

What are the priorities in prevention?

Interviewees gave a number of responses to the question 'what preventive interventions are needed?' Again, these tended to focus on the wider social responses that were required for prevention.

One interviewee said that women needed to be targeted more, as their use of substances was generally hidden. This same interviewee said that any interventions needed to target the partners and families because they may collude with women to hide their drug use because of the associated stigma or for economic reasons. The interviewee spoke about Eastern European women who worked in the sex industry and said that this was a 'hard-to-reach' group because of the environment in which they lived and worked.

There was a consensus amongst interviewees that tackling social problems such as housing and unemployment were the priorities in preventing asylum seekers and refugees from involvement with substances.

A number of interviewees also placed an emphasis on the asylum application procedure. There was a belief that the attitude and culture towards asylum seekers needs to change. One interviewee said 'we need to treat asylum seekers better. Making conditions so bad for them that they won't want to come to Britain is not conducive to preventing drug use.' Another interviewee said that asylum seekers need a more positive experience on arrival in the UK. The importance of prevention is particularly important given the belief, held by a number of interviewees, that substance use amongst recently-arrived asylum seekers might be low, but was likely to increase. One interviewer said that those asylum seekers who had been in the UK for a while were more 'cynical and hardened' than those who were newly-arrived and this could have an impact on possible future drug use amongst them: as another interviewee said 'they [asylum seekers] have all the classic risk factors [for involvement in drug use].'

Another interviewee highlighted the gaps in services for newly arrived asylum seekers and said that it was easy for them to end up alone and unsupported in the UK. The interviewee suggested that properly funded community centres, where there is access to a range of services, might be a good way of supporting those who have just arrived in the UK.

4. Conclusion

Key points from the research

With a couple of qualified exceptions (two interviewees suggested that drug use was more frequent than others did), the consensus was that the use of substances amongst asylum seekers and refugees is low. None of the interviewees felt that substance use amongst these groups was problematic, although it was believed that a wide range of substances were used. The exception was khat, which was mentioned frequently by interviewees as being problematically used amongst Somali and Yemeni communities in the UK (currently, there is no evidence to suggest that khat is being used outside these communities). Further research needs to be conducted to ascertain the extent to which the emphasis on the use of khat among a small number of refugees and asylum seekers in the UK is obscuring other drug use amongst these communities.

Interviewees

- stated that there were differences in the types of substances that were used in the UK and those used in the homelands.
- felt that the social context of substance use in the UK was likely to make this use problematic for some refugees and asylum seekers in the future.
- highlighted a number of reasons for asylum seekers and refugees using substances and that their knowledge of the risks involved was low.
- did not feel that there were many preventive conditions or interventions in place for asylum seekers.

The preventive conditions and interventions that interviewees felt were needed to prevent substance use amongst these groups included better living conditions, more social inclusion and better support throughout the asylum application process.

Recommendations

The following recommendations were made by the key individuals interviewed in the RAR:

- Asylum process to be made quicker.
- Asylum seekers and refugees to receive more support.
- Increase the ability of asylum seekers and refugees to contribute to society.
- Better living conditions, housing, employment and access to services, including health and mental health services.
- Regarding drug services, most interviewees focused on education and prevention rather than treatment.

The following recommendations are drawn from the literature reviewed as part of the RAR process.

Social Issues

- The risk factors for problematic drug use centre on social exclusion and deprivation, and asylum seekers and refugees are highly likely to be vulnerable to these living conditions (FOUNTAIN et al., 2003; PATEL et al. 2004).
- Drug education to be fully integrated targeting in particular community groups and encompassing wider issues than just drugs (BASHFORD, BUFFIN and PATEL, 2003).
- Increased training, education and employment opportunities to break the cycle of deprivation and associated drug use (BASHFORD, BUFFIN and PATEL 2003).

Partnership and multi-agency working

- Multi-agency, outreach work, community engagement (FOUNTAIN et al., 2003)
- 'It is necessary to establish networks and partnerships working between drug agencies and the Kurdish, Turkish and Turkish Cypriot community organisations.' (BEKTAS et al., 2001 p. 61)
- Capacity building to enable communities to fully participate (BASHFORD, BUFFIN and PATEL, 2003).
- 'There is a need for drug service providers to develop further partnerships and work with other agencies in the statutory, voluntary and community sectors, especially BME community organisations given the reluctance of Refugees and Asylum Seekers to approach statutory service providers directly, and as a consequence make serious contributions to reducing drug misuse from a multi-agency perspective.' (BECTOR 2001 p. 60)

Promoting cultural sensitivity and addressing racism

- Drug workers etc. should have a knowledge of substances used in target countries/groups and drug trends in the UK e.g. patterns and cultures of use (FLEMEN, 2003).
- The Race Relations (Amendment) Act 2000 challenges all public services to eradicate discrimination and disadvantage and it requires public organisations to have clear race equality action plans. This provides the impetus for drug services to address the shortfalls in the provision of appropriate and accessible services for these groups (FOUNTAIN et al., 2003).
- In order for drug services to meet the needs of the Black and ethnic minority communities, they will have to be set within a context of addressing institutional racism (SANGSTER et al., 2003 p.54).
- Drug education materials need to be produced in community languages and for them to be culturally sensitive (BASHFORD, BUFFIN and PATEL, 2003).
- Drug education using different media and non-written formats (BASHFORD, BUFFIN and PATEL, 2003)

Access to services

- Barriers to accessing services are identified as the lack of acknowledgement of drug use by these groups themselves, ethnicity of staff, lack of understanding of minority ethnic cultures, language, lack of awareness of services, breaches of confidentiality (FOUNTAIN et al., 2003).

- Greater liaison between GPs, mental health teams and drug services, with greater knowledge 'of key substances used in target countries, and likely issues for care' (FLEMEN, 2003).

- '*We strongly recommend in the Qat issue that the Government should enable Yemeni communities in the UK and other groups concerned with the Qat issue to start addressing this problem in the community level through education, activities and awareness campaigns*.' (AL-KASH et al., 2001 p.104)

5. Next steps

This study has tracked the current situation on drug use and related services for asylum seekers and refugees in the UK, using the relevant literature and media reports and interviews with a number of key individuals. This work needs to be followed up with a detailed research study involving asylum seeker and refugee communities themselves. The follow-up work needs to further examine the extent of substance use amongst these groups and is necessary because, as a number of interviewees in the RAR pointed out, there is not enough research in this area, and the research that is conducted may under-report substance use amongst asylum seekers and refugees. The study then needs to look at the appropriate preventive conditions and interventions to reduce substance use amongst these communities.

It is particularly important that the asylum-seeking and refugee communities are supported in conducting their own RAR, by use of the Community Engagement model (see WINTERS and PATEL, 2003 and BASHFORD, BUFFIN and PATEL, 2003). This would allow groups of asylum seekers and refugees to own their own research – it isn't done 'on' them and they have some influence on the outcomes of the study. If groups themselves conduct the RAR there may be more accuracy in responses as they will feel less stigmatised, and can overcome many of the problems of access and language that regularly hinders research this area.

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9. 'SEARCH II' in Germany

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Drogenberatung e.V. in Lippe, Detmold, Germany

Dietrich Höcker
Wolfgang Schreiber
Vesselka Vassileva-Hilgefort

1. The new SEARCH partner – Drogenberatung e.V. in Lippe (Detmold)

The Drogenberatung e.V. in Lippe is a drug counselling centre that has existed since the beginning of 1994 and currently employs 9 staff. In the area of illicit drugs, it has been charged by the region of Lippe with ensuring care for people addicted to or at risk of drugs. The responsible body behind them is the Drogenberatung e.V., a drug counselling organisation in Bielefeld. The RAR team for the SEARCH project in Lippe consists of three staff: Wolfgang Schreiber, the head of the facility, Dietrich Höcker from the drug prevention office and Vesselka Vassileva-Hilgefort, who was employed for the duration of this project and works exclusively for the SEARCH project. Mr Schreiber and Mr Höcker have many years of experience with clients from the CIS states. This is because, since 1997, the Drogenberatung Lippe has been dealing with an increasing proportion of so-called Spaetaussiedler – ethnic German migrants from the former Soviet Union who have been allowed to resettle in Germany (cf. Figure 1 in the Annex). Through their functions in the facility, Mr Schreiber and Mr Höcker have numerous contacts with co-operation partners in Lippe and North Rhine-Westphalia (NRW). Ms Vassileva-Hilgefort is a journalist and speaks fluent Russian. In consultation with the other project members, she took over the organisational preparation of the interviews, the documentation, data processing and when necessary, the interpreting when interviewing asylum seekers.
The RAR team jointly conducted the semi-structured and structured interviews. The work together has been so structured that all members of the RAR team have a good overview of the tendencies and the development of the problem. Already during the preparation of the project and when searching for key persons, a network of experts was formed in Lippe which became even more closely knit during the course of the project and is expected to remain in existence after its completion. The aims and results of the project were presented in several working groups, which means that the project is well known throughout large parts of the region of Lippe.
We have been so convinced by the RAR that we have conceived a further project in the field of juvenile drug use that is to use the RAR and for which we are actively seeking finance at the moment.

1.1. An overview of the activities of the Detmold RAR team:

- October 2002, start of Search II with the workshop in Putten
- Collecting information on refugees and asylum seekers in Lippe
- Forming the RAR team
- Finding target group and key persons
- Conducting and assessing the SSI
- Conducting and assessing the SI
- Focus group I and II
- Developing prevention ideas
- Producing prevention materials
- Training multiplicators
- Documentation and prospects

1.2. The region of Lippe

Traditionally, the Lippe people are considered to be obstinate, mean, reserved and rather mistrustful of anything new. One thing is certain, however: with a population of 340,460 citizens, of which 30,414 are foreigners, Lippe is already one of the most multicultural regions in Germany.
The region covers a total area of 1,246 square kilometres. It consists of a total of 16 municipalities and districts. After the war, Lippe became a centre for the furniture and textile industry and a destination for

health resort visitors and tourists, whereby agriculture continues to play an important role.
From 1987 until 2002, 163,281 Russian German migrants from the former Soviet Union found a new home in East Westphalia–Lippe (EWL). **(see "Bevölkerungsentwicklung in OWL", September 2003).**
According to the Department of the Interior of the Federal State of North Rhine-Westphalia, in 2002 there were 24,437 Russian German migrants living in Lippe. Thus the region of Lippe lies in second place in NRW behind the Rhine-Sieg region.
The policy of the aliens office is influenced by the number of Russian German migrants in the individual districts. Thus the districts of Augustdorf, Barntrup, Blomberg and Dörentrup will not be assigned any new asylum seekers from the CIS states because firstly an adverse climate has developed amongst the population regarding 'foreigners', and secondly there are limited financial means.

2. Selection of the target group

On the cut-off date of 31 December 2002, 1,615 refugees and asylum seekers were registered at the aliens office for the region of Lippe (a total of 9,874 in EWL, as of 31 July 2003). 610 of them come fromth former Soviet Union. As far as the processing of asylum seekers is concerned, Lippe has a national reputation for its relatively quick processing of individual cases and its efficient organisation of deportations.
The group of refugees and asylum seekers from the CIS states has not been researched by any other project partner as part of SEARCH. A further point for opting to work with this group were the features common to both the asylum seekers and the Russian German migrants. The groups' shared experience with problematic substances in their home countries enabled a greater understanding of aspects already partly known of through the daily counselling and prevention work in the centre, while the RAR also provided important additional and more detailed information about how drugs are dealt with in the former Soviet union.

2.1. Who is who?

"I was born in Armenia, then flew from Azerbaijan and later lived in Moscow. I don't know who I am anymore.'' (47 year-old Yezidi from Baku)

At the beginning of the project, the target group of Russian-speaking asylum seekers in Lippe consisted of asylum seekers from the Russian Federation, the Republic of Armenia, Azerbaijan, Georgia, Kazakhstan, and Turkmenistan. The numbers vary considerably. Since June 2003, the authorities have intensified the deportations and, meanwhile, almost a quarter of the people have either returned to their countries of origin or have gone into hiding. Most asylum seekers have been here for 2 to 2.5 years. Some of them, after appealing against an initial refusal to grant them asylum, have been here for 6 to 7 years. Two thirds of the asylum seekers are here with their families and try to behave as inconspicuously as possible. In the last two years, hardly any asylum seeker from the target group has been formally granted refugee or asylum seeker status.
A very specific group are the Yezidi with Azerbaijani or Armenian passes. They are an ethnic and religious minority who, after the 1916 massacre in Turkey, flew to southern Russia, Armenia and Georgia. They also form a closed group in Lippe, to which neither the authorities nor the carers have been able to develop good contacts.
The asylum seekers from the CIS states are scattered throughout all the districts in the region of Lippe. Owing to a lack of funding, the social workers rent private houses in which 2 to 3 families are accommodated. Classic temporary hostels can only be found in Detmold, Kalletal-Hohenhausen and Lage. Most asylum seekers in Lippe have all but no contact with one another and are relatively good at screening themselves off, including from social workers.

2.2. Drugs and alcohol – part of everyday life from Moscow to Tbilisi?

"The drugs came with the soldiers returning from Afghanistan. Now they are everywhere and everyone is earning money with them, even the police.'' (45 year-old Azerbaijani)

Despite the increasing numbers of Russian German migrants in Germany, relatively little is known about the use and range of drugs in the former Soviet republics. Our research has revealed the following information:

- In 2001, 88.8% of the 506,850 registered drug addicts in the Russian Federation used hard drugs (the UNDCP estimates the true number of drug addicts to be 2,365,000). The daily requirement for heroin costs in St. Petersburg, for example, 3 Euro as the market has been glutted.
- In Kazakhstan there are 279 registered drug addicts per 100,000 inhabitants (70 per 100,000 inhabitants in 1992).
- In Tadzhikistan, two thirds of the newly registered drug addicts are addicted to heroin. In Uzbekistan, the number of newly registered drug addicts has increased sevenfold since 1992.
- By the middle of the 1990s, predominantly boiled down opiate ('compote') was injected intravenously in almost all CIS states. Heroin has been preferred since 1998. Shared use of needles is normal.

The RAR team was presented with a difficult task concerning the use of alcohol and tobacco by asylum seekers from the CIS states. Daily amounts of alcohol regarded as normal in Russia, for example, would tend to be considered in Germany as 'problematic use'. During the discussion we were constantly confronted with statements such as the following: "*The asylum seekers don't have any problem with alcohol. They can still get out of bed the next day*'' (caretaker in the temporary hostel).

A further problem area was concerning the problematic use of sleeping tablets and sedatives. Since many of the asylum seekers have had traumatic experiences (experienced violence) in civil wars, they were prescribed corresponding drugs by the doctors. In the countries of origin, questions as to medicine use are considered to be of a personal nature, which is why we did not receive any clear answers on this point from our interview partners from the target group.

2.3. Our interview partners

All interviews were conducted from March until June 2003. *The results relate to this period of time*.

During the conducting of the semi-structured interviews (SSI), we worked together with 11 key persons, including social workers and caretakers who generally had considerable experience in dealing with asylum seekers and refugees. Some of our respondents were themselves Russian German migrants. Since they did not have to overcome any language barrier when contacting the target group, they had a good insight into the prevalence of addiction in the group.
The group of respondents during the structured interview (SI) phase comprised 9 asylum seekers from Aserbaidschan, Armenia and Georgia, who has also lived for considerable periods in other CIS states (Russian Federation, Kazakhstan). It was relative difficult to organise the interviews. For example in Detmold the asylum seekers refused to make contact after they learned that we were part of the drug counselling organisation. As far as the use of problematic substances was concerned, most of them had had bad experiences with the authorities in their homelands. Many assumed that the drug counselling organisation, the police and the deportation authorities were collaborating. Despite pointing out

that the SEARCH interviews were anonymous, many did not want to participate because they feared this would lead to them being 'black listed'.

3. Our new clients from the CIS states

''*I hardly know anybody who is completely abstinent.*'' (Female social worker providing care in temporary hostels)

The studies are in accordance in showing that there are 3 affected groups among the asylum seekers and refugees from the CIS states. 9 of the 11 key persons interviewed agreed that there is problematic use in the target community. The first affected group of asylum seekers and refugees from the former CIS states is the group of single young men using drugs.

3.1. Single young men who use drugs

From a total of 20 respondents, 14 described the group as at risk. "*After 1997 a new wave of refugees arrived. These were young people, 21 to 27 years old, from Georgia. It was the residents of the temporary hostel who provided us with the first indications that drugs were being used. It was heroin being used, and empty needles lay in the rooms.*" (Social worker who has been looking after asylum seekers since 1990). All 14 interview partners had only had experience with men from the Caucasus republics – predominantly Georgians and, to a lesser extent, Azerbaijanis and Armenians. It is difficult to estimate the current percentage of drug addicts.
According to the respondents, most of those who use drugs problematically are aged between 18 and 30. This mostly involves intravenous heroin use, and rarely hashish and synthetic drugs. Often drugs and alcohol are consumed at the same time. ''*Alcohol, hashish, heroin – everything is taken at the same time. Vodka is drunk like water.*'' (Social worker who has been looking after asylum seekers for 10 years)
They were unanimous in their response to the question as to how the drug use manifested itself: The first thing that is recognised is their generally poorer physical condition: ''*After detoxification the man came to me again. By chance his dossier lay on the table and his passport photograph could be seen on top, which was taken two years ago. You would hardly believe that this was one and the same person.*'' (Female administrator, has been looking after asylum seekers for 7 years).
The second way that drug use manifests itself is in drug-related crime: ''*Almost all of them are caught up in drug-related crime because they are poor.*'' (Psychologist, has been looking after transit hostels for 7 years). Many of the drug addicts are themselves dealers so that they can finance their own need. Thirdly, aggression and depression are identified as signs of drug use. (Cf. Figure 2 in the Annex)
With the question as to the causes of substance use there were the following explanations: Most of those affected were already addicted to drugs when they came to Germany. The lack of any perspective also played an important role since the asylum seekers quickly recognise that they will not be entitled to stay permanently in Germany. ''*You ask me why do the asylum seekers take drugs? They don't have anything else to do. And why start with drugs? Because drugs were cheaper than alcohol in their homeland.*'' (Caretaker, Russian German migrant)
The respondents all agree that there is widespread belief among the asylum seekers that drugs "are allowed in Germany – in contrast to the Soviet Union''. This is because the asylum seekers find it difficult to comprehend the legal situation in which the use of drugs is allowed but their possession and purchase is forbidden. In addition, many asylum seekers are aware that there is obviously considerable drug dealing and use of drugs, but that relatively little is done to prevent this. This is taken as evidence that these laws are not really taken seriously. Isolation and the financial dependence in the host country are also mentioned as important factors for drug use.
As far as general information is concerned, the asylum seekers are all in agreement: the drug addicts know precisely the risks entailed by using substances. ''*Each drug addict is an excellent chemist.*''

(Azerbaijani, 47 years old)
The respondents are also unanimous concerning the ''benefits'' of drugs. Drug use enables you to forget the lack of perspective caused by the situation, to suppress the traumata suffered in the homeland and to ''be part of the community''. During the SSIs we determined that there are currently no effective preventive interventions. Only in the most seldom cases do the social workers provide individual counselling with those affected.

The asylum seekers themselves only have a sketchy recollection of information events in the first distribution centres – if they can remember at all. The doctors have also been subject to criticism because they often only provide purely medical treatment with the drug addicts – without any additional educational work or counselling.

In the last two years, the funding for social services in Lippe have been drastically cut back and many of the social workers are overstretched. There is therefore neither enough money nor time for preventive work with asylum seekers who are ''anyway going to be deported tomorrow or the day after''. In response to the question as to which effective preventive interventions or conditions will be required, we received a broad range of answers. We have listed the most important ones here:
''*The German care strategy is not understood by the asylum seekers from the CIS states. They need clear direction as to who is responsible for what – a clear agreement on objectives.*'' (Social worker, has been looking after asylum seekers since 1995)
''*There is only one priority in prevention work – unfortunately we don't have much influence here – a clear perspective for the refugees and asylums seekers, integration work as prevention, and the right to work.*'' (Psychologist, looks after temporary hostels)

3.2. Men – single and with families – using alcohol problematically

...were identified as the second most vulnerable group among asylum seekers from the CIS states. As far as the numbers are concerned, this group is undoubtedly larger than the group of drug addicts. ''*With alcohol, the situation is no longer controllable.*'' (Social worker, looks after asylum seekers and Russian German migrants)
The asylum seekers themselves do not consider alcohol as a particular problem. ''*Everyone drinks. If everyone drinks then it's not a problem, that's life.*'' (Jew from Azerbaijan, 24 years old)
Alcohol misuse manifests itself in an overall worse mental condition, aggression and depression, and alcohol-related crime (see also Figure 4 in the Annex). Our respondents frequently mentioned the negative effects that married men's use of alcohol has on families. The financial consequences are also significant: ''*Money is scarce, that's why the alcohol is mostly stolen from shops,*'' (administrator in the social welfare office). As far as the factors influencing the development of problematic alcohol use are concerned, two thirds of the respondents are in agreement: in the countries of origin larger amounts of use are also recognised as ''normal''. In the host country, other reasons also play a role – such as boredom and uprooting.
We heard the same answers in response to the question as to the benefits of drinking: forgetting problems, ''party atmosphere'' and the feeling of belonging to a community.
As far as the prevention work is concerned, the results are identical with those ascertained with the group of drug addicts: 80% believe that priority must be given to integration work. 30% of the respondents believe that individual counselling could help, whereby it important to speak to the families and not just to individual persons. Publicity events are described as useless, as the asylum seekers were

witness to the many years of anti-alcohol propaganda during the Gorbachev period.

3.3. Female and male chain smokers

This group was not noticed during the first interviews and for one simple reason: many of the respondents are themselves smokers. They accept smoking as normal and only have contact to the asylum seekers for a very short period of time. Later, during SIs, it was the asylum seekers themselves who reported on this group. Here women believed that smoking is more common amongst men from Georgia and the Russian Federation. ''*Most of them can't live without cigarettes, they become nervous if there's no cigarette packet beside the bed,*'' according to one social worker who frequently spends long hours in the temporary hostels.
According to our key persons, the problematic use of tobacco leads to a worse overall physical condition and to cigarette-related crime. Particularly interesting are the answers of asylum seekers who have come to Germany from smaller towns or villages. ''*At home the girls and women are not allowed to smoke, it is only when they arrive in large cities where everything is anonymous that they begin to smoke. Here in the hostel everyone smokes, even the 10-year-olds, since it's allowed,*'' (asylum seeker from Armenia). A considerable number of our respondents from the former Soviet Union were surprised to learn that smoking in the aforementioned age group is against the law.
As far as prevention with chain smokers is concerned, integration has again been given highest priority. The interviewed women have also mentioned one other important factor: future mothers among the female asylum seekers should receive more medical information on how smoking harms the unborn child.

4. Concrete prevention

Purely in terms of the organisation, the SEARCH team had already built up a network of social workers, carers and refugees when conducting the interviews. Both the focus groups that met in May and June have shown, however, that future work will be difficult since the contact partners are widely dispersed throughout the overall region of Lippe and the target group itself is not compact.
The first focus group, with participants from the district police authorities in Lippe, the Blaukreuz counselling centre and social workers from various social welfare offices, clearly showed the difficulties entailed in providing effective prevention work: with the target group of refugees and asylum seekers it is neither possible to begin prevention at an early stage nor to continually implement it over the long term. Prevention through integration was desired by all the respondents during the interviews. Such a concept, however, stands contrary to the official policy that expressly envisages integration only after recognition of the right to stay.
The participants in the focus group came to the conclusion that it is sensible to work in two directions. Firstly, to provide training to support multiplicators, i.e. social workers, carers, volunteers from the religious communities, etc. Secondly, to pursue a policy of gradual steps that allows integration at many places at the same time, whereby people and groups of people are sought who are prepared to become involved in this sense.
The drug counselling centre can provide help by providing addiction experts and information material in Russian. In addition, it can also contribute by providing the multiplicators with information on existing services.
During the discussion in the first focus group, there were no notable differences of opinion as to the measures to be taken. Nevertheless, we decided to present the SEARCH results once more in a larger forum in order to gather further ideas and suggestions. On 24 June, Wolfgang Schreiber and Vesselka Vassileva-Hilgefort conducted a second focus group with members of the ecumenical forum

'Refugees in Lippe'. The members of the forum come from almost all the districts in the region. The RAR team reported on the results of the interviews, and the suggestions that the first focus group had developed were introduced during the course of the meeting. For us it was particularly important to hear the opinions of those guests who come into daily contact with the target group.
A particular problem was considered to be how to deal with drug-addicted asylum seekers. It was emphasised that it is difficult to find good psychotherapists in Lippe who are prepared to work with this group of people. It is just as difficult to obtain money from the local authorities for detoxicating and providing therapy for drug-addicted asylum seekers. The German Asylbewerberleistungsgesetz, the special law that regulates benefits for asylum seekers, prescribes that asylum seekers may only be medically treated at the cost of the municipalities in cases where there is risk to life. Lack of knowledge of foreign languages was also mentioned as an additional problem.
One of the suggestions of the focus group for further work was to establish a sponsorship scheme to ensure that the prevention in the target group reaches both those affected and their families and children. Previous experience has shown that several districts and associations in Lippe take such sponsorship schemes very seriously. A project is currently running for providing care for school children, etc.
After documenting the results of the two focus groups, the RAR team decided to work in three directions:

1. Providing training for qualified contact persons (multiplicators)
2. Producing a flyer written in Russian offering integration possibilities for refugees and asylum seekers from the CIS states who are in EWL.
3. Further networking through publicity work with organisations and working groups in Lippe.

The idea for training came from key persons who, through the interviews and having their attention drawn to the subject, realised just how little they actually knew about addiction, the effects of drugs, addiction and migration, and preventive measures, etc. The training was provided in November 203.

4.1. Prevention I – or the policy of gradual steps

It seemed to us to be a relatively easy task to produce a flyer with information on integration possibilities for asylum seekers and refugees in EWL. Here the intention was to include each association, church parish or any other institution that was also prepared to make their facilities available to asylum seekers. We also wanted to indicate whether there were native speakers available.
The public collectively views the refugees and asylum seekers from the former Soviet Union and the group of Russian German migrants as "the Russians". For this reason, we first contacted the associations for Russian Germans to ask whether they could help refugees from the same countries of origin. The results were very positive – the drop-in centres of the 'Druschba - Freundschaft' organisation in Detmold, Schieder - Schwalenberg, Lemgo, Lage and Bad Salzuflen have declared their readiness to help the asylum seekers with contacts, tips and information. The self-help group 'Hoffnung' ('Hope' – drug addicts and people using alcohol problematically), which is supported by the Blaukreuz – Detmold, agreed to work with those asylum seekers who volunteered to participate in the groups.

Most facilities that can offer counselling and care with different problems are in Bielefeld. The city has a well-developed network of voluntary and full-time psychologists and legal experts, etc. For this reason, we also included some addresses from Bielefeld in our flyer.
Our experience in producing the flyers has shown that most contact persons reacted positively to our request to work with asylum seekers when required. As a team we are eager to know to what extent we will be able to reach our target group with the flyer, which has been distributed throughout the parishes and refugees counselling centres of the Lippische Landeskirche (State Church of Lippe).

Parallel to the production of the flyer, other ideas for prevention were developed, whose implementation shall be carried out in gradual steps. Together with the refugee counselling centre in Bad Salzuflen, we are planning to develop a project for parents of school-age children from Russian German migrant and refugee families. Topics for discussion will include drugs, alcohol and migration.
Besides the production of the flyer, we have also further developed the structural prevention, i.e. we improved the structures (by linking networks and disseminating prevention know-how in institutions and with key persons) where drug prevention can be experienced everyday.

4.2. Prevention II – training multiplicators

Culturally-sensitive drug prevention presupposes that those carrying it out are in a position to put themselves in the position of the target group as impartially as possible. We were able to build up on the experience gained from the drug counselling provided for the group of Russian German migrants and pass this on to the multiplicators. It was important to us that the proposed training addressed those who enjoy the trust of the asylum seekers for reason of their professional or voluntary work.
The training in Haus Stapellage took place on 6 and 7 November 2003. We issued 35 invitations. 10 social workers and volunteers from the migration field took part.
The training programme:

1st day:

- Background information on the EU project SEARCH (explanations about the RAR, results in Lippe);
- How addiction develops (explanations);
- Drug prevention (development, current state, methods;)
- Effect of drugs (substances, effect on the central nervous system, application forms and effects, physical and psychiatric addiction, withdrawal symptoms);
- Addiction care system using the examples of the Blaukreuz centre in Bad Salzuflen and the Drogenberatung e.V. in Lippe (with the film 'Ein Angebot für Sie' from the DHS, which was produced by the Drogenberatung e.V. in Lippe on behalf of the DHS).

2nd day:

- Addiction and migration, (materials and contacts; report on her experiences by Ludmilla Dickmann, former employee at the Drogenberatung e.V. in Lippe, these days working in the in-patient field; discussion;)
- Interventions in individual cases (what is necessary, what is sensible?);
- Preventive measures (what is possible, what is sensible?);
- Possibilities for transferring acquired knowledge into everyday work.

The event took place in the 'Haus Stapelage' learning centre, and was moderated by Dietrich Höcker (Drogenberatung e.V. in Lippe) and Holger Nickel (Blaukreuz – Centre – Bad Salzuflen).
There was a lively discussion about the possibilities for prevention through better integration. The flyer on counselling services in Lippe and Bielefeld was judged to be very helpful. What was deemed to be particularly successful was the talk from Ms Dickmann, who was brought up in Kazakhstan, trained in Germany as a social educationalist and addiction therapist, and who reported about her experiences in working with two drug counselling centres and an in-patient therapy facility. Overall, it was an event that contributed to improving the networking and which, besides dealing with the subject of 'addiction and migration', opened up concrete possibilities for everyday professional work with asylum seekers

and refugees. All participants said they were very satisfied with the form and content.

5. Preliminary conclusions

- The RAR work has enabled us not to only obtain results relating to possible risks with relatively little expenditure, but also to discuss the problem with important contact persons, in existing networks and in the target group.

- Through participating in Search II, the Drogenberatung e.V. in Lippe has contributed to raising awareness of the subject of 'addiction and drug prevention' amongst (almost) all persons and institutions that work with refugees and asylum seekers.

- Through participating in Search II, the Drogenberatung e.V. in Lippe has contributed to raising awareness of the subject of 'asylum seekers and refugees' in addiction care and drug prevention in Lippe.

- Through Search II, the existing network in the field of refugees and asylum seekers has been linked to the existing networks in the field of drug prevention and care.

- Through the considerable support from the European partners (mainly in sharing ideas at the joint meetings), the LWL (telephone discussions, supporting visits and at meetings), and through the CVO (telephone discussions, at the meetings, and through support meetings on location), we constantly received new suggestions and felt secure in dealing with RAR and with its portrayal in public, which was very beneficial for the project in Lippe.

- We are very satisfied with the results. Although we have been deeply involved with the problem of Russian German migrants since 1998 and have considerable experience with migrants from the CIS states, and although staff from the drug counselling centre have personal experience of the problem through participating in a study trip to Kazakhstan and Kyrgyzstan, we have gained knowledge that is new and important for us – not just for the work with asylum seekers and refugees but also for the work with Russian German migrants.

Annex:

Graphs and tables

Figure 1: Proportion of Russian German migrants amongst the clients of the drug counselling centre.
There are no precise figures for 1997. In the operations report for 1996, the Drogenberatung e.V. in Lippe states: "Without being able to provide precise figures – the place of birth is mostly not known or documented – it can be ascertained that there has been a clear increase in the number of Russian German migrants from countries in the former USSR in the drug counselling centre." (p. 11)

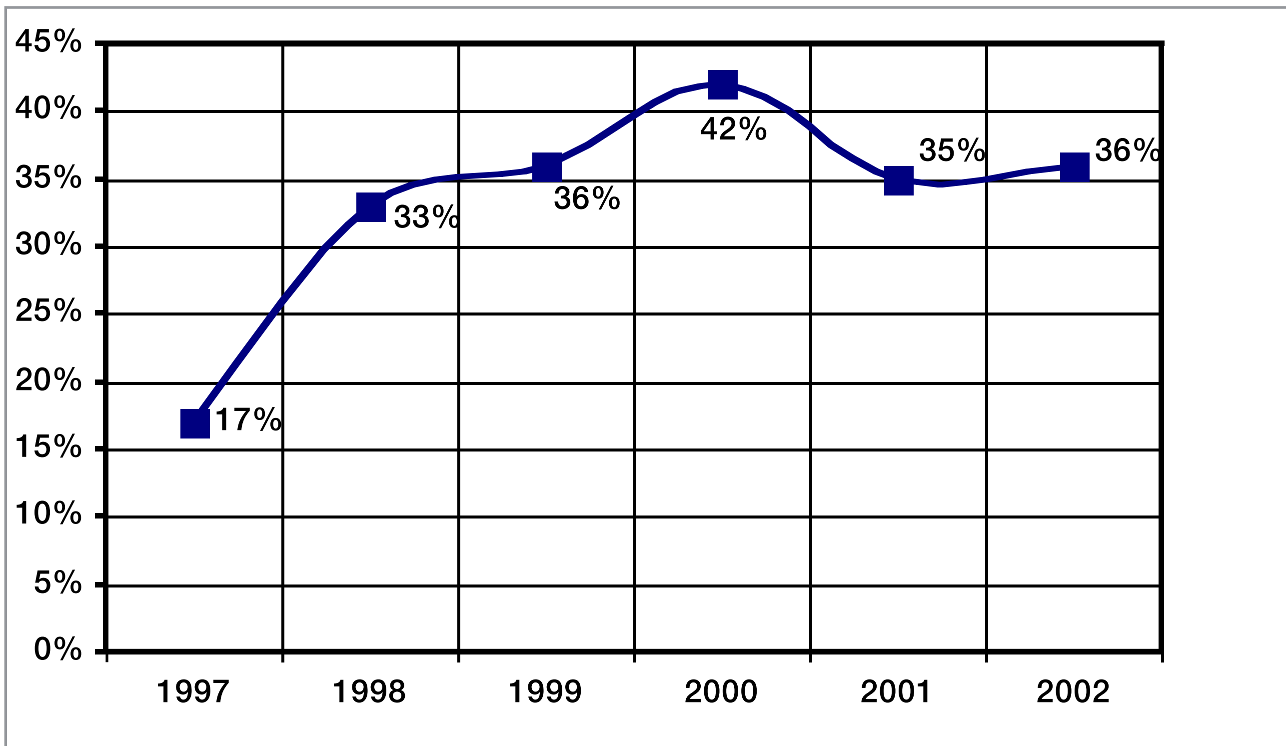


Table 1: Profile of the respondents

Gender:		Age:		Function:	
Men	13	- 40 years old	8	Social worker	4
				Administrator	4
Women	7	40-50 years old	12	Caretaker	3
				Asylum seeker	9

Figure 2: The three main problems

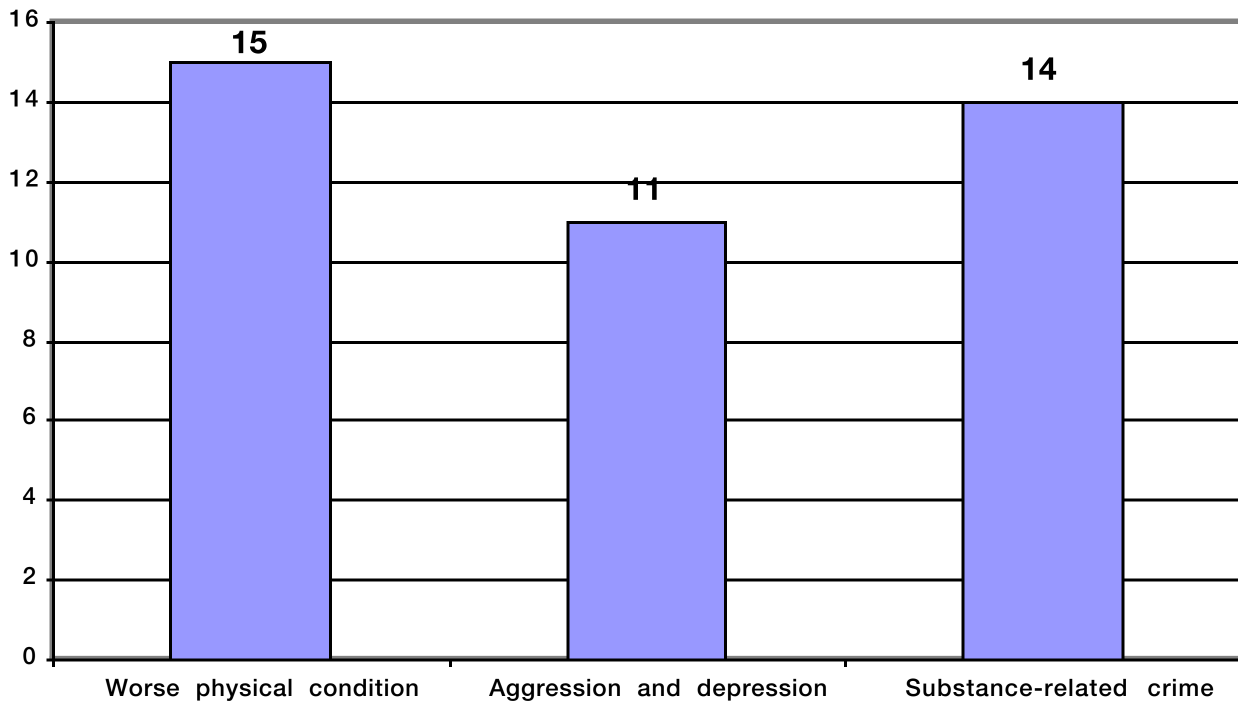


Figure 3: Causes of substance use

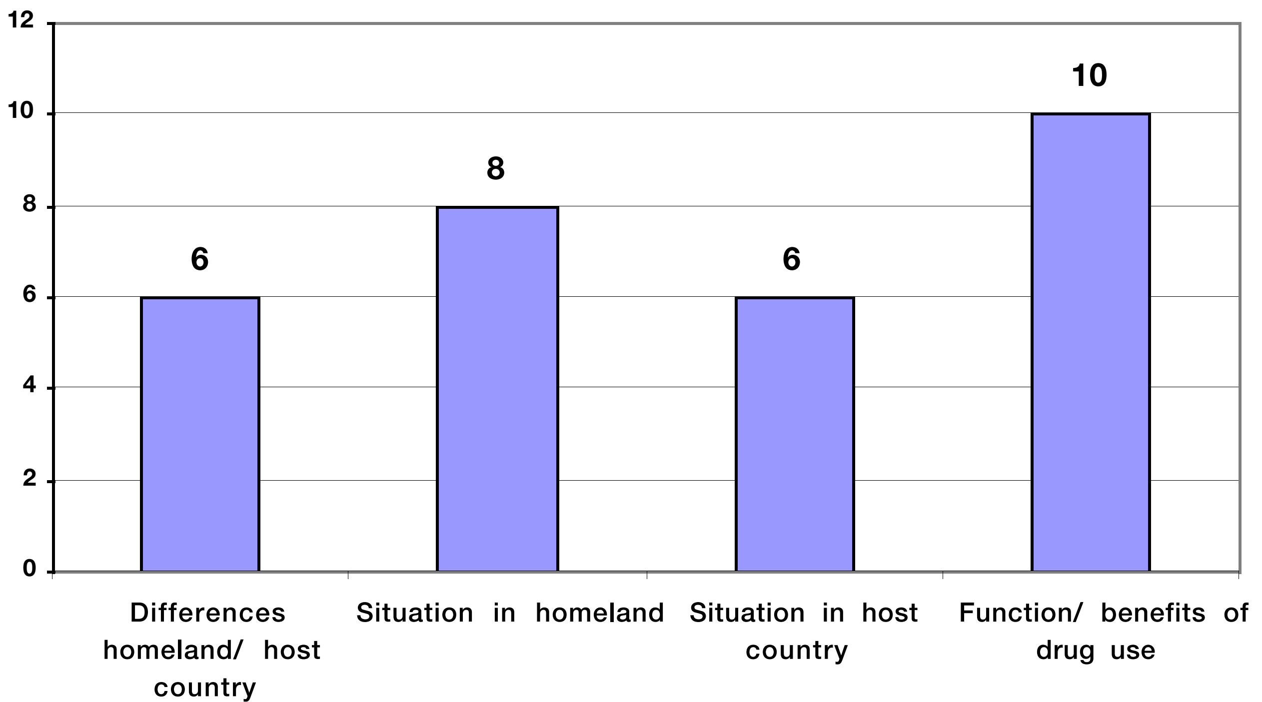
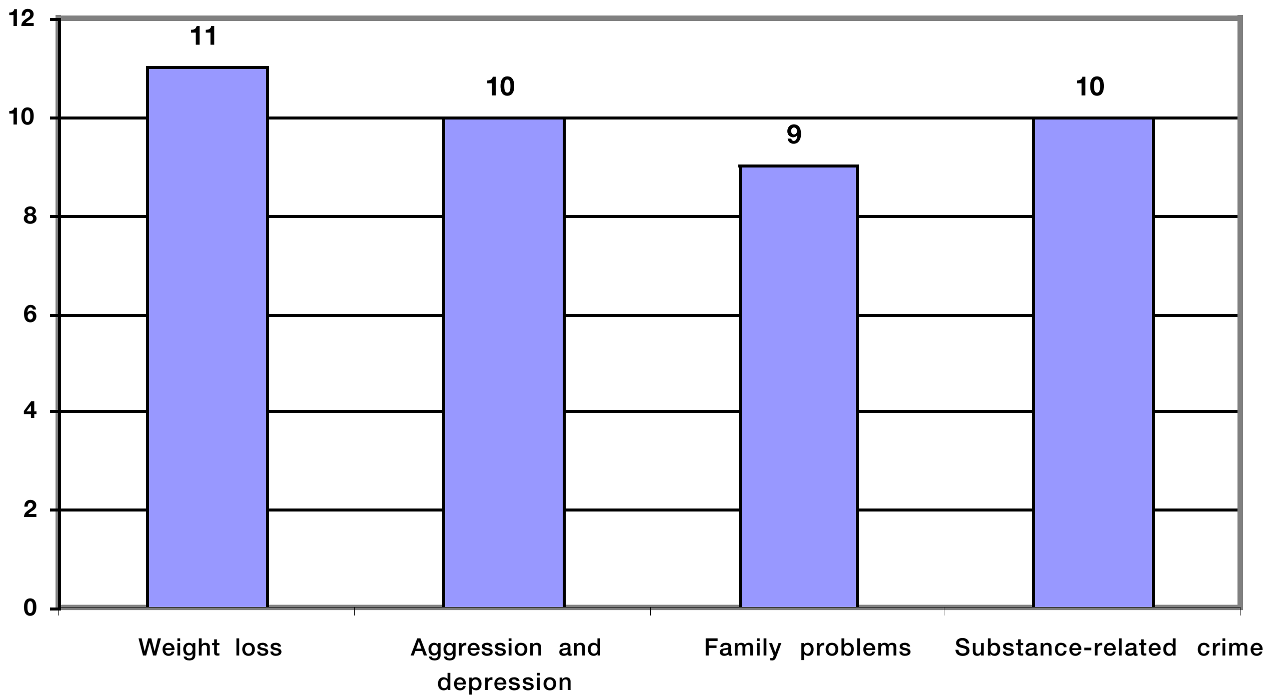


Figure 4: Main problems with problematic alcohol use



10. 'SEARCH II' in Greece

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OKANA ("Organisation Against Drugs"),
UMHRI (University Mental Health Research Institute), both Athens, Greece

Elpida Kalaitzi (OKANA)
Nadina Kanellopoulou (UMHRI)

1. Brief description of OKANA

The Organisation Against Drugs (OKANA) was founded in 1993 after the Greek parliament unanimously voted for a law that eventually came into force in 1995. It is a self-regulated legal entity, supervised by the Ministry of Health and Welfare.

General aims of the organisation:

- Planning, promoting, co-ordinating (inter-ministerial) and implementing national policy concerning primary, secondary and tertiary prevention of drug dependence.
- Scientific research on the problem of drug use at a national level.
- Providing valid and reliable information to the public and raising awareness.
- The establishment of community drug prevention centres in Greece, treatment units, social rehabilitation programmes and vocational training centres.

General responsibilities of the organisation:

- To approve and finance primary, secondary and tertiary prevention programmes.
- To supervise their implementation by the local government organisations, non-governmental organisations as well as by the organisational network of the community.
- To provide a liaison with the European Drug Monitoring Centre.
- To establish and operate the Greek Focal Point of the European Monitoring Centre for Drugs and Drugs Addiction.
- To actively participate in the international organisations involved in responding to the problem of psychoactive substance use and abuse.

Currently OKANA is in the 2nd year of implementing the National Action Plan Against Drugs (2002-2006), and is focusing its efforts on pursuing the objectives set in the demand reduction field. These efforts include establishing new programmes, implementing new co-operation schemes between different agencies and launching innovative interventions. These are all geared towards furthering the action taken against drug addiction in various fields and settings and enabling existing needs to be better met.

2. Brief description of UMHRI

The University Mental Health Research Institute (U.M.H.R.I.) was founded in 1989 – originally as the Academic Research Institute on Mental Health. The institute is a non-profit organisation linked to the University of Athens (Medical School) but administratively and financially independent.

The objectives of the U.M.H.R.I. are:

- To conduct and promote research at a national and international level on the basic sectors of mental health (biological, psychological and social), in collaboration with relevant organisations in Greece and abroad.
- To undertake advisory roles and offer relevant medical information and services to the government, domestic and foreign universities, other public or private agents, individuals, medical organisations and, in general, any organisation related to the medical profession.
- To plan and develop educational programmes on mental health corresponding to the needs and perspectives of the existing post-graduate programmes of the University of Athens Medical School; to help in dissertation work for post-graduate students.

In order to fulfil its objectives, the institute:

- Designs and implements proposals and undertakes research programmes relating to the fields of interest of the scientific organisations involved.
- Organises conferences, lectures and seminars and promotes any educational or other activity relevant to its objectives.
- Collaborates with domestic and foreign universities, school departments, research institutes, ministries and other public and private agents or organisations consistent with its scientific remit, as well as with any person who may provide information and assistance to the advancement of the institute's work.
- Provides financial support for post-graduate scientists studying subjects relevant to its aim, undertaking responsibility to pay part or all of the expenses that accrue.
- Publishes books, research projects and other educational material. It also issues material for publicising the institute.
- Collects all relevant information from a variety of sources in order to establish a library and archive, and acquires all necessary supporting equipment to sustain the aforementioned activities.

3. Final Report

The geographical position of Greece makes it a transit country for migrating populations, as well as for drug trafficking between other continents and Europe.
This report attempts to outline the scale of drug misuse among migrants in Greece so that in future best practices can be implemented for this particular population.

3.1. Historical review of the migrant situation in Greece

Traditionally, Greece was just a transit country for migrants. It was only in the early 1990s (1993) that it changed into a reception country as a result of economic and political changes of a national and global scale.

Historically, the phenomenon of national immigration in Greece started in 1952 and lasted until the mid-1970s. The two world wars and the 1947-1949 civil war prevented the country from evolving technologically, and agriculture (the only sector available to the population) was not sufficiently large enough to absorb the Greek labour force. Unemployment became the most serious problem afflicting post-war Greece, leading to serious economic repercussions. The solution proposed was intensive emigration. Between 1951 and 1881, 12 per cent of the Greek population emigrated to counties such as France, Belgium, US, Canada and, above all, to Germany.
A particular feature of this emigration flow was its temporary nature. It was stemmed by international events such as the oil crisis of 1973 and domestic ones such as the restoration of democracy after seven years of dictatorship and improvements in the Greek economy. Similarly the Greeks, imitating the Spanish, Italian and Portuguese guest workers in the northern Europe, started returning to their homelands. However, a substantial percentage decided to remain permanently in the guest countries, and southern Mediterranean countries started importing labour from Africa to cope with the acute labour shortage in rural areas.

During the 1980s, dramatic political changes in Europe utterly transformed the migration flows. The Iron Curtain fell and the reunification of Germany heralded a news era that was to have unpredictable consequences for all communist countries. The eventual collapse of the USSR and its fragmentation was followed by the subsequent collapse of all the socialist countries in and around the Balkan region as their economies failed. The situation worsened in the 1990s, with the disintegration of the former Republic of Yugoslavia, the bloody civil wars and the bombarding of Kosovo, leading to the displacement of millions of people in search of a better future. This constitutes one of the driving factors responsible for changing the immigration patterns in southern Europe, particularly in Greece, with the largest group of immigrants residing in Greece now coming from former communist countries (SIADIMA, 2001).

These abrupt changes, the short space of time, the pressures resulting from immigration, the lack of any previous experience and perhaps even the lack of any political have left Greece with no room to organise an adequate infrastructure to accommodate this population.

3.2. Current situation

Irregular transit migration is a continuously increasing phenomenon. A recent study by the International Organisation for Migration estimates that, worldwide, between 15 and 30 million people are regularly moving between countries. According to Eurostat, since 1989 net migration accounts for most of the annual population change in the European Union. In 2000, the annual net migration rate was 2 per

1000 population, representing around 65 % of the total population growth. Without positive net migration, the populations of Germany, Greece, Italy and Sweden would be in decline.

In order to sufficiently understand the key parameters for immigration in Greece, it is imperative that we have some idea of their number, nationalities and occupations. Immigrants are mostly employed in the seasonal or tertiary economy, (before they were mostly employed in large-scale industries). Their social position is at the bottom of the social scale with little opportunities for integration. They are not organised in trade unions, most of them are illegal and lastly, greater numbers of women are migrating, with considerable changes in the gender patterns.

The status of the migrants depends on several factors. If they are political immigrants and refugees, they are granted a temporary residence permit in Greece. There are also some immigrants that come to Greece with temporary work or tourist visas. However, the overwhelming majority of the immigrants that reside in Greece are illegal. Today, data on immigration in Greece varies according to the source. In 1999, government estimates suggested there were 500 – 600,000 legal and illegal migrants, which represents 5 per cent of the labour force, whereas other estimates suggested there were more than 800,000 legal and illegal migrants. Based on the last population census of 2001, the National Statistic Service of Greece (NSSG) estimates that the number of legal and illegal migrants is 797,093. With a total population 11 million, this means that 7 per cent are migrants.

According to a research study from the Operational Programme for Migrants of Panteion University, Greece has the highest proportion of migrants in Europe after Luxemburg, and the highest proportion of irregular migrants.

In an effort to deal with the problem of irregular migration, from 1996-98 the Greek Government implemented a selective procedure allowing for "conditional legalisation" of irregular migrants for a limited period. It effectively offered a kind of ‘amnesty’ to undocumented immigrants already residing and working in the country.

The immigration communities responded positively. According to the official report: 373,000 applied for and received the ‘white card’, which entitled them to reside in Greece for an undefined, short-term basis, seek work and meet the requirements necessary to obtain a ‘green card’. Approximately 220,000 workers then went on to apply for a ‘green card’, which, if they met its requirements and could prove that they had been employed during their temporary stay, entitled them to a work and residence permit for up to 5 years. Although the percentage of legal and illegal immigrants was very low (below 7 %), the law was amended with a second law being introduced in 2001. This enabled foreigners to legalise their situation if they could demonstrate that they had entered Greece before 2002. Following this second law, approximately 380,000 immigrants were documented. Provided that the legalisation procedures are successfully implemented, it is estimated that the percentage of documented immigrants could increase to 40-50 %. From the above numbers, it can be estimated that only one out of three migrants holds a green card, i.e. has the right to work, has health insurance and all the privileges or obligations that any citizen enjoys.

Finally, the Amnesty International Report for Greece states that 205,000 undocumented immigrants were arrested in 2002 for illegal entry and residence.

3.3. Asylum seekers and refugees

The latest data estimates that there are 25 – 30,000 asylum seekers.

Asylum applications:

1999	*2000*	*2001*	*2002*
1528	3004	5499	5664

Between 1999 and 2001, 10,031 applications were submitted; in the rest of the EU the number of applications for the same period was 1,167,554.

The recognition rate for Greece is 11%, and 16 % for Europe. (Source UNHCR - United Nation Health Council of Refugees). The percentage change in pending cases for Greece is 71 %.

3.4. About their origin

Data collected from applications for legalisation made after the second law was introduced is not yet available. The following data comes from the first legalisation procedures in 1997:

a) Approximately 78 % of immigrants come from the Balkans (65 % from Albania, 7 % from Bulgaria, 5 % from Rumania, 1 % from republics of the former Yugoslavia)

b) Another 10 % of immigrants come from central and eastern European countries (2.5 % from Poland and 7% from countries belonging to the former Soviet Union),

c) 8 % come from Asian countries (India, Pakistan, Philippines),

d) 4 % of immigrants come from African countries.

The asylum seekers and refugees mainly come from Iraq and Afghanistan, while a small number also come from Pakistan, India, Nigeria, Sri Lanka, Sudan and Sierra Leone.

3 .4.1.Where do they live and work

Research in the metropolitan areas of Greece has shown that immigrants live in the poorest districts where drug trafficking, prostitution, low quality housing and infrastructure are common place. It would be incorrect to describe these areas as ghettos, however, because they are not homogeneous and they are also occupied by the indigenous population. According to a survey carried out by the Department of Urban Development & Housing, approximately 66.5 % of immigrants live under conditions of poverty in substandard rented housing. Their residence is characterised by instability because the stereotypical "criminal immigrant" influences Greek owners, who are very reluctant to rent their properties to non-Europeans. 47.26 % live in Athens and another 15.8% in Macedonia (Thessalonica).

In the urban areas, they are employed mainly in the service sector and its sub-sectors like building, domestic work, entertainment and catering. This even includes the sex industry, which in the past decade has considerably expanded as a result of women and children being trafficked from the former

Soviet Union countries. In the rest of the country they are mainly employed in agriculture. The Ministry of Agriculture points out that seasonal immigrants have saved agriculture from disaster and have increased the competitiveness of Greek products in the European market by satisfying needs in harvesting, poultry and animal husbandry. Their participation in the country's labour dynamic has steadied wages.

3.4.2. Their children

Increasing numbers of migrant children regularly attend state schools throughout Greece. In the year 2000, 105,000 pupils attended primary and secondary schools, a total of 7.9 % of the pupil population. At the moment there are 26 Intercultural Education Schools, as well as reception classes in some state schools.

3.4.3. Governmental policies

The existing legal provisions for migrants (the 1991 Act) proved insufficient for dealing with and controlling the increase influx of migrants into the country. The Greek government was forced to respond by developing a long-term immigration policy. As a result, in 2001 a law was introduced to parliament defining the conditions for giving regular/legal status to migrants entering the country, for giving them legal working status, for securing the already existing migrant population in terms of the above, and for integrating them into the Greek community/society.

3.4.4. Organisations working with migrants

Currently there are many non-governmental organisations working with migrants and refugees in the country. Overall, they provide services in the following areas:

a) psycho-social education

b) counselling

c) legal help

d) medical care (Doctors without Frontiers and Doctors of the World)

e) financial support

f) occupational training and support

g) nursery schools

h) leisure activities, such as summer camps

i) sensitisation of the public's opinion on issues of racism and social exclusion

4. Migrants and substance abuse: steps taken for 'SEARCH II'

Within the context of 'SEARCH II', the two participating organisations OKANA and UMHRI decided that the first step would be to conduct a survey of the existing organisations (governmental and non-governmental) that are involved with migrants. The migrants' illegal status and more specifically, the nature of the sub-group of substance users and abusers, means that this population is a hidden one and very difficult to identify. In order to have access to official data from all the governmental and non-governmental organisations that come into contact with potential substance abuse migrants, a letter with a questionnaire was send to 63 drug prevention centres throughout Greece and to 28 national and local organisations dealing with migrants. Data was gathered and processed and these are the results: The Ministry of Public Order responded by sending the statistics for drug-related indictments from 1993 to 2002. The cases and indictments involve drug possession, usage and trafficking.

Table 1: Cases and indictments

YEAR	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CASES	2049	2531	3360	4695	6382	6948	7014	7995	9820	10424
INDICTMENTS	2958	3719	4778	6821	9507	10745	10626	12306	15026	15667
GREEKS	2708	3400	4170	5999	8555	9522	9457	11154	13750	14378
FOREIGNERS	250	319	608	822	952	1223	1169	1152	1276	1289

The National Statistic Service, under the auspices of the Ministry of Finance, provided data on drug convictions in relation to gender for each prefecture of Greece from 1993 to 1998. Drug convictions include: drug use, drug possession and trafficking, and drug cultivation.

Table 2: Drug-related convictions per prefecture and gender

YEAR	TOTAL	FOREIGN	GENDER	A	B	C	D	E	F	G	H	I	J
1993	1056	51	M	380	67	91	12	18	77	206	33	52	52
			F	32	2	5	2	1	3	12	2	4	3
1994	1016	45	M	399	48	103	16	16	32	182	27	51	76
			F	25	5	3	2	-	4	3	1	5	5
1995	1211	75	M	353	60	182	48	13	62	241	34	57	131
			F	17	5	6	1	-	2	-	-	5	3
1996	1484	187	M	444	93	228	30	55	38	307	58	89	60
			F	24	5	2	4	3	1	16	1	11	-
1997	1906	75	M	618	145	267	37	59	99	292	45	200	59
			F	26	1	6	1	3	5	16	-	8	3
1998	1725	82	M	614	143	139	9	66	62	346	51	148	57
			F	25	9	3	-	1	9	18	6	12	-

• A. Attika • B. St.Ellada and Evia • C. Peloponnesus • D. Ionian Islands • E. Epirus •
F. Thessaly • G. Macedonia • H. Thrace • I. Aegean Islands • J. Crete

The data above is only indicative, and no conclusions should be drawn regarding substance use and the targeted population.

Another significant source of information came from the responses provided by the OKANA prevention centres and therapeutic communities throughout Greece, which deal with drug addicts and provide therapy and/or counselling. From a total of 63 prevention centres, 24 replied. Out of those, 9 centres have provided counselling and/or referral services for drug detoxification for the target population. It is important to stress that most prevention centres requested more information and educational material to help them tackle the target population's specific socio-cultural and psychological needs.

Table 3: Cases seeking counselling/referrals from prevention centres

CASES	TYPE OF HELP	LOCATION
2	Drug related counselling	Athens
4 groups of parents and teachers	Counselling	Thessalonica
5	Drug related counselling	Athens
1	Counselling/referral	Kozani
2	Counselling/referral	Kefallonia
3 +mixed counselling groups	Drug related counselling	Crete
4	Drug related counselling	Zakinthos
8	Drug related counselling	Thessalonica
Unspecified number 5-10% per cent of total visits	Drug related counselling	Athens

The Greek REITOX Focal Point provided data for the last 3 years, collected from 24 drug therapeutic units throughout Greece, regarding the total number of migrant drug users that requested drug detoxification. It also provided data from the methadone substitution programmes and the OKANA Help Centre.

YEAR	TOTAL NUMBER
2000	60
2001	43
2002	63

Table 4: Migrant drug users requesting therapy

YEAR	TOTAL NUMBER
2000	5
2001	5
2002	6

Table 5: Migrant drug users admitted to OKANA substitution programmes

YEAR	TOTAL NUMBER
2000	31
2001	25
2002	19

Table 6: Migrant drug users approaching the help centre

KETHEA (Therapy Centre for Addicted Individuals), a well-established organisation in the fields of drug therapy and prevention implementation, provided data from its Multi Intervention Drug Centre report from the year 2002. According to this, 4,681 cases of drug use among migrants were dealt with.

Finally, the newly established "STEKI", a day centre for OKANA drug users, stated that there were 21 cases of drug-dependent migrants using its facilities during the year 2003.
In an effort to compile and summarise all the above information in regards to substance use and the investigated population, it is important to stress that, in a country that has seen a large influx of migrants during the last decade, a relatively small proportion of those users seeking help are migrants. One possible explanation for this could be that, by definition, drug users are a socially marginalized group. This places a double burden on the shoulders of the migrant groups, which are already stigmatised and marginalised with serious educational and vocational problems. In order to deal with this double exclusion, government policies aimed at implementing drug detoxification and prevention programmes should take into consideration the socio-cultural and psychological needs of the target population. These should also consider issues concerning the migrant population's access to services.

5. Special action for migrants and substance use

In order to meet the special needs of this population, KETHEA has very recently established a transitional support centre called "Mosaic". This centre will be ready to receive its first members in February 2004. In the past, the same organisation has implemented a drug-related programme in northern Greece, which was exclusively conducted in the Russian language.
The OKANA Help Centre has acknowledged the need for implementing specialised programmes to accommodate the needs of this population. Although outreach workers from the centre are already dealing with migrants, they acknowledge the need for further training to help to cope with this population.

In conclusion, Greece has recently entered a period when it is receiving large numbers of economic migrants. A period of adjustment is needed, both in terms of policy-making as well as socio-cultural integration, since Greece is facing difficulties at a variety of societal, political and economic levels. Drastic changes and long-term planning are needed. Apart from the fact that there are still no adequate official records on the migrant situation in Greece, the main difficulty in working towards this goal is that policy responses are fragmented. Different ministries are left to determine and define their own competencies, which leads to a lack of common strategic goals.

Comments:

The above information on migrants and drug abuse, as well as on the organisation working with migrants, is not exhaustive and needs further investigation.

11. 'SEARCH II' in Ireland

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North Eastern Health Board, Navan, Irland

Dr. Nazih Eldin
Joanne Murphy /author

1. The 'Search II' Partner from Ireland

1.1 North Eastern Health Board (NEHB)

The North Eastern Health Board is the Health Service provider to the North East region of Ireland covering four counties: Louth, Meath, Cavan and Monaghan.
It's aim is to provide and develop the highest quality health service for the people of this region - both in the promotion of health and in the prevention, diagnosis and treatment of illness. The North Eastern Health Board is committed to:

(a) Promoting healthy lifestyles
(b) Preventing, diagnosing and treating ill health
(c) Caring for those suffering from long term illness and disabilities
(d) Providing social services to individuals and families at risk.

Within the structure of the NEHB lies the Health Promotion Department. Over the years Health Promotion has become increasingly important in pursuing national health goals in Ireland. The Health Promotion Department's underlying principles and objectives are:

- To enable and support the resident population of the NEHB to adopt healthier lifestyles.
- To identify existing resources, structures and processes and orchestrate a collaborative mechanism to achieve a healthier environment in all targeted settings.
- To develop joint approaches i.e. provide centrality to the specific requirements of target groups within our settings and topic programmes.
- To support care groups and providers within the NEHB and without to integrate health promotion into everyday work.
- To ensure each programme addresses inequalities by including at least one disadvantaged group or setting within its remit.
- To continue the re-orientation process by providing training in health promotion principles and practice to professionals etc.
- To embed all actions in an evidence framework.
- In line with the above continue formal needs assessment, evaluation and research in line based on W.H.O. recommendations for Health Promotion Evaluation.

The Department carries out it's services in a framework of three overlapping approaches i.e. topics, settings and lifestyles (Health Promotion Department, 2003, Service and operational plan, 2004).

1.2 Substance misuse in the North East region

Research initiatives have been carried out to directly answer some critical questions on the extent and nature of drugs and substance misuse in the NE region. Research in 1997 and 2003 to assess and document the prevalence and patterns of drug use by adolescents was undertaken by the North Eastern Health Board.
The results indicated an increase in the proportion of adolescents misusing illicit drugs in 2002 compared to 1997, with cannabis the main drug of misuse:

- Overall the lifetime prevalence (i.e. taken an illicit drug once in their lives) was 41.2% in 2002 compared to 34.9% in 1997.
- 15.1% of the adolescents reported that they misuse drugs regularly (i.e. at least once in

the previous month) compared to 11.9% in 1997.
- Discos (46%) and the street (45.9%) were the most commonly reported places where drugs were offered.
- The drugs most commonly misused in 2002 by regular misusers were cannabis (12.5%), glue/solvents (2.5%) and ecstasy (1.3%).
- The most commonly indicated reason why young people take drugs was because "the people they hang around with do it" (58.6%).

(FLANANAGAN et al, 2003, Smoking, alcohol and drug use among young people, NEHB, p 5-6)

1.3 Drug services in the NEHB

The Substance Misuse Team in the NEHB under the guidance of Dr. Nazih Eldin, Regional Health Promotion Officer/Drug Services Coordinator work to the National Drugs Strategy 2001-2008. The aim of the team is to significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention treatment and research.
The team provide a number of training programmes on substance misuse and related issues:

Prevention/education

These courses include:

- Community Awareness of Drugs
- Peer Education Courses
- Life Skills Drug Awareness Courses
- Training courses for teachers, youth workers and healthcare staff.

Treatment

The addiction counselling service consists of information, support, counselling and referral to rehabilitation and detoxification programmes.

Research

- Research into the level of IV drug use is being carried out currently.
- Guidelines into school substance misuse policy in all post primary schools have been devised.
- Coordinated and hosted the International Prevnet Conference.

2. Asylum in Ireland

2.1 The asylum and immigration process in Ireland

Ireland's policy and procedures in relation to the asylum and immigration are the responsibility of the Minister for Justice, Equality and Law Reform supported by the relevant agencies in this area.
The process is divided into a number of distinct elements as follows:

(a) Processing of asylum applications
Asylum applications are made to the Minister for Justice, Equality and Law reform but are processed by the Refugee Applications Commissioner. The provision of accommodation and the co-ordination of

other support services for asylum seekers is the responsibility of the Reception and Integration Agency which is part of the Department of Justice, Equality and Law Reform. This agency also deals with the integration of refugees into Irish Society.

(b) Immigration including entry, residence and deportation
- Rules governing the entry to and the residence in the state of non-nationals in accordance with immigration legislation as well as the relevant EU law.
- Overall policy in relation to the issuing of visas
- Applications for citizenship
- Dealing with the deportation of persons

(c)Tackling Trafficking
Operational strategies in this area are the responsibility of the Garda (police) National Immigration Bureau. The aim is to co-ordination and direction of strategies to combat trafficking in illegal immigrants.

2.2 Important developments in Irish asylum and immigration policy

The government's policy is influenced by a number of key factors namely:

- Meeting the states obligation to refugees under the 1951 Geneva Convention and its related 1967 protocol.

- Continue to process asylum applications more speedily and within a six month time scale.

- As a result of the Supreme Court's decision of the 23rd January 2003 the immigration division of the Department of Justice, Equality and Law Reform no longer accepts applications from persons for residency based on their parentage of an Irish born child.

(Minister for Justice, 2004, Government Publications)

2.3 Asylum figures in Ireland as at 31st August 2003

- In the first eight months of 2003, a total of 879 applicants were recognised as refugees.
- As of 31st August 2003, a total of 6,051 asylum applications have been processed this year as had 2712 appeals.
- There were 5,082 asylum seekers in 58 accommodation centres in 24 counties as of mid-July 2003.
- Just over 50% of all new asylum applications were from Nigeria (40.4%) or Romania (10.6%). The other top countries of origin were DR Congo, Moldova and Ghana.
- In terms of new asylum applicants for the first half of the year, Ireland was ranked 12th in Europe, with asylum applications in Europe being the lowest since current records were first kept by the UNHCR in 1999.

(Irish Refugee Council, Oct, 2003)

2.4. Asylum figures in NEHB

The figures outlined below are the concentration of asylum seekers in the NEHB as at March 2002.

	Claimants	Spouse	Dependents	Total
Region	962	445	867	2274
Cavan/Monaghan	62	34	64	160
Louth	598	257	529	1384
Meath	302	154	274	730
Region (non direct provision)	693	328	683	1704
Region (direct provision)	269	117	184	570

3. Setting for RAR in NEHB

3.1 Mosney-Direct Provision Centre - NEHB

The setting chosen is Mosney Centre, Co. Meath which is a designated direct provision centre in the NEHB region. In November 1999 in response to alack of accommodation in the Dublin area and a desire to deter future asylum applications, the Government announced a pilot programme to "disperse" asylum seekers to locations outside Dublin. As a result asylum seekers were sent to communal accommodation centres on full-board and reduced social welfare payments. The accommodation centres provide asylum seekers with 3 meals a day and a small cash allowance of 19.10 euros per adult and 9.55 euros per child per week, plus child benefit.
Mosney accommodation centre was opened in December 2000 with 193 residents. The number now stands at 745. In addition sanction has been given to increase the capacity by a further 100 to 850.
The following services are provided at present in Mosney:

- GP Surgery
- Primary Childhood Immunization clinics.
- Area Medical Officer clinics (Screening infectious diseases & follow ups, X-rays, BCG's and developments)
- Public Health Nurse/Midwifery clinics (including ante-natal care, post-natal care, child development, health education, infant weighing, feeding etc.)
- Psychiatric Clinics
- Community Welfare Officers clinics.

The top nationalities that reside in Mosney are:

• Nigeria, • DR Congo, • Czech Republic and • Ukraine.

3.2 Access to research site / ethical approval

Access to the research site was carried out over a three week period. Gaining access to people, places and situations is a vital part of fieldwork research. Written documentation outlining brief details of

the study and the likely impact of it was forwarded to the key gatekeeper which is the Reception and Integration agency of the Department of Justice, Equality and Law Reform. A meeting was arranged with professional gatekeepers who are Mosney Health Service Providers, to stress the significance of the work, to outline the commitment that will be required from the group i.e. key informants and to project what the centre will gain from this study.
During this period ethical approval was sought from management of the NEHB.

3.3 RAR team Ireland

The group that worked together for the RAR process consisted of four people:

- Joanne Murphy, Co-ordinator, Health Education Officer-Drugs. Substance misuse training programmes for Health professionals and community youth workers are facilitated by Joanne. She has also worked extensively with travellers and the Roma community in Ireland.

- Frances Mc Ardle, Public Health Nurse, who works in Mosney Direct Provision centre and has direct responsibility for asylum seekers.

- Cindy Conaty, Drug Outreach Worker for Co. Meath. Cindy provides drug education programmes to community groups and one-to-one support/guidance to clients. She has previously worked with asylum seekers/refugees in a homeless project in the UK.

- Rose Mc Cusker-Community Welfare Officer who has responsibility for asylum seekers. As part of the CWO job, the objective is the provision of income maintenance service to asylum seekers.

The group has a mixture of expertise and experience which balanced well within the team. A one day training session was facilitated by the co-ordinator, Joanne Murphy.
The aim of the training day was to bring together members of the RAR team and to discuss issues of asylum, addiction, research methods and action planning for the NE region. The team met twice to discuss results and process information but were also met by the co-ordinator on a number of occasions in order to support and monitor the process.

4. RAR process and results

4.1 Target group

During the training day the issue of what target group to investigate was discussed. The main nationalities in Mosney are Nigeria (n=240), Czech Republic (n=23), DR Congo (n=26) and Ukraine (n=18).

It was decided to choose the largest cohort of people i.e. Nigerian community for the following reasons:

1. Numbers: There are 240 Nigerian people in Mosney. By choosing this group we would maximize confidentiality and protection of the research participant. Also we may get a richness of experience that we may not have gotten with smaller groups of nationalities.

2. Language: As English is one of the principal languages of Nigeria, it would minimize costs in having to employ a translator in order to process information and conducting semi structured interviews.

3. Anecdotal evidence: Anecdotal evidence from other direct provision centres in Ireland suggests that the Nigerian population were dealing and misusing substances within these centres.

4. Accessibility: It was felt by the RAR team that the Nigerians were the most accessible group in order to interview. Early indications suggested that they would be open to the process.

4.2 Mapping the community

At the start of the RAR process in Ireland there was no information available about drug-related issues among asylum seekers/refugees other than some anecdotal evidence to suggest Nigerian community were using drugs in the wider community. Venturing in an unexplored field, all members of the RAR team brainstormed during the training day as to potential informants who had a good knowledge of the Nigerian community/culture.

Potential informants were identified as:
- Family Support Workers
- Irish Refugee Council
- Head of Security in Mosney
- Publicans
- Nigerian Community in Mosney
- Community Welfare Officers
- Accident and Emergency
- Public Health Nurse/GP
- Addiction Counsellors
- Probation Officers
- Intercultural Development Worker
- Drug Dealers/Users
- Domestic Workers in Mosney
- Religious Leaders from the Nigerian Community.

A time frame of six weeks was given to the team to access informants and glean information about substance misuse and the Nigerian community. In hindsight, this was not a realistic timeframe to gain trust which is vital to the successful completion of the project.

4.3 Process of ssi's

Semi-structured interviews (ssi) will be the qualitative research tool employed during the RAR process. The research is explorative and interviewing respondents is the most effective way to collect data. The respondents of the ssi's in the NEHB were:

- Closely connected to the Nigerian community or
- Had daily contact with the target communities on a professional basis or
- Have central positions within the Nigerian community.

17 semi-structured interviews took place in the time frame of six weeks. The categories of people finally interviewed were:

- 2 family support workers
- 1 probation and welfare officer
- 1 social worker
- 1 alcohol education efficer
- 2 cleaning ladies
- 6 Nigerian people
- 1 area medical officer
- 1 public health nurse
- 1 general manager of Mosney
- 1 Ex-CWO of Direct provision centre.

4.4 Results from the RAR process in Ireland

The overriding principle of the RAR team Ireland while conducting the research was that researchers must maintain the safe exploration of people's lives and their underpinning assumptions by applying ethical codes of practice.

"This private world needs to be explored in such a way that it is protected and safeguarded, and the knowledge gained from the research has to be useful to further the understanding of Health Promotion interventions as well as to be directed towards the ultimate good of the research participant."
(ELLISTON, 2002)

The results of the research were as follows:

15 respondents indicated that they were not aware of alcohol/substance misuse issues amongst the target group. When asked about the reasons why the target group did not use drugs, the following responses were given:

- religious Traditions (n=4)

- No incentive to get into drug dealing. Legal status of participants would be put in jeopardy *"In Mosney everyone is the same…. We would notice if someone had more than us…. They would be found out quickly"*.

- 11 out of 17 respondents had no knowledge of drug related problems/effects.

- 1 respondent who works in Mosney stated that they heard the target group talk about "rolling up pieces of paper" and the target group not being able to" hold drink". They also talked among themselves about being sick (alcohol related).

- 1 NEHB respondent stated that substance misuse is probably much hidden; however they have no cases pending regarding this issue. *"I have no idea about signs and symptoms of substance misuse so I wouldn't know what to look for".*

- 1 respondent – male-Nigerian, not a resident of Mosney. Involved in a number of community groups in Co. Meath. He has seen evidence of substance misuse among Nigerian families living in the wider community. He is not aware of substance misuse within the Mosney community. The most commonly used drug is Indian hemp which is used at house parties. Men between the ages of 25-45 are most common users. Their partners do not know they are using drugs. The interviewee felt this was a practice formed since their arrival in the host country.

The reasons for using the drug were:

1. Boredom
2. No permit to partake in full-time work or education
3. Trauma of arriving in a new country
4. No pub culture in Nigeria so they felt displaced on a social level
5. The drug was affordable and acceptable among the peer group.

It was estimated that 8-10 families were affected by this practice in the Drogheda area which is close to the Direct Provision Centre.

4.5 Limiting factors during the RAR process

A number of factors hampered the process. Outlined are some of these factors:

- **Time.** Although 17 ssi's were conducted, given extra time on the project, an engagement of people who had greater knowledge of substance misuse issues would have been achieved.
- **Trust.** Trust needs to be built up and earned among the target group. There was not enough time to build on this process although some very positive contacts were made and have potential to develop them further.
- **Knowledge.** There was a general lack of awareness of drug related issues among professionals and people who worked in the centre.
- **Population group**. This population group is an ever changing and transient group, therefore there is not enough time to build up working relationships with people in order for them to open up.
- **Centre approach vs. open setting**. Mosney prides itself on being a very secure centre. Security is paramount in the centre. There are strict guidelines for residents. The RAR team questioned if the RAR process was conducted in the wider community, would we have got different results?
- **Priority of needs.** The research was conducted in a Direct Provision Centre. The residents receive an allowance of 19 euros per week. There are a number of basic physiological/psychological needs i.e housing, food, security etc. that need to be satisfied before residents look towards wider issues like alcohol/drugs.
- **Outside influences**. During the RAR process, residents of Mosney went on hunger strike for better conditions. This inhibited the process and access to the site had to be renegotiated and treated in a sensitive manner.

4.6 Opportunities for progression of 'SEARCH II' Ireland

As a result of the RAR process there are a number of training initiatives and health promotion interventions that could be implemented in the NEHB region. These are not exhaustive and were chosen by the RAR team as achievable and realistic. Outlined are these health promotion interventions:

1. To examine all current substance misuse educational material and culturally proof material to make it appropriate for all ethnic minorities.
2. To ethnically monitor results of programmes and train asylum seekers in the design and delivery of substance use programmes.
3. To highlight addiction services with all professionals who work with asylum seekers.
4. Long term goal: Establish a satellite clinic within the Direct Provision Centre to address substance misuse issues.
5. Long term goal: To employ a Health Promotion Officer with special responsibility for ethnic minorities to work in conjunction with HEO-drugs to bring forward these issues.

5. Conclusions

- Respondents appear to have limited knowledge of alcohol/substance misuse issues amongst the target group.
- 3/4 of the respondents had no knowledge of drug related problems or effects.
- As a result of 1 interview, it was stated that substance misuse was happening in the wider Nigerian community, with Indian hemp being the drug of choice.

The reasons for drug use in the wider community were:

- Boredom
- No permit to partake in full-time work or education.
- Trauma of a new country.
- No pub culture in Nigeria so they felt displaced on a social level.
- The drug was affordable/available

6. Recommendations

- The research will raise awareness about drugs and drug service provision within ethnic minority groups in the NEHB.

- These results could form a part of a review of current training programmes in the light of new awareness of ethnic minorities.

- Do health professionals know the needs of ethnic minorities from a health promotion focus?

- There is a lack of prevalence estimates of drug use among asylum seekers in Ireland and there is a lack of recognition that drugs are used by them.

- The lack of evidence of substance use can be used as a justification not to address it, yet it is only through acknowledging it that debate and further investigation can be initiated.

Examples of Policy papers that could be written are:

- Good practice of planning and delivering drug services to asylum seekers.
- Factors affecting drug using patterns among ethnic groups.
- The reasons for the under representation of asylum seekers as drug service clients.
- Examples of good practice in methods of researching drug use and the related service needs amongst asylum seekers.

All of these recommendations are within the operational plan of Health Promotion for 2004. It is envisaged that these participative interventions within the NEHB will be met in current and future service and operational plans.

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12. ‘SEARCH II’ in Italy

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Gruppo Abele, Turin, Italy

Giorgio Morbello
Marina Marchisio

1. Brief description of the organisation: Gruppo Abele

The Gruppo Abele is a charitable organisation that has been working in the social field for around 35 years in support of the most disadvantaged in society. The group's activities are focussed in three different, but interrelated directions:

- Initial outreach /community work,
- "cultural" and
- "vocational" work.

The overriding principle behind this organisation is that it is not sufficient to merely show solidarity through general projects, it is much more important to directly strive for social justice. For this reason, apart from the rehabilitation centres for drug addicts, harm reduction projects, low-threshold and drop-in centres, and support projects for prostitutes, cultural initiatives are instigated that aim to examine and compare these experiences while adopting and disseminating theories, ideas, themes and initiatives concerned with complex social needs.

A substantial part of the activities of the Gruppo Abele include:

- a study centre for documentation and research [Centro Studi Documentazione e Ricerche], which is directly involved with 'SEARCH';
- the journals Narcomafie, Animazione sociale and Macramé and
- the training programme, youth programme, publishing house, etc.

Within this context, great importance is attached to vocational activities. This is not just because more than 100 persons are employed by Gruppo Abele, including educationalists, psychologists, researchers, journalists and staff in the secretarial and accounting departments, but because the association has directly contributed to the establishment of numerous social cooperatives. These include joinery and tanning workshops, horticulture, recycling and work in penal institutions, etc. The function of these organisations is to provide an educational and emancipative means to reintegrate socially disadvantaged persons back into work. It is therefore clearly evident that a research and intervention instrument such as the RAR, which closely links research to the need for effective action, is extremely suited to the Gruppe Abele and its special facilities.

Moreover, the Gruppo Abele has already been dealing with the problem of drug use in the immigrant population for several years. This occurs primarily through a mobile project, which was the first outreach project in Turin. The members of this team contacted Italian and foreign drug users on the streets and in the squares of the city. Those who approached the street workers were given information, sterile injection equipment and counselling. The project is now being run under the direct auspices of the National Health Service [Servizio Sanitario Nazionale].

The Gruppo Abele is also tackling the phenomenon of substance use among immigrants from non-EU countries as part of other activities. The drop-in centre is a facility open to anybody who does not know where to stay during the day. Many immigrants also go there. It is a low-threshold service that has frequent contact with foreigners with substance-related problems who have entered the country illegally.

There are considerable similarities between the 'SEARCH' project and the various activities of the Gruppe Abele, and not just in terms of method but also regarding the actual scope of action. It was able to incorporate existing knowledge into the 'SEARCH' project and link the association's existing resources with other resources available in the city.

2. The transition from 'SEARCH' to 'SEARCH II'

2.1. The results of 'SEARCH'

The research and analysis work conducted in accordance with the Rapid Assessment method in SEARCH showed that, in terms of general substance use, the North African population in Turin is most at risk, although other groups such as South Americans and Romanians are also identified, particularly in connection with alcohol misuse. Within the North African community there are at least three vulnerable groups:

1) Adult users using different substances,
2) Problematic alcohol users,
3) Youths and juveniles who are users of different substances

1) The adults
These are drug addicts who have been using substances for a considerable time and, in some cases, are already known to the staff in the specialist establishments. Heroin and cocaine are the most frequently used substances and many people from this group are in prison for drug dealing. The life context in which these people find themselves places them under considerable physical, mental and social pressure, caused in most cases by unemployment, lack of any perspective, lack of accommodation and isolation. The situation is worsened by the harm caused by the continual misuse of drugs, which are often used under the most dire hygiene conditions. This creates living conditions that are characterised by considerable exclusion. In general it can be said that a feature typical of this group is the search for a numbing and "self-healing" effect. Although this group appears to be relatively well informed about the risks associated with the substance use, their knowledge of the available care facilities, however, is deemed to be insufficient.

2) Alcohol users:
Problematic drinking appears to affect three different North African user groups: Working adult users (during leisure time, at parties); adult users suffering from exclusion (chronic drinking, homelessness); youths and juvenile users (emulation, feeling of freedom, etc.). Often the alcohol misuse leads to serious problems in the families; in many cases it serves as support, for example when activities are conducted that are considered "degrading" such as window cleaning or begging. It has turned out that the aspect of religion plays a central role with alcohol. Some people are of the view that, in this group, the differences with their homelands are not so great as might be believed because alcohol use is actually quite prevalent there (even if secretly and with the specific intention of becoming inebriated). Other people, on the other hand, point out that Muslims are forbidden from drinking alcohol and this accordingly gives rise to feelings of guilt when alcohol is drunk. Nevertheless, one thing that can be ascertained is that a lack of social control, which in the homeland is exercised by relatives, friends and neighbours, is a factor leading to an increase in alcohol misuse in the reception country.

3) Youths and juvenile persons (12 to 25 years old)
The use of heroin through injection seems to be hardly existent among younger persons. The most widespread psychotropic substances are cocaine, Ecstasy, hashish, alcohol and, in sporadic cases, solvents. Often, some of these substances are used in combination (alcohol + hashish, alcohol + Ecstasy). Within this group it is possible to distinguish between two types of substance users:
- Social fringe groups (young people without families, without a home or work);
- integrated youths who have work or a family and attend school, and who use substances for the first time under the same conditions as their Italian peers.

In the former case, they begin using substances as a result of drug dealing, for which the migrant North African youths are recruited.

The final focus groups that were held as part of the RA have led us to believe that it would be more effective to target preventive measures at the last mentioned "vulnerable group" (i.e. youths).

One of the results of the preventive measures taken in 'SEARCH' was the creation of a network between all staff in public and independent social services that deal with foreign minors. This is the work group that, within the framework of 'SEARCH', developed the guidelines for a preventive campaign that is aimed specifically at the target group in question. It turned out that the aforementioned youths often lack basic knowledge about the substances. Sometimes they are incorrectly informed and sometimes not at all. One of the most practical suggestions for prevention envisages the use of creative communication forms in order to reach the target group. Here it also became clear that the educational work would be more effective if the youths belonging to the target group were already involved in the production of the information material. A first step in developing an efficient educational campaign consisted of networking those staff in public and independent care establishments who come into constant contact with these youths. At the conclusion of 'SEARCH', those professionals who were involved in the network developed a joint project, having agreed upon a working method. The specific recommendations of the working group are as follows:

1) Developing "culturally sensitive" information material,
2) Involving a group of North African youths in the production of the material,
3) Conducting regular monitoring.

Thus the activities conducted within the framework of 'SEARCH II' have accordingly concentrated on these three working areas.

2.2. The dissemination of the RA methods

During the period between 'SEARCH' and 'SEARCH II', the Gruppo Abele's study and educational centre sought approval for three different drug addiction projects from the local authorities in Turin and the Piomont regional government – projects that were able to use and disseminate the Rapid Assessment Method. As a result, the RA methods and their utilisation in the problem area of substance use in the immigrant population met with growing interest and greater openness. The extent to which interest in this method has grown is illustrated by the fact that all three projects were positively assessed, even if only one of them was ranked high enough to be financed. This is concerned with a training event for the Rapid Assessment Method that will begin in February 2004 and for which more than 20 professionals from public and independent social services have registered.

3. The RAR monitoring as clarification process: results, further developments, changes

The situation in Italy is currently changing. The reasons for these developments are:

1) the new immigration law,
2) the new (not yet authorized) provisions for asylum seekers,
3) the abolishment of the visa requirement for travellers from Romania,
4) the possibility to legalise 700,0000 immigrants (in addition this includes the corresponding uniting of families).

Particularly in Turin, there is increasing social concern about the growing problem of criminal gangs of youths (pickpockets, beggars, drug dealers; some of whom are less than 14 years old). There are no epidemiological studies or observations regarding increased drug use among juvenile immigrants that would provide an overall picture. However, street workers and members of the mobile team know of very young Romanian youths who inject heroin. The monitoring process envisaged as part of 'SEARCH II' was introduced against this background.

3.1. New information about the context

The most important sources that we drew upon in order to gain new information on substance use in North African or other immigrant populations are:

- Newspaper articles,
- Members of mobile teams,
- Street workers,
- Staff from authorities in the city of Turin responsible for juvenile foreigners.

From the aforementioned sources, we were able to gleam the following insights:

1) There still exists the phenomenon of drug dealing and substance use (cocaine, alcohol, inhaled heroin, Ecstasy) in the young North African population.

2) There are bands of youths (some of whom of less then 14 years old) that are smuggled in by adult criminals from Romania and forced into drug dealing, pick pocketing and, according to anecdotal evidence, possibly even into prostitution.

In April 2003, a police raid led to the arrest of 10 adults who controlled part of the aforementioned illegal activities. Generally, however, the situation has not changed.

3.2. Selection of key informants, Focus groups

The selection of key informants for the systematic observation of the phenomenon occurred via those persons who proved to be the best informed within the framework of 'SEARCH'. The aforesaid persons, who belong to different working areas (street workers, cultural mediators, members of the Moroccan and Rumanian community, teachers, employees in the aliens office, representatives of facilities providing drug care), were asked to identify other persons who could possibly know about the latest developments concerning this phenomenon.

Based on the information that we had already collected, it was decided to set up two focus groups that would purely concentrate on assessing the current situation and development. The first focus group concentrated in particular on the group that had proved to be the most problematic within the framework of 'SEARCH' (juvenile persons from North Africa). The second focus group was given the task of examining the situation of illegal substance use in the remaining population of young immigrants in Turin. The composition of the two focus groups was as follows:

Focus group 1 : 2 cultural mediators
2 social workers
1 lawyer

Focus group 2 : 2 employees from public drug care facilities
4 social workers
1 teacher at the youth detention centre
1 cultural mediator
1 responsible member of staff from the authorities for foreign juveniles
1 member of staff from the authorities for foreign juveniles

Focus group 1:
Results are in summarised form, organised according to the individual key questions:

➠ *Who are the users?*
The young North African users of illegal substances living in Turin can be distinguished by two characteristics that are also decisive for their different access to drugs.
• Youths who live in families
• Unaccompanied youths.

➠ *What do they use?*
The substances which are not only used most of all, but which also raise the greatest concern, are: cocaine, alcohol and Ecstasy. We were able to confirm the use of heroin through smoking or snorting (only a few cases of intravenous use were able to be confirmed), the occasional use of solvents and the widespread use of cannabis.

➠ *Definition of problematic use*
The greatest problems that are associated with substance use are related to the living conditions of the young immigrants. This particularly applies to youths without parents or guardians. Thus it is not just the substance use alone that is problematic but also the general situation. Their involvement in criminal activities (often drug dealing) not only causes psychiatric and physical harm to the youths through the use of substances, above all it exposes them to the risks inherent to a life of crime.

With those youths who live with their families and in many cases attend school and have Italian friends, the problem of substance use is also a cultural problem. There is no culture of alcohol use or "freedom" as known by Italian youths of the same age. This culture is misunderstood by the Moroccan youths, which leads to excessive and dangerous behaviour.

➠ *Factors*
As has already been explained, the existence of a family environment has proved to be a distinctive feature that is linked to different behaviour patterns and situations. Families cannot always be regarded as a positive resource. In some cases, difficult family relations and differences between traditional values experienced in the family of origin and those acquired in Italian society, as well as too strong parental control, produce situations that encourage deviant behaviour. Furthermore, in many cases it was ascertained that there was a lack of correct information, in particular regarding synthetic drugs.

The results produced by this focus group confirmed the results that we had managed to gain during 'SEARCH'. As a consequence, the members of the focus group have decided to develop a joint prevention programme specially designed for educating the target population. The last focus group meetings were already used for planning these measures (see section 2.3).

Focus group 2

➠ *Who are the users?*
These are very young Romanian youths who are smuggled into Turin by criminal organisations. They are mostly of Romany origin.

➠ *What do they use?*
The substance giving most cause for concern is heroin, which the immigrants have until now not used by injection.

➠ *Definition of problematic use*
In this case as well, the psychiatric and physical problems caused by substance use are also closely linked to the general living conditions. The youths often live on the street, sleeping in derelict factories or, if at all possible, in extremely run-down boarding houses. When they arrive in Italy, they have often left a social situation in their homelands characterised by exclusion. In Turin, Romanian youths face considerable social stigmatisation that can be attributed to their illegal activities – a context that is very unfavourable for developing schemes for resocialisation and integration.

➠ *Factors*
The factors that have contributed to the increasing phenomenon of substance use among juvenile Romanians seem at first sight to be linked to the easing of restrictions for entering Italy (there is no longer a visa requirement). The fact that many youths are used to living on the streets makes it more difficult to establish contact and to find a starting point for including the youths in the resocialisation and support projects. Forced prostitution, for which there is no certain proof, however, could also be an important factor for the spread of substance use.

Finally, given that there are a series of possible projects for foreign minors, the participants in this focus group agreed to hold regular meetings to consider the possibilities for collaborating and conducting the various initiatives.

4. The (local) tasks and their implementation:

As has already been explained, in terms of prevention work the results from 'SEARCH' have already shown the need for developing instruments for educating North African youths living in Turin about substance use. Since 'SEARCH', it has been considered essential to involve the target community in the development of the instruments. The monitoring assessment conducted as part of 'SEARCH' confirmed these findings.

4.1. Prevention

Some of the members of the network that had been activated since 'SEARCH' were involved in the first phase of the preventive interventions (May until September 2003). In particular these included persons who were in direct and constant contact with the North African youths. Six meetings were held at which some reference persons participated from the following public and independent social services:

1) Publicly-run drug care facility at the Ferrante Aporti youth detention centre,
2) The Sanabil cooperative for cultural mediation,
3) The ASAI association for intercultural care.

The contacted reference persons have declared their willingness to get involved in the youth work envisaged by the action programmes developed in 'SEARCH'.
The participants in the meetings dealt with the following themes:

- Choice of context and the group of youths to be involved
- Updating the teachers' general knowledge regarding drug misuse
- Modalities for accessing the youths to be involved
- Determining the working stages and timeframe for the meetings

This work phase, which was completed in September 2003, led to the following results:

1) As a result of the times and work modalities foreseen by the project, it was decided to involve a group of youths in the prevention work for 'SEARCH II' who attend the Sanabil cooperative's day centre. The North African youths visit the cooperative every day after 5.30 pm to spend several hours there with the teachers or to participate in initiatives aimed at their social and cultural integration. They also receive support should there be any problems (school, residence permit, information on overnight shelters, possibilities for board and lodging, etc). In the period foreseen for SEARCH II, the dates scheduled for youth work by the ASAI association (a youth centre for foreign juveniles) were already reserved, and collaboration with the youth detention centre would have required so much bureaucratic effort to obtain the necessary permission that the start of the work programme would have had to have been postponed. However, both faculties have declared their willingness to follow the prevention work and have expressed their interest in disseminating the educational material produced. Furthermore, in view of a possible resumption of this kind of work, they are interested in evaluating the results of this direct drug work with young North Africans.

2) The attempt was made at these meetings to gain an overview of the situation concerning substance use in the Turin area and to update relevant knowledge. Here, the fact that a representative from the local drug care centre took part in the meetings proved to be useful.

3) It was determined how the youths in question were to be persuaded to get involved in the work and how the workshops should be designed. It should be born in mind that some of these youths using substances do not have the correct papers and some of them are also involved in minor drug dealing. Accordingly, the following procedure was agreed upon:

- The proposal to participate in the work programme was to be put to the group of youths by the teacher, a Moroccan, who spends considerable time with them and enjoys their complete trust. This teacher was also to take part in all workshops as an interpreter and provide support.
- It was intended to introduce the work programme to the youths as a series of rather informal discussions on the subject of drugs. It should be clarified here that the latter purpose was to compile information to be incorporated into a brochure that was to be written in a language (Arabic or French) that can be understood by the North African youths.
- The attempt was to be made to identify those persons within the group who are most attentive and receptive in order to stimulate their ability to lead and to convey information.

4) Finally, a schedule was determined for the workshops with the youths and a title for this initiative decided upon: ("*Tell everyone*: Joint production of information material on narcotics for the target group of North African youths"). Everyone agreed that although the production of information material is in itself important when conducting this type of prevention work (which in Turin does not exist in the Arabic language), perhaps much greater importance should be attached to the method of working. The direct inclusion of the youths encourages them to adopt the prevention-relevant contents themselves. In addition, it is assumed that the youths' newly gained insights will be passed on to their friends and peers and that this oral communication will have a greater effect than the written material.

It should already be pointed out here that this workshop phase eventually required considerably more time to discuss the predetermined points than had been originally envisaged. There are several reasons for this, which will be discussed in more detail below. Therefore it also makes sense to describe the original work programme that was developed in order to be able to then compare it with what was actually carried out. The start of work was fixed for 9th October. The first workshop was to be concerned with the following key questions:

- Which substances do you know of? (brainstorming)
- How are they described in your language?
- How were you introduced to these substances and when?
- How are these substances used and where?
- What are the differences between Italy and Morocco in this regard (which substances do and do not exist, what are the differences in use and in terms of 'social stigma')?
- List the substances (including alcohol) according to their degree of risk and substantiate this!
- Characteristics and hazardous of the individual substances

The second workshop was designed as follows:

In the group: Analyse the information brochures written in Italian:

- Have you already seen these brochures anywhere before?
- What do you understand and what don't you understand?
- In your opinion, what should be made clearer?
- What's missing?
- What would you change to make these brochures easier to understand for Arab-speaking youths?
- Where should they be distributed?

Presentation of the results of the group work:

Based on the information collected, texts were to be written in Italian that would be presented to the youths with the help of the interpreter/accompanying person in order that the following points could be completed by the next meeting:

- Analysis of the rough version
- Collecting comments
- Joint correction

4.2. Production and results

This led to a series of workshops in which around 12 youths participated who were aged between 14 and 19.

➠ The group

The group, which consisted entirely of Moroccans, turned out to be heterogeneous since the youths came from different regions, had different cultural backgrounds and had lived in Italy for different lengths of time. There were "integrated" youths who attended school, spoke good Italian and whose relation to the substances was similar to that of their Italian classmates, and there were timid new arrivals who came from small towns in the most backward regions of Morocco and thus had a completely different cultural background. It became clear that the youths had little or no knowledge of French.

➠ *The workshops*
As has already been mentioned, it soon became necessary to change the timeframe for the meetings. What were originally planned as occasional meetings (two meetings to discuss the content and one meeting for correcting the rough version) became weekly events, which took place from October 2003 until January 2004. Here it should be born in mind that in November all participating youths observed Ramadan. Therefore it was ensured that the times of the planned workshops (which were the only possible times considering that some of the youths attend school or were trainees) coincided with the time of day in which the youths were allowed to eat. The cooperative supplied bread, eggs, tuna fish, biscuits and milk. In this month, however, it was still possible to tackle the planned subjects in accordance with the work programme.

The second aspect that should be pointed out concerns the living conditions of the youths. Many of them are waiting for a residence permit for juveniles, others on the other hand are occasionally mixed up with small-time drug dealing, while others are still struggling with the language. What they all have in common, however, is the fear to speak openly since they believe that the police and their informants have a greater presence in Italy than is actually the case. As a consequence, it took a considerable length of time before it was possible for spontaneous discussions to take place as part of genuine group work and for the real impressions of the youths to come to light. Therefore the first two meetings were almost exclusively used for mutually 'studying' one another, and it was interesting to observe that the youths always spoke Arabic to the mediator who was present (even if they could speak Italian), as if to have it confirmed that what they wanted to say could really be said. In the end, instead of the two meetings that were originally envisaged for developing the text, six meetings actually took place. In January 2004, the text was "authorized" by the youths and it was possible to move on to technical aspects such as the translation and layout.

➠ *Multicultural aspects*
From the analysis of the work carried out it has been possible to gleam several useful insights that can provide suggestions and guidelines for all professionals intending to focus on drug prevention work in connection with North African youths. Obviously, the following aspects are relevant:

• Basic knowledge
The group of youths seemed to have a very heterogeneous state of knowledge regarding the phenomenon of drugs. This applies both to the various substances circulating in Turin and the risks involved in using substances. In particular, two aspects needed to be taken into account:

• How long they had stayed in Italy;
• the Moroccan region of origin.

Those youths who have already been living for one or two years in Italy were informed about substances to an extent commensurate with any group of Italian youths. In terms of the regions, we were able to ascertain that in the north of Morocco, which is closer to Europe, there is certainly some knowledge of the substances usually used, including synthetic substances such as Ecstasy, etc. The youths from the southern parts of the country, however, have only come into any form of contact with drugs upon arriving in Italy, albeit in terms of just having knowledge of them. This aspect turned out to be of particular importance when choosing the content of the information material. The first meetings served to circulate the available material, which some youths already had, and to add new details and information, in particular regarding legal aspects and the social and healthcare services available to persons with substance-related problems.

• Language

It turned out that the French language is not very widespread. Therefore it was decided to just translate the brochure into Arabic. The information also clearly needed to be brief and to the point. Some material written in Italian seemed "strange", which was hardly surprising since a presumed youth language had been used, mixed with jargon and slang expressions. It is hard to recreate such linguistic styles for the young Moroccan readers of the brochure. Therefore a brief, concise and blunt text was chosen that was limited to the necessary information.

• Legal aspects

The work with the group revealed that there is often no knowledge of the legal aspects. The fact that Italian law distinguishes between individual substances as well as between possession and dealing in drugs is hardly known. It is also possible that the aforesaid provisions, which are less strict than the Moroccan ones, are underestimated and are considered more lenient than they are. In this case, we also limited it to the essentials, preferring to keep the presentation clear and simple.

• Analysis of the means of presentation

One meeting was devoted to Internet research. A search was made for Moroccan sites or sites with information relevant to drugs. We were unable to find any important sites, however, but just a few sites about HIV prevention that were assessed in terms of their graphic and visual design. We were not able to determine any substantial differences between the material and that which is published in Italy, which may be because some of these campaigns are in turn modelled on European ones. The analysis of the Italian material showed that the graphic design, consisting of comics, drawings and images, was certainly understandable, which indicates the closeness of the Moroccan youth culture to the European one. The references to music, including hip-hop culture and rap music, were immediately clear and understandable, and therefore useful.

• Respect

A last important aspect concerned the 'style' to be adopted in conveying the content to the youths. The joint work showed that the entire group (including youths who live on the street) generally had considerable respect for the adults. This was habitual, and was due to the social and family model in which they have grown up. It was an altitude that almost proved to be an obstacle at the beginning, but which we were then able to utilise in maintaining keen interest and increasing the youths' involvement. This aspect was discussed with the mediator and the other teachers. Finally, both in the brochure and in the relationship to the youths, it was decided not to overemphasise the authority aspect, while at the same time avoiding an accomplice-like tone that is often characteristic of analogue prevention projects addressed at Italian youths. It was felt that too much familiarity, or the delegation of responsibility ("I'll tell you the risks and you do what you think is right…"), would run the risk of being viewed by the youths as weakness, as a lack of authority and sincerity. The content and the information on prevention would therefore lose credibility.

5. Conclusions, prospects (networking, political implementation, etc)

Between November and January, several prevention projects financed by the Health Ministry were run in Turin that specifically addressed substance use in the young immigrant population. In February, the members of the network founded as part of 'SEARCH' will meet to gain an overview of the above-mentioned projects and to sound out the possibilities for interaction. As far as the work with youths in the Sanabil cooperative is concerned, it has already been fundamentally agreed that the material shall be used and distributed where the most North African youths can be reached (authorities for foreign youths, youth detention centres, youth clubs). These groups and establishments had followed the work with interest. For their part, they have also expressed a willingness to take up this work within their own areas.

The entire work carried out within the framework of 'SEARCH' and 'SEARCH II' can be seen within the context of increasing public awareness of the problem of substance use in the immigrant population and has contributed to a more coherent and coordinated public response. It should not be forgotten that, inevitably, future development depends to a considerable extent on the political decisions of the Italian government. The draft law introduced by the government will make the existing legislation considerably more severe: it plans to abolish the distinction between 'hard' and 'soft' drugs, to strictly limit the amounts of substances that persons may possess for personal use (should these limits be exceeded, possession will be put on an equal footing with dealing), and it will considerably reduce the possibilities for conducting projects for harm reduction. When the act has been ratified, these provisions will undoubtedly affect those projects that have been developed for the immigrant population. It is easy to foresee that in future it will be more difficult to involve the foreign population (in particular the substance users among them) in programmes that serve to cultivate open dialogue, debate and the sharing of information.

13. SEARCH II' in Luxembourg:

Preliminary results concerning problematic substance use by refugees, asylum seekers and illegal immigrants

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Coordination: Centre de Prévention des Toxicomanies (CePT), Luxembourg, in collaboration with ASTI, Luxemburg and zepf, Germany

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1. Introduction

The *Centre de Prévention des Toxicomanies* (CePT) in Luxembourg is one of the new project partners in the second phase of the European 'SEARCH' project. With the background knowledge gained with the help of a workshop on the "Rapid Assessment and Response" (RAR) process, the CePT organised in autumn 2003 a RAR team to investigate the current situation of asylum seekers and refugees who are using substances in a problematic way in Luxembourg .

The CePT is collaborating on the SEARCH project in Luxembourg with the ASTI (*Association de Soutien aux Travailleurs Immigrés*) and the zepf (*Zentrum für empirische pädagogische Forschung*). The institutions will be briefly introduced below. The following section provides an overview of the situation for asylum seekers in Luxembourg and describes the execution and first phases of the rapid assessment. The report concludes by taking a look at other measures as part of the RAR process and offering initial starting points for drug prevention.

2. The institutions involved

Centre de Prévention des Toxicomanies (CePT)
The declared aim of the CePT, which was officially founded in 1995, is to focus on and pursue health promotion as defined by the WHO as part of its mandate for primary drug prevention. This includes developing, disseminating and promoting ideas and procedures aimed at fostering healthy and positive lifestyles. In particular the intention is to prevent specific behaviour patterns that could lead to different forms of addiction and dependence. The work and studies of the CePT focus on humans and their environment, whereby various living environments (family, job, school, leisure time, etc,) are taken into consideration and thus different target groups. Within these living environments, the primary prevention essentially addresses adults who play an important role as multiplicators. Exchanging ideas and collaborating with all those involved, as well as involving external partners within the European context, form an indispensable component of prevention work. The work focuses on information campaigns and sensitisation for all and, particularly for multiplicators, education and training. The large proportion of migrants in Luxembourg and the large number seeking asylum in recent years also provide a considerable intercultural challenge for drug prevention, which needs to be addressed.

Association de Soutien aux Travailleurs Immigrés (ASTI)
ASTI is a registered charity founded in 1979, which is supported by donations. It is committed to equal rights and electoral rights for all. In its specific work in the field with children, youths and adults, ASTI campaigns on behalf of such issues as school attendance, equal rights, anti-discrimination and support for refugees, asylum seekers and illegal immigrants. As part of its cooperation with ministries, it develops activities for children, youths and adults and maintains an intercultural documentation centre. ASTI runs information courses for recognised refugees and language courses for asylum seekers and refugees, and also provides recognised refugees individual support when looking for work. ASTI's existing experience and access to asylum seekers provide an important resource and potential for use in working together on the SEARCH project.

Zentrum für empirische pädagogische Forschung (zepf)
The zepf is a scientific institute at the University of Koblenz and Landau in Germany. It is concerned with scientific research and monitoring educational, social and health-relevant areas that are beneficial for solving problems. It collaborates with various institutions at both the regional and international level. In the field of heath promotion and drug prevention, it has many years of experience working together

with practice-oriented institutions, which is also partly attributable to its fruitful cooperation with the CePT. Apart from the health area, the question as to the status of migrants and asylum seekers in Europe is also dealt with educationally (intercultural teaching competence, duel citizenship). As part of the 'SEARCH' project, zepf's task is to monitor the scientific application of the RAR methods in Luxembourg.

3. The situation for asylum seekers and illegal immigrants in Luxembourg

The right of asylum and the asylum procedure

In Luxembourg, the right of asylum is based on the International Human Rights Declaration, the Geneva Declaration on asylum rights and the Dublin Convention in terms of the jurisdiction. A registered asylum seeker has a right to accommodation and medical treatment. The financial support depends on the accommodation and the age of the children. For example, single adults in full board accommodation receive 100 euros per month (as of 1.11.2002). Children of asylum seekers who are under the age of 15 are obliged to attend school. To ease the integration of the children, since 1999 the Ministry of Education has appointed intercultural mediators who are available at all times. From the age of 16, asylum seekers can register for free language courses in French and German. Asylum seekers are forbidden from working in the Grand Duchy of Luxembourg while their asylum claims are being processed. Asylum seekers may only move within the country's borders. The processing of claims can last from several months to several years. When there is high demand, it is not unknown for processing periods to last up to five years.

Legal status of asylum seekers concerning their right to stay

The various legal situations concerning their right to stay are differentiated as follows:

- Asylum seekers in accordance with the Geneva Convention
- Recognised refugees according to the Geneva Convention with an identity card for foreigners for five years, which can be renewed. They have a right to work, to receive a minimum wage and to re-unite their families.
- Rejected asylum seekers usually have to leave the country.
- Temporary protection status (introduced in March 2000 as part of a new asylum law) can be introduced when mass influxes of people arrive from conflict regions. The duration of this status may not exceed three years. The asylum claim is suspended for the period of this status. Otherwise, they have the same rights as asylum seekers.
- It is possible to grant rejected asylum seekers who cannot return home for material reasons with exceptional leave to remain (since March 2002), which guarantees a right to social welfare.
- Rejected asylum seekers can apply for a residence permit for humanitarian reasons according to the rules of the European and international conventions.

Origin and number of asylum seekers

The asylum seeker situation in Luxembourg is taking a course comparable to the other neighbouring European countries. Due to the small size of the country, however, the considerable and rapid changes are having a greater impact.

The claims for asylum in Luxembourg increased drastically from 1998 to 1999 during the course of the Balkan conflict in the regions of the former Yugoslavia and Albania (1996: 263 vs. 1998: 2921 claims). Accordingly, members of the Balkan states (more than 80 %) dominate the asylum seeker situation during this and the subsequent period. After a drop in the total number of applicants during 2000 and 2001, a slight increase can again be ascertained in the last two years. This increase can be attributed

to an increase in the number of asylum seekers from Africa and countries in the former USSR. The number of asylum seekers from the Balkan states is also slightly increasing again. However, in terms of the overall proportion of asylum seekers there is a shift towards the Africans (cf. Fig. 2). This means that, taken overall, the largest proportion of asylum seekers in 2002 and 2003 came from the Balkan states with 55%, followed by the Africans (22%) and asylum seekers from countries in the former USSR (16%). Besides Algeria as the country origin, it is mostly asylum seekers from West Africa (Nigeria, Liberia, Guinea, Sierra Leone, Cameroon, Togo, etc.) as well as Burundi who are responsible for the increase from African countries. The countries mostly concerned from the former USSR are Russia, White Russia, Georgia, the Ukraine and Moldavia. Overall, it can be ascertained that the variety of countries of origin has increased since (2000: 41 vs. 2003: 65 countries).

Fig. 1: Number of asylum applications in Luxembourg

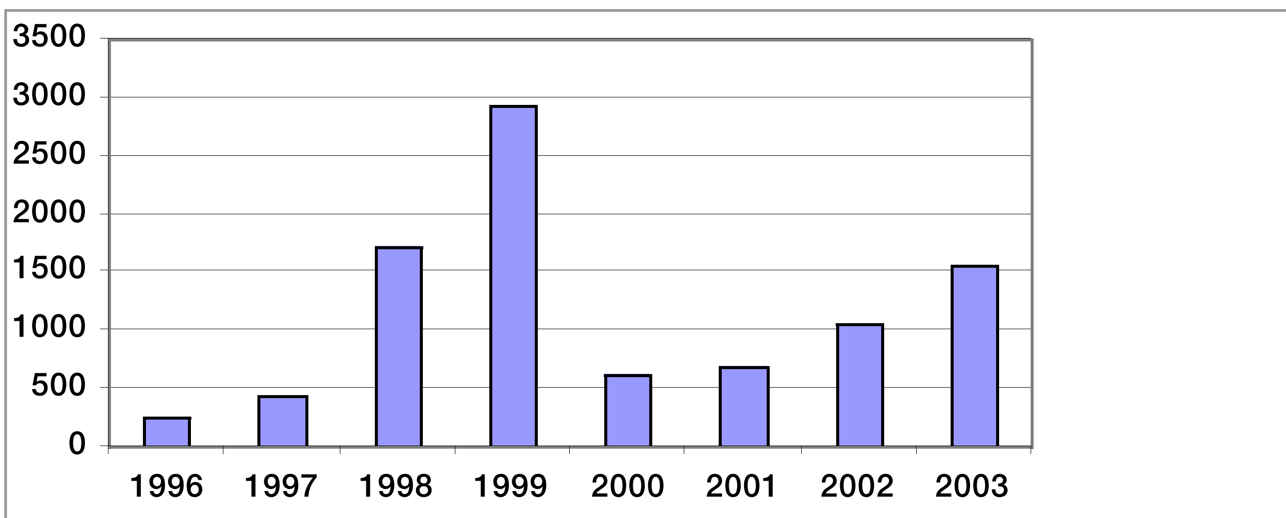
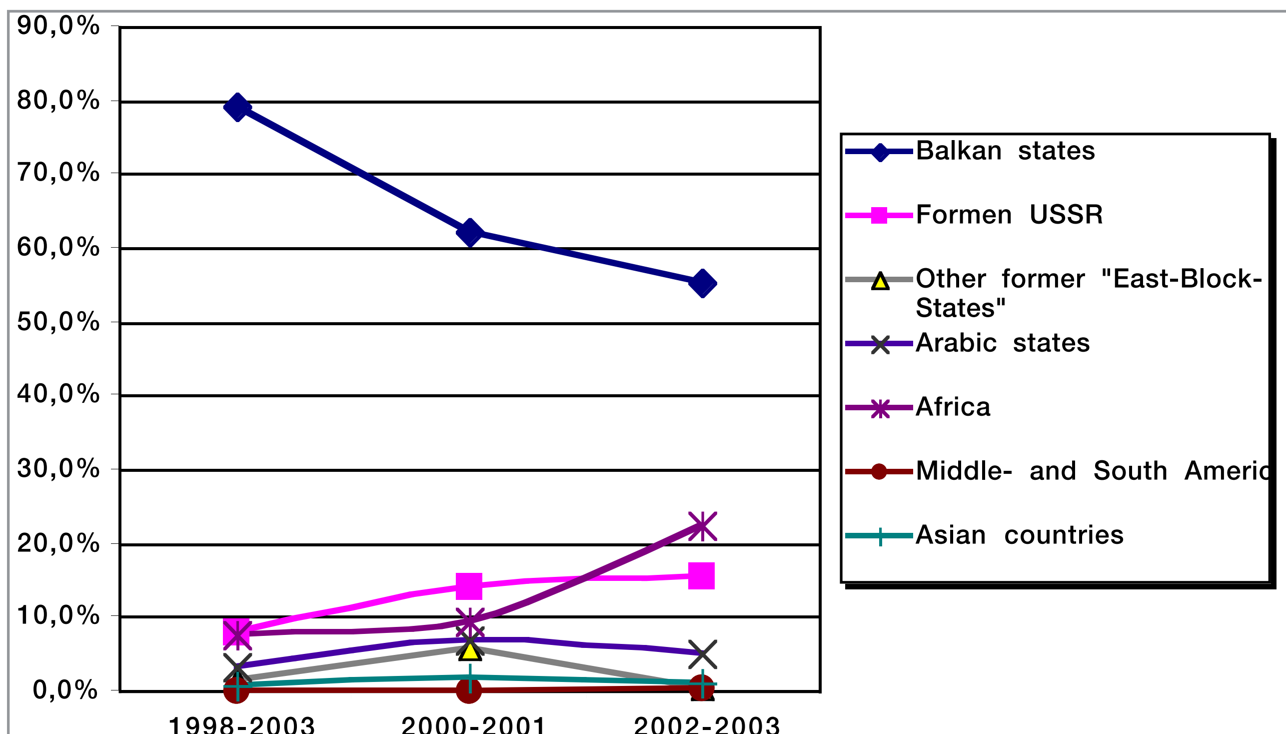


Fig. 2: Percentage of native countries represented by asylum applicants in Luxembourg



A further change in the characteristic of the asylum seekers that can be ascertained is that more young and single people are seeking asylum and fewer families. Some of these have already travelled through other European countries or travel on to other European countries.

According to the CGE (Commissariat au Gouvernement des Etrangers), 3018 asylum seekers were accommodated in Luxembourg up to 31 December 2002. Around 6-8% of the refugee claims are recognised. Since 2000, there has been an active policy of returning asylum seekers which is financially supported.

According to an internal study by Médecins Sans Frontières in Luxembourg, most of the predominantly young asylum seekers in Luxembourg enjoy good physical health with the exception of their dental health. However, their psychological condition is poor. A large majority of the adults interviewed reported feeling anxious, stressed or depressed. This is mostly related to the insecurity, inactivity and duration of the asylum process. This is confirmed by a survey conducted by the CLAE (Comité de Liaison et d'Action des Etrangers) on 100 asylum seekers, according to which 81 % of the respondents show evidence of psychiatric disorders in the form of anxiety symptoms, sleeplessness and social problems as well as psychosomatic and depressive symptoms.

The situation of illegal immigrants
There is very little information concerning immigrants who live in the country illegally. According to an internal report from the MSF (Médecins Sans Frontières) in Luxembourg, illegal immigrants are usually integrated within existing circles of friends or family groups. The vast majority work and, because of their comparative youthfulness, are generally in good physical health (with the exception of dental problems). According to the CLAE, there are no conspicuous medical emergency situations. The illegal migrants normally know how to trick their way into getting medical treatment or find doctors who are willing to help. The situation of pregnant women, however, appears to be difficult.

The ensuing professional debate between various organisations over the MSF Luxembourg's internal study on the health care of asylum seekers and illegal immigrants has shown, however, that they have heightened psychiatric problems that are difficult to contain due to cultural and linguistic barriers. It has been noted that this group is increasingly becoming caught up in drug dealing and addiction.
Based on the current situation, it appears necessary to collect further information in collaboration with the affected institutions and develop joint strategies for finding solutions.

4. The Rapid Assessment methods and their results

4.1 Method of approach

Based on the workshop on the RAR method held between 10-14 September 2003 in Turin, a working team was formed and an initial concept for conducting the rapid assessment developed. The interdisciplinary team comprises Thérèse Michaelis, the head of the CePT and coordinator of the 'SEARCH' project in Luxembourg, Laurence Mortier, a member of staff at ASTI, Anne-Carole Herz, responsible for public relations work at the CePT, and Uwe Fischer, a scientific researcher at the zepf. The main work of compiling addresses, collecting information and conducting interviews was carried out by Laurence Mortier and Anne-Carole Herz, whilst Uwe Fischer was responsible for the scientific coordination, collating the results and compiling the report.
The individual team members' background knowledge made it possible to collect extensive context information and a large number of potential contact persons for the interviews. It has been possible to

achieve a general overview of the current situation for asylum seekers using statistics from the Ministry of Justice, newspaper articles, documents on the asylum situation, brochures for asylum seekers and their carers as well as internal studies and oral information from affected organisations. Since this information has already been summarised in the previous chapter, the following sections will focus on the conducting of the interviews.

The address list of potential interview candidates, which was already very extensive at the beginning, was further supplemented by means of the snowball process during the course of the interviews, with other contacts and addresses being referred to by the respondents. In view of the extensive number of people who could have been interviewed, a priority list was compiled which was based on criteria regarding the wealth of information that could be gained, accessibility, objectivity and the heterogeneity of the viewpoints.

There was no initial limitation to a specific target community through which the information was to be obtained. The overall population of asylum seekers and the presumed proportion of persons using substances problematically ought to remain reasonably comprehensible in Luxembourg. Rather, as a first step the intention was to obtain an overall view of the communities using substances problematically, on the basis of which it would be possible to focus on specific groups in a second step.

The semi-structured interview guidelines were based on the SSI instrumentarium for the SEARCH project, which was somewhat adapted in terms of the various guidelines and questions to be asked. The interview guidelines with the key questions were then translated into French for multilingual interviewers. The emphasis for conducting the interviews was on achieving a pleasant interview flow, i.e. it was not so much about mechanically asking one key question after the other but about dealing with the questions in a flexible way, whereby the purpose of the guidelines was to ensure that no important questions were omitted.

The first interviews were conducted in November and December 2003, with data being collected from 17 interviews. The interviews were conducted where the respondents are located. In three exceptional cases, the interview guidelines were sent as questionnaires with open answer spaces.

The team mostly worked together in transferring the interview results into the designated grids for each key question. It was possible to clarify ambiguous points, contradictions and equivalent statements, enabling them to be summarised to form a picture of the various statements that was as uniform as possible. The summaries were discussed in the team and will be described below.

4.2 Results of the interviews

Between November and December 2003, a total of 17 persons were interviewed with the help of the semi-structured questionnaires. The first interviews concentrated on persons who are involved with asylum seekers and immigrants in an administrative, care or helping capacity. A policeman was also interviewed. The results are shown in the order of the key questions with respect to the summaries of the grid tables developed for the RAR process during the previous project.

The identification of problematic communities concentrated on two groups that were given precedence: people from the former Eastern Block countries (Balkan states and former USSR) and black Africans. Although specific former Eastern Block countries are sometimes named, several ethnic groups are frequently identified. For this reason, the Eastern Block countries have been kept as one large group. The results of the surveys will be shown separately for the two groups (former Eastern Block countries and black Africans).

The following results reflect the summarised answers of the respondents while taking into consideration the different validities. Named contexts, e.g. possible factors for consumption, should therefore sometimes be interpreted as assumptions based on professional experience rather than as proven facts.

4.2.1 Results for the community comprising former Eastern Block countries
Frequently, people from the Balkan states and the former USSR are collectively viewed as a single community where there is problematic substance use.
Heroin and cocaine are identified the most often in relation to problematic substance use. There is, however, no clear link between the two drugs. Alcohol is also sometimes listed, however it stands less to the fore. Vulnerable groups that can be identified include young people aged 18 to 30. These are predominantly single men but also include women. Family fathers have also been named in relation to alcohol use.

Definition of problematic substance use
According to the interviews, problematic substance use can be specified according to the following criteria:

➟ ***Physical:***
Only a few comments are made concerning physical symptoms, which is perhaps partly attributable to some of the respondents' lack of medical knowledge and partly to the fact that it may be considered obvious that there are physical symptoms of dependency. Most of the answers refer to infections, in particular Hepatitis C.

➟ ***Psychiatric:*** Psychiatric problems are frequently mentioned. However, it is not usually differentiated between general psychiatric problems and those caused through using substances.

➟ ***Social:***
Social problems are mentioned very frequently. These include problems in and around the hostels that become apparent through violence or problems with the neighbours, and unreliability in terms of keeping important appointments or ignoring rules. However, increased integration problems and loneliness through substance use are also mentioned.

➟ ***Financial***:
Financial problems are frequently mentioned since it is inconceivable that substance use can be financed with the pocket money received.

➟ ***Criminal***: Using and dealing in drugs and other drug-related crimes (theft) have legal consequences that in turn can jeopardise the asylum claims.
Overall, the following important target problems can be ascertained:
1. Social problems
2. Infections, in particular Hepatitis C
3. Financial problems

Factors influencing problematic substance use
The respondents' answers regarding the factors influencing problematic substance use can be summarised as follows:

Factors arising out of the differences between the homeland and the host country: social differences combined with increased loneliness in the host country. Addicts are even more marginalized in the homeland and subject to tougher punishments. Alcohol is considerably cheaper to buy. There are diverging answers regarding the question as to whether problematic use already existed in the homeland or not. If, however, the respondents' reliability, the frequency of their contacts and the number of times it was mentioned are taken into consideration, then the view that the use already took place in the homeland, but increased in the host country, ought to come closest to reality. This impression is underlined by the statement of a Russian woman, who refers to the restrictive criminal prosecution and marginalisation of addicts in her former homeland. On the other hand, there are also individual statements that presume, for instance, that those who used alcohol in their homeland only became addicted to heroin once they arrived the host country.
Factors which the respondents consider to have originally arisen in the homeland: Trauma caused by war or personal experiences, economic and family problems, insecurity and lack of perspective, lack of prevention and care in the homeland, misuse already in the homeland and easy access to high-proof alcohol in the homeland.
The respondents mentioned a series of factors that are attributable to the host country: Crushed hopes and illusions, loneliness, isolation, no right to work, insecurity about the future, asylum status, lack of supervision, long asylum procedures (up to 5 years), no income, boredom, marginalisation, confrontation with a consumer society to which they have no access.
A particular case is that of youths who fall between two cultures: whilst they integrate more easily (school), they also endeavour to become more integrated as far as the culturally defined use of drugs in the host country is concerned (alcohol, nicotine, cannabis).
For this group of people, there seems to be a greater availability of hard drugs in Luxembourg than in their homeland. However, relative to their homeland, alcohol is more difficult to obtain as it is more expensive in Luxembourg.
Which functions or uses do the respondents see in problematic substance use? Escaping from and coping with the situation and sense of insecurity through finding distraction and relaxation are factors that are most frequently mentioned. Substance use also occurs as a continuation of an already existing addiction. To a certain extent, the use of drugs also arises through drug dealing to acquire money. For youths, particularly with males, curiosity and the wish to integrate play an important function with alcohol, nicotine and cannabis. In contrast, with female youths the emphasis seems to be more on cultural rebellion.
Other individual factors that are more speculative in nature relate to the promiscuity of young single adults in the host country, peer pressure and family problems.
In summarising, three main causes can be identified:

- The asylum situation, characterised by disappointment and disillusion combined with loneliness and being prevented from working in the host country as well as the lack of supervision.
- Already existing dependency in the homeland.
- Fatal economic and political situation, combined with psychiatric stress in the homeland.

The target group's knowledge of the risks of substance use
From the point of view of the respondents communication problems (linguistic) and lack of education restrict their knowledge. Many have obtained their knowledge from their countries of origin, which, however, only offer limited prevention and care services, as well as through their own experiences and from other users. Parents are usually not informed about the risks. Those interviewed have different opinions as to the degree of knowledge about the risks, since on the one hand there is very little prevention and education in the home countries and drug use is considered a taboo subject. There are

various opinions as to the drug users' level of knowledge. Those people interviewed who are responsible for harm reduction (e.g. involved in needle replacement programmes), describe the level of knowledge as good, even if the level of behaviour does not always correspond to this or the knowledge is sometimes mixed with myths. Other respondents, however, doubt that the users have sufficient knowledge, in particular regarding the risk of infection.

Existing effective preventive interventions or conditions
There is already basic medical care and needle replacement programmes (harm reduction), as for all people in Luxembourg. There are no special interventions for this community.

The respondents' views on necessary effective preventive interventions or conditions:

- Information (if possible in the respective languages);
- Multiplicators/contact persons (however there are different opinions as to who is a multiplicator: peers, parents, social workers);
- Social integration;
- Prevention activities (on location or with the help of youth centres);

Other ideas mentioned: accommodate drug-using asylum seekers separately, general campaign for migrants, ability to work is prevention, harm reduction at all levels, more controls.

The respondents' views on the priorities for preventive interventions or conditions

- Information, including for parents
- Culture and asylum seeker-specific prevention
- Miscellaneous: ability to work, social integration, communication and family as protective factor

4.2.2 Results for the community of black African asylum seekers
No countries of origin are usually specified and generally it is just referred to the African community. Individual respondents specified language communities or individual countries which can be generally attributed to the West African countries There is no mention of Algeria or other North African countries, therefore the community shall be limited in the following section to black Africans.

Cannabis is mentioned most of all as a problematic substance for Luxembourg. However, the problem seems to have more to do with social acceptance than with physical and psychiatric stress. There is no clear problematic use of cocaine. The main problem at the moment seems more to do with dealing in it. It cannot be excluded, however, that some of the dealers also use it. It has emerged from considerable context information that an organised network belonging to an African group, which has already been conspicuous for some years in Switzerland and Austria, is flooding the market with cocaine. This has had the result that heroin users are also now using cocaine more frequently. On the other hand, it is necessary for cocaine users to increasingly take sedative substances such as heroin in order to be able to relax again. Overall, this has an effect on the behaviour patterns of the users, who appear increasingly aggressive.
Single young men are identified as a vulnerable group for using both cocaine and cannabis.

Definition of problematic substance use
Only a few criteria concerning the effects of problematic substance use can be determined, which makes it particularly difficult to define problematic cannabis use. The comments are limited to aspects of hygiene and ignoring rules. For cocaine, besides the criminal aspects of dealing in it, it is noticeable

that there is an increased potential for violence, which, within the context of using and dealing in cocaine is judged to be a particularly dangerous and uncontrollable factor. It has been seen that it is not just the affected persons whose health is harmed but, in particular, innocent people who are directly or indirectly exposed to aggressive behaviour.

Factors influencing problematic substance use
The use of cannabis appears to be generally socially accepted in the homelands and meets with social and legal problems with continued use in the host country. The continued or increased use of cannabis in the host country is viewed against the background of an uncertain future and existing boredom. In terms of the problematic use of cocaine and dealing in it, it has been cited that this to some extent does not begin until in Luxembourg. The situation as a disillusioned economic refugee without a work permit is viewed as a triggering factor in the host country.

It is assumed that there is little knowledge about the risks of drugs. Cannabis is generally considered by the African asylum seekers to be harmless. There are no specific prevention programmes for black Africans. There is seen to be a need for prevention in terms of providing information and education: through multiplicators in the form of direct contact persons or parents within the family context, and through improving the integration of the asylum seekers.

4.3 Discussion & conclusions

Discussion of the RAR methods
The RAR process is still in progress. Therefore it is not yet possible to provide any concluding assessments. Previous experience has shown that the RAR is a suitable method for collecting information, for providing an overview of current tendencies and for indicating necessary measures. The interview situation can differ considerably in terms of its course and the degree of knowledge and role of the respondents, which requires a flexible approach without omitting any key questions. The prescribed questions can therefore be sometimes too specific, too abstract or sometimes even inappropriate to the interviewee's situation, which requires the interviewer to act flexibly and to explain the questions.

A particular feature was the large variety of possible interview candidates. Inevitably, the number of interviews had to be restricted due to limited time and personnel resources, which was not without a slight concern that possibly important information could be lost. This was solved with the help of a priority list, which was compiled on the basis of various criteria.

Discussion of the results
The picture that is derived from the first interview process concentrates on two communities given precedence, which represented the largest proportion of the current asylum seekers in Luxembourg: people from the former Eastern Block, in particularly from the former USSR and the Balkans, and black Africans, in particular West Africans. Whereas there is an obvious need for preventive measures in terms of reducing health risks for the community from the former USSR and the Balkan countries, this seems to be less clear for the West African community. It is beginning to emerge, however, that cocaine is becoming more significant in Luxembourg, independent of any specific community of asylum seekers and refugees. This needs to be addressed. Other information is necessary in order to ascertain who the users of the increasing market for cocaine are and to what extent the asylum seekers are also affected.
The current change in the characteristic of the asylum seekers could increase problematic substance use in this group. Whereas many asylum seekers from the Balkan countries, for example, originally escaped with their entire families, increasing numbers of single asylum seekers are now arriving who are to some extent suspected of entering Luxembourg for economic reasons. As a consequence, be-

sides the psychiatric trauma that induced them to flee from their own countries, and the new stress for reason of the asylum situation, factors such as loneliness, boredom and disillusion are having an additional impact on single asylum seekers. The almost only social contact for these people is provided by their own countrymen, who find themselves in a similar situation. If there is already a problematic consumption pattern in these structures, then these provide a further risk factor. On the other hand, it is precisely these single persons who appear more difficult to approach than families. The heightened mobility and social independence of single asylum seekers makes it difficult to provide constant supervision. Any preventive addiction measures must meet this challenge.

The fact that some of those asylum seekers who have been seen to use substances in a problematic way have already used drugs in their home countries would point to the necessity of intensifying harm reduction, even if it can be assumed that this group has fragmentary knowledge of the risks. In particular, new arrivals require knowledge not just of the risks but also of the available resources (condoms, replacement needles, medical care, etc.)

Information that takes into account the respective culture and language is indispensable for both primary and secondary prevention. However, information alone is not enough and this general principle of prevention also applies to asylum seekers. Reducing risk factors and strengthening resources cannot be achieved without a certain expenditure of effort while questioning existing structures and processes within the framework of asylum policies.

5. Outlook

5.1 Focussing the collecting and assessing of information

The intention is to establish a focus group as this will enable contradictions to be clarified and, in particular, joint aims and strategies to be developed for all stakeholders involved. This focus group and the existing data will provide the basis for enabling further specific interviews. Here people in the target group can provide important information.

The cocaine problem shows that there is an information gap in terms of generally assessing the current use of this substance in Luxembourg and as to which preventive approaches appear necessary. This goes beyond the actual group of asylum seekers. The collected information can, however, be seen as a motivating factor in carrying out a specific study in Luxembourg.

5.2 Possible preventive approaches

Faced with the continuing increase in the number of asylum seekers from the Eastern Block countries, it would seem sensible to have suitable information that is both linguistic and culturally specific as a preliminary measure. This view is shared by a large number of respondents.

Preventive measures that address psychiatric problems and ways of coping with them emotionally appear essential for primary drug prevention. The MSF study has already identified an urgent need for all asylum seekers. For the subgroup of asylum seekers where there is problematic substance use, the psychiatric-emotional stress contributes to a quantitative and qualitative increase in the use and is even partly suspected of helping to trigger problematic use.

The respondents' suggestion that multiplicators should be used appears to be a sensible way. The fact that asylum seekers are generally under stress from the asylum situation and are not available on a

long-term basis, however, restricts the possibilities for involving multiplicators from among the asylum seekers. It would therefore seem to be more promising to use and train existing professional and voluntary carers working with asylum seekers. The fact, however, that there are only a few carers faced with a large number of asylum seekers, which means that the individual supervision which would be necessary for using multiplicators can hardly be realised, draws attention to the necessity of generally rethinking the care concept for asylum seekers.

The entire process of the asylum procedure is characterised by a large degree of anonymity, inactivity and insecurity. This prevents integration and increases the risks of psychiatric illnesses, problematic substance use and criminal behaviour.

This degree of anonymity in Luxembourg society is, in fact, somewhat unusual, since as a consequence of its size it can look back on a certain tradition of social inclusion, closeness and thus social control. This social control could, in a society with restrictive opinions, have negative consequences for outsiders, but in an open society it provides an important resource for every individual and prevents individuals from being harmed due to the benevolence and responsibility shown.

Tackling the asylum problems faced by asylum seekers and the state alike needs to be viewed as a task for society as a whole and be addressed as such by the various organs of society. A sustainable prevention approach will not be able to succeed without involving state and non-state organisations as part of a general strategy for asylum seekers. A social care or supervision policy for asylum seekers which manages to draw them out of their anonymity will prevent and reduce harm. Anonymity provides a protective space for criminal activities and irresponsibility. Anonymity is, however, desired if the wish is not to accept potential immigrants but to send them back as soon as possible before they can put down roots in the country.

The extent of conflicts in the world and the increasing mobility and number of economic migrants makes the asylum situation a permanent problem for Europe and therefore Luxembourg. Short-term increases in asylum seekers during specific phases of conflicts, which then peter out again by themselves after short periods of time, appear to be a thing of the past. For the future, long-term structures are necessary that are suitable for coping with this situation for the protection and well being of both Luxembourgers and asylum seekers alike.

14. 'SEARCH II' in the Netherlands

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Most attachments mentioned in the report are available on the enclosed cd Rom (in Dutch)

TACTUS, Institute for Addiction Care, Department for Prevention and Counselling Deventer/Enschede, The Netherlands

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1. TACTUS, Institute for Addiction Care

TACTUS is a specialist facility in the field of addiction care: TACTUS offers outpatient care as well as some inpatient and clinical treatment for people who have problems with alcohol, drugs, medicines, gambling or eating, or who wish to bring about changes through awareness of their own problems. We try to recognise, solve and prevent addiction problems as well as to educate people about using drugs.

TACTUS is active in the East Netherlands. It has 25 centres distributed among different locations in the region of Twente, the Zutphen-Apeldoorn-Deventer 'urban triangle' and the region of East Gelderland.

TACTUS has existed as an organisation since 2001. The organisation was created by merging different addiction care facilities that often already existed for decades, some of them for even more than one hundred years.

TACTUS welcomes people who seek help voluntarily as well as those that come into conflict with the law as a result of their addiction (whereby with the latter group, however, this cannot really be called 'voluntary treatment').

A further target group for the TACTUS work is the network in which the clients live, for example, the partners, the families, the schools or the employers, but also other care institutions.

TACTUS works according to the care principle: nothing more than necessary but nothing less than what is responsible (we call that the 'stepped care method').

1.1. Transition from 'SEARCH' to 'SEARCH II'

After 'SEARCH' was completed, TACTUS formed an 'AMA Prevention' (AMA = unaccompanied juvenile refugee, UJR) steering group. Most of the members had been members of the focus group during the first project phase. This steering group began by

1. developing a draft proposal for the 'Detect and Educate' training programme and
2. developing additional prevention material.

It was a laborious process, as has already been reported at the conference in October 2002. Particularly difficult was convincing the managers from the participating organisations. The participants from these organisations initially took part in the steering group on their own accord. This meant that it was not possible to make any binding agreements. However, after all the managers had officially agreed that their organisations could participate in the steering group, it was possible to continue developing both the training and the prevention material at a greater tempo.

It is noticeable that not one single organisation was prepared to pay anything for the training and material offered by TACTUS.

During the previous two years, each steering group meeting had discussed the development and consequences of the Dutch government's asylum policy. Although the Dutch policy regarding AMAs had changed, the drop-in centres for asylum seekers in Twente that we visited during 'SEARCH' remained open to AMAs and other young adults of foreign origin. We gained the impression that there would be very few changes for 'SEARCH II' in terms of the target groups and the use and the misuse of drugs.

2. The RAR method

2.1. Introduction

Two steps were taken in the 'SEARCH II' work before commencing with the concrete activities.

- The first step consisted of a short assessment of the existing information. We looked to see whether anything had changed since 'SEARCH' and, if yes, what.
- In the second phase, using the information we had gained, we interviewed important key persons. The conclusions from steps 1 and 2 were summarised and presented to the focus group. This led to the development of concrete activities,

2.2. Assessment of the existing information

'SEARCH II' began with a survey of the developments in connection with AMAs. The survey consisted of researching the Internet for available information on new developments. Afterwards, 6 interviews were conducted with key persons from organisations that have direct contact with the AMAs. This provided information on the arrivals and departures to and from the Netherlands, general information on the policies towards AMAs and on the consequences for them and the future.

We discovered that there is frequent mention both in politics and society of the 'accelerated assessment procedure', whereby higher thresholds are set for those who wish to come to the Netherlands. What's more, the asylum policy is increasingly oriented towards having the asylum seekers, including the AMAs, returned (to their homelands). As a consequence of this, fewer asylum seekers (and also AMAs) are coming to the Netherlands. When they do arrive, they must wait for the decision on their future in an admission centre. This in turn means that there are many empty places in the asylum seeker centres and small residential units, so that it is now being claimed that there are "too many personnel." Accordingly, some of the asylum seeker centres are being closed with the personnel being distributed to the other asylum seeker centres. This is leading to increasing uncertainty among the personnel.

➠ *Arrivals and departures to and from the Netherlands*
There are clearly fewer AMAs arriving in the country: in 2002 the number was 2,199, two years previously it was three times this amount. There are also clearly fewer asylum seekers arriving in the country: in 2002 there were 18,667, whereas in 2001 there were 32,579 and in 2000 even 43,895.

The decreasing flow of new asylum applications has enabled the immigration and naturalisation service (IND) to concentrate on a more systematic and quicker assessment of asylum applications in the admission centres (AC). In combination with a toughening of the national policy, this has led to a substantial increase in the percentage of asylum seekers who remain for the entire period of the asylum process in the ACs. As a result of the rapid AC decisions (within 48 hours) and the quick follow-up procedures (maximum 6 months), asylum seekers no longer have to wait for years to hear the results of their asylum application from the IND.

The number of (executed) asylum-related deportations has increased by almost a third (32.6 %) in 2002. In 2002, 21,255 persons were deported, whereas in 2001 there were only 16.023 deportations.

➠ *The policy regarding AMAs*
The policy towards AMAs has changed. It is distinguished between two possibilities:

1. The development perspective oriented to their return: this is the so-called basic variant, also known as the return variant.
2. The development perspective oriented to integration: this is the residence variant, also known as the integration variant.

The result is that the prospects for both adult and juvenile asylum seekers have become clearly worse. Likewise, the living conditions have become much worse. Previously, AMAs were able to wait in peace for the results of their process, for example in a small residential unit. This is no longer possible. They must spend the waiting period during their process in a reception or asylum seeker centre. They then move to a campus or an asylum seeker centre with a 'return policy', a small residential unit or shared accommodation, or a supplementary reception centre. In the asylum centres they are confronted with diverse nationalities and must sleep, etc, with a larger number of people in a single room. In short, the asylum seekers leave these quickly. Furthermore, the possibilities for getting through the process are quickly exhausted and the asylum seekers may only leave the asylum seeker centres on receipt of a residence permit.
AMAs must go to a 'campus' if they are rejected. This is a centre that has a policy of deportation to the country of origin.

➠ *The consequences*
All these developments cause more stress, problems and tension. This manifests itself among asylum seekers in the form of kinds of mental and physical symptoms such as insomnia, anxiety attacks, depression, headaches and stomach aches.
The increase in stress and tension leads to an increase in the use of drugs, particularly alcohol and cannabis. Although this is mostly concerned with experimental use, there is also sometimes problematic use.

➠ *The future*
For the 'Central Asylum Seeker Reception', 30,000 reception places are planned for 2005. It is probable that the aforementioned consequences will increase in severity as a result.

What applies nationally, also applies for the Twente region. There are much fewer asylum seekers arriving, particularly fewer AMAs. Of the 120 centres in the Twente region, 34 of them have been closed down within a short period of time. Many asylum seekers are therefore forced to move. Above all the smaller reception facilities such as the supplementary reception houses, the small central reception centre and the self-help initiatives are being closed. This is uncertainty about the future. Many of the asylum seekers have been forced to return to an asylum centre although they were used to living in a house in a city or village. Currently (mid 2003) 80 – 85 AMAs are housed in the Markelo asylum seeker centre. They are waiting for a residence permit and attend school outside of the asylum centre. Most AMAs come from Africa (Congo, Angola and Sierra Leone). This could be different, however, in some years.

➠ *Conclusion*
Based on the available information, we assumed that we would probably encounter the same target group in 'SEARCH II'. Whether that would turn out to be true was tested with the help of interviews with the key persons.

2.3. Interviews with key persons

A total of 6 interviews were conducted with representatives from the following organisations:

1. Asylum seeker centre
2. MOA AZC (2x)
3. Borne police
4. Nidos Enschede
5. 'Thuiszorg' office, Hengelo; social work office for 'new arrivals / integration'

The questions posed in the interviews were concerned with:

- the developments concerning AMAs within the organisation
- the trends relating to drug and alcohol use
- the substances used and/or the forms of alcohol
- the places where the drug use occurs
- whether the use is considered to be problematic
- the factors that are influential here
- the groups where there appears to be problematic use and
- the substance which is concerned here.

From the answers we reached a series of conclusions:

1. A consequence of the new AMA policy is that fewer AMAs are accepted and that they remain longer in the reception centres. They are not transferred so quickly to other residential units.
2. Tension and insecurity primarily lead to greater alcohol consumption.
3. It is primarily alcohol and cannabis that are used in the centres.
4. It is not clear whether there is going on trafficking in the centres.
5. The target group for 'SEARCH II' is almost the same as for 'SEARCH': young single adults in the centres.

Compared with the results of 'SEARCH', we have ascertained that there are few basic differences. Significant is the fact that there are increased indications although the new AMA policy has ensured that fewer AMAs reach the Netherlands. At the same time we have ascertained that there is an increasing number of illegal asylum seekers (including AMAs), with all the associated problems and consequences.

➠ *Focus group meetings*
We presented the results of the survey to a focus group. Two discussions took place (in April and June), which were distributed across three sessions. We used the contacts from 'SEARCH' to form the focus group. We asked the steering group members to become members of the focus group or to ask somebody from their organisation. The focus group comprised people from the following organisations: Adhesie (out-patient 'mental health care'), 'Internationale Schakelkassen' (ISK), Medical Reception Centre for Asylum Seekers (MOA), Nidos (guardianship association), Jarabee (youth care) and the Central Reception Centre for Asylum Seekers (COA). TACTUS took the initiative each time and organised and chaired the meetings.

During the first focus group meeting we presented the participants with the results of the interviews. A discussion was held to reach consensus on the conclusions. The first conclusion was amended to take

into account that, as a consequence of the closures, AMAs are also sometimes more quickly transferred, with far-reaching consequences for the personnel. A further conclusion was that AMAs are increasingly coming under pressure as a result of the more probable deportation. This pressure makes the AMAs unsure during their stay in the Netherlands as to what will happen to them. This leads to more alcohol being consumed.

The conclusion that alcohol and cannabis are predominantly consumed in the centres was amended by the fact that this use is apparently increasing. It still remains unclear, however, whether there is dealing going on in the centres.

For 'SEARCH II', the target group has remained almost the same: we have merely expanded the target group of AMAs to include young single adults in the centres. The background of 'SEARCH II' is thus practically identical with that of 'SEARCH'.

AMAs and other young adult asylum seekers live in an asylum centre where they are left to their own devices. Since the new asylum policy has been introduced, there are ever fewer young adults who live independently. Youths up to the age of 18 are supported by Nidos, a guardianship organisation. The life in asylum seeker centres tends to be rather secluded, whereas other residential units are much more open to what is going on in the outside world.

During the following meetings it became clear to us that it would be difficult to produce any plans. All members were agreed that what today is important could be quite different tomorrow.

3. Specifying needs using 'wish lists'

3.1 Introduction

During the focus group meeting in April 2003, all the wishes of the participating organisations were listed. These wishes are listed in a table that can be found in Annex I (on the CD Rom in Dutch).

It seems that the wishes of the different organisations are very similar to one another:

- There is a need for the AMAs themselves to be generally educated about drugs.
- There is a need to develop educational (hand out) material and.
- There is a need to provide training/coaching for the staff who work with the AMAs.
- Also on the requirement lists of all the organisations was the ability to be able to better detect the use of drugs and/or alcohol and the ability to be able to discuss this with the AMAs.

Based on these wishes, TACTUS developed a programme of activities and distributed it among the different organisations. This programme of activities is included in Annex II (on the CD Rom in Dutch).

3.2 Activities

The programme was presented to the various organisations. Although this was based on the wishes of the organisations, there was not the demand that had been expected. The reason that was given was that the internal problems were so great as a consequence of the changes in the asylum policy that they were no longer able to send staff to the training sessions. Regardless of this, different prevention activities were conducted:

<table>
<tr><th>Description of the activity</th><th>Duration</th><th>Target group</th></tr>
<tr><td>General basic education on drugs</td><td>2 hours</td><td>AMAs</td></tr>
<tr><td>‘Dopeheads!’ workshop</td><td>2 hours</td><td rowspan="3">Multiplicators :
• GVO staff
• Teachers from the
• ISK Rijssen and Almelo
• MOA carers
• AMA staff from the COA</td></tr>
<tr><td>Training seminar: ‘Detect and Teach’</td><td>3 blocks of 3 hours</td></tr>
<tr><td>Training seminar: ‘Detect and Support’</td><td>4 blocks of 3 hours</td></tr>
</table>

3.3. Products

As had become clear from the wishes of the organisations, there was a need for educational material for the AMAs. We developed an educational package that was called ‘Dopeheads!’ This name was selected because this is an expression used in youth culture. This is a derogatory term used for youths who use drugs.
The material had to fulfil a series of requirements. It needed to be useful for young asylum seekers; i.e. this material needed to have as little text as possible and be profusely illustrated.

- The illustrations used needed to be as international as possible.
- The materials were introduced as a package. They can either be used independently from one another or as a whole. In each case when used in their entirety, however, they achieve more than the sum of their parts.
- Dopeheads! is suitable for anybody who wishes to develop a discussion on drugs, alcohol and gambling in a group of juveniles and/or young adult asylum seekers and migrants.
- The drugs, alcohol and types of gambling mentioned are divided into three clear groups. The division is based on the effects ‘numbing’, ‘stimulating’ and ‘mind-bending’. Each of these three effects also has its own colour. However, there are also drugs with a double effect and these also have double colours. The range of colours can be found throughout the entire educational package.

Four questions are asked about the depicted drugs, alcohol and types of gambling:

- ➠ What is it?
- ➠ What’s its effect?
- ➠ Does it lead to adddiction?
- ➠ What are the risks?

The educational package includes instructions, workbooks for the youths, three little men, each of which expresses its own emotion, a set of 40 laminated cards and a music CD. This CD includes 12 pieces of music. The emotions, drugs, alcohol and types of gambling are all given their own ‘world’, i.e. their own musical style. Annex III provides an example of this material (on the CD Rom in Dutch).

The transparencies used in the workshop are provided in Annex IV. Guidelines were developed for the training sessions. These guidelines are enclosed as Annex V (both annexes are on the CD Rom in Dutch).

3.4. The results

With the implementation of the prevention activities, we checked to see what sort of initial impression the multiplicators had of the developed material and whether they can imagine working with this material. Furthermore, we found it interesting to learn whether the method chosen by us to present the material to the multiplicators was the correct one. The question as to whether the developed materials are the best was not assessed in this project. The questionnaire used and the results are included as Annex VI (on the CD Rom in Dutch). The most important conclusions are presented below, whereby it should be taken into account that the groups of respondents were small.

The workshops

Two workshops were conducted. Ten teachers from the ISK took part in the first workshop and four GVO workers took part in the second workshop. During the two-hour workshops, they were familiarised with the 'Dopeheads!' material.

The programme for the workshops was organised as follows:

- 10-minute introduction to TACTUS
- 60-minute explanation about alcohol, cannabis, mushrooms, ecstasy, kwat and sedatives
- 10-minute discussion on the subject of 'perception'
- 40-minute introduction and exercises relating to 'Dopeheads!'.

The workshops were evaluated with an average score of '8' (out of 10).
The GVO staff found that the group was too small; the teachers, on the other hand, were satisfied with the group size. None of the participants found that the relevant themes had not been dealt with, although in general it was commented that there was far too little time to be able to deal with everything satisfactorily. The structure of the programme must also be rethought since, according to some comments, there are considerable differences as far as the remarks on the relation between theory and practice are concerned.

The initial impression on 'Dopeheads!' is generally positive. The participants were very pleased. The teachers gave an average score of 7.9 and the GVO workers gave an average score of 8.8.
The GVO workers intend to work with the material. The teachers are somewhat more cautious, especially concerning the use of the music CD and the little men.

The training programmes

A 'detect and teach' training programme was conducted in which 9 MOA carers took part as well as a 'detect and support' training programme in which 4 AMA workers from the COA participated.

The first three sessions were identical for both training programmes; the 'detect and support' training programmes included a fourth seminar in addition. Each session lasted for 3.5 hours.

Overall, the training programmes were evaluated with a score of '8'. Most participants found the number of sessions to be good. It was felt that the training sessions failed, however, to cover some subject areas, in particular psychiatry and the results of studies relating to physical, psychiatric and physiological aspects, as well as short and long-term deviations.

All participants believe that they will be able to implement what they have learned directly into practice.

4. Conclusions, discussion and recommendations

'SEARCH II' got off to a slow start and developed sluggishly. The main reason for this was the amended AMA policy. During the meeting in August 2003 it became clear that various members of the focus group – and later the steering group – were looking for new jobs as a result of the change policy. They found them and as a result moved away. This meant that a new contact person had to be found for the project. Furthermore, we were not even sure whether the present focus group members would be there the next time. In addition, through the members of the steering group it became ever more apparent that the management of their organisations did not want to invest in the training sessions, which was once again demonstrated by the fact that not a single organisation was prepared to pay for the programme offered by TACTUS. Even when the offer was made to finance everything by the project, there was still no enthusiasm. The most important reason given was the fact that the amended asylum seeker policy had caused considerable internal reorganisation, whereby people could not be sure whether they would be able to do any further work.

Despite these developments as a result of the AMA policy, there was still a demand for material that would enable them to independently educate people about drugs, alcohol and gambling.

According to our view, this material needed to fulfil a series of requirements. First of all, providing education on drugs, alcohol and gambling is specialist area in itself. The prevention workers in addiction care facilities are experts in this. They have the knowledge about the drugs and alcohol and keep themselves up-to-date. They also understand how to impart this knowledge. Thus they know how a multiplicator should best provide such education. In view of these criteria, it was decided to develop a simple structure that could nevertheless be implemented by other professionals in practice. We decided for working methods in which the most important aim is to encourage discussions among the youths. This is where the emphasis was given, the actual knowledge of substances is of secondary importance. The knowledge that a multiplicator imparts is reduced to four questions: (1) What is it? (2) What's its effect? (3) What are the risks? and (4) How addictive is it? These questions apply to every substance. All this means that the multiplicator both leads the discussion and teaches.

Another criterion is that the material to be developed should have as little text as possible and as many pictures as possible to illustrate the meaning. This is the reason why considerable pictorial material was used in the workbook and on the plastic cards, and why the little men and the music CD were used.

Whether we were successful in this respect remains to be seen. During the workshops it became clear that a number of participants were unsure whether they would be at all able to implement the package. Although enthusiastic about the design of the material, they were nevertheless doubtful as to whether they had sufficient background information. Furthermore, we had the impression that it was the teachers, in particular, who were doubtful as to whether they can work with the material, for which there is relative little information available about how to use it. This is a point worth considering, and which needs to be further examined in future.

Another important effect is that the multiplicators have to decide on the attitude they should take regarding the drugs and alcohol when working with the 'Dopeheads!' package. This has led to discussions within the school and the organisation, where TACTUS has been able to provide help. This is also an aspect worth considering and examining in future.

The duration of the project was too short to ascertain whether the developed material is adequate for the practical demands. Although an evaluation was made of the implemented activities with which the

prevention materials were introduced, it would have been desirable if there had been more time for evaluating the practical implementation.

A second list with evaluation questions was given to the participants in the training programmes, where they could record their experiences. We hope that this can also provide further information, although we are quite aware that it is the everyday things that always stand to the fore.

Finally, we would like to comment on the future.
On completion of 'SEARCH', we ascertained that the RAR method is a valuable and very usable method. We ascertained that it is essential to develop and establish a network (which we successfully managed) and that the project duration was too short.

Now, on looking back at the conclusion of 'SEARCH II', we have ascertained that despite the many changes that have occurred in the area of work, we have nevertheless been able to work very well with the different organisations. The time that was available to use was necessary in both cases. The fact, however, that project workers are given time in order to conduct the activities within the project, appears necessary if the project is going to be brought to a successful conclusion. 'SEARCH II' has now come to an end. The activities have got of the ground and we can ascertain that we cannot, and should not, cease the activities although the project funding has ended. As we have already described in the conclusions:

There is (and remains) much to do!

15. 'SEARCH II' in Portugal

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Instituto da Droga e da Toxicodependencia (IDT), Lisbon/Setúbal, Portugal

Joaquim Fonseca
Célia Santos

1. The Institute for Drugs and Drug Addiction (IDT)

After the parliamentary elections in March 2002, the newly elected government transferred the responsibility for coordinating drug policy to the Ministry of Health (it was previously under the aegis of the Council of Ministers). At the same time, the Portuguese Institute for Drugs and Drug Addiction (IPDT) merged with the Organisation for Drug Misuse, Prevention and Treatment to form a new institution – the current Institute for Drugs and Drug Addiction (IDT).

2. The National Coordination Structure

Examination of the coordination mechanism that has developed since instigating and adopting the Portuguese Drug Strategy in 1999 will show that two levels of coordination have crystallised:

- The political level with the appointment of a member of government with special responsibility for the drug policy (since March 2002, the coordination of the drug policy has been under the responsibility of the Ministry of Health)

- The technical level with a government agency (the IDT) under the aegis of the aforesaid member of government.

The chairman of the board of the IDT is also given the role of National Coordinator, who reports directly to the Health Minister and ensures the implementation of the national drug strategy. The National Coordinator also promotes the forming of local, regional and national administration structures for jointly combating drug problems and, at the same time, represents Portugal at the government level in combating drug misuse.

Furthermore, there is an inter-ministerial and a national council:

The Inter-ministerial Council for Combating Drugs and Drug Addiction is the leading body at the ministerial level, with the task of observing and evaluating the implementation of the national strategy; it authorises the action plan and implements any necessary amendments to the national policy for combating drugs. The Inter-ministerial Council comprises representatives from the 11 ministries (Finance, Defence, Foreign Office, Interior Ministry, Justice, Education, Science and Universities, Urban Development, Environment, Employment and Social Security, and Health). This also includes a Technical Committee that consists of minister delegates.

The National Council for Drugs and Drug Addiction is a consultative body for the Prime Minister and is responsible for formulating recommendations for all aspects covered by the national strategy for combating drugs. It is presided over by the Prime Minister or his official delegate and is composed of the National Coordinator and representatives of the treatment and prevention facilities, local authorities, justice institutions, public and religious organisations, universities, NGOs and the media. The National Council advises on the national strategy and its development, the action plan and – when needed – activities, initiatives and concrete projects for implementing the strategy.

3. The objective of the IDT

The objective of the IDT is to consolidate the planning, conceiving, management, monitoring, estimation and assessment of the various prevention, treatment, reintegration and rehabilitation phases and to consolidate the control and containment of drugs and addiction; its intention is to achieve the highest efficiency in terms of coordinating and politically implementing the defined strategies.

The responsibilities of the IDT:

(a) Coordinating the national strategy towards the drug problem. This task has been conferred to it by the Health Minister.

(b) Promoting, planning, coordinating, conducting and assessing the programme for the prevention, treatment, harm reduction and social reintegration of drug addicts. These responsibilities are carried out by the IDT in cooperation with public and private bodies in this field of work (in the local communities).

(c) Promoting, coordinating, supporting and conducting public and private initiatives in the field of drug prevention and drug-related addiction illnesses.

(d) Supporting the government commissions in developing views on drug addiction (Act No. 30/2000 from 29 November 2000).

(e) Surveying, processing and disseminating data, information and scientifically structured documentation on drug problems, namely in terms of using and dealing in narcotics and other psychotropic substances and their early recognition.

(f) Creating and establishing a national information system concerned with aspects of drugs and addiction.

(g) Ensuring the quality of the national focus point as an obligation of the Portuguese state (in cooperation with the Observatorio Europeu da Droga e da Toxodependencia [OEDT]).

(h) Further development of political strategies to combat drugs and drug-related addiction illnesses, as well as their evaluation and assessment.

(i) Ensuring cooperation with external bodies in containing drugs and drug-related addiction illnesses.

(j) Proposing and developing studies on drugs and drug-related addiction illnesses.

(k) Supporting the training and further education of professionals in the fields of prevention and treatment of drug and drug-related addiction illnesses.

(l) Supporting and presenting legal and administrative measures in the field of drugs and drug-related addiction illnesses and supporting the various bodies in their implementation.

(m) Responding to queries regarding ‘authorization/responsibilities’ made by the public administration service (Servico da Administracao Publica) or other private and public bodies.

(n) Developing measures that appear suitable for improving the containment of addiction risks when distributing medicines and other addictive substances (supplementing the area of competence of the National Institute of Pharmacy and Medicines [Instituto Nacional da Farmacia e do Medicamento]).

(o) Licensing/authorising private health care facilities in the field of 'drug-related addiction illnesses'.

(p) Ensuring continual cooperation with the general health authorities (Direccao-Geral da Saude) and other health service providers that are integrated in the health system as well as with the IDT care services.

4. The structure of the IDT

The activities of the IDT are developed within national and international frameworks and incorporate the following instruments:

➠ *Within the national framework:*
- Through the 'National Strategy for Combating Drugs' (Estrategia National de Luta Contra a Droga),
- Through the 30 main aims of the 2004 campaign against drugs and drug-related addiction illness and
- through the national action plan 'Campaign against drugs and drug-related addiction illness' (2004) ,
- Through collecting documentation that deals with programmatic and fundamental aspects within the context of preventing and treating drug-related addiction illnesses, reducing risks and harm reduction, decriminalising illicit drugs, controlling supply and demand, combating money laundering and increasing international cooperation;

➠ *Within the international framework*:
Through the United Nations conventions and through participating in the European Union measures, and in particular here, through participating in the action plan 'Drugs and Addiction'.

5. Types of Services

The IDT bodies consist of the:

- Administrative Council; consisting of a chairman and three members; the chairman has a right of veto
- Technical and Scientific Council (the IDT's advisory body)
- Commission for Ethics and Health (CES)

In order to fulfill its responsibilities, the IDT has central, regional and local services.

The decentralised services are controlled by the IDT's central bodies and are answerable to the Health Minister (Ministro da Saude).

The central services include the:

- Department for Prevention (DP)
- Department for Treatment, Reintegration and Harm Reduction (DTRDR)
- Department for Planning and General Administration (DPAG)
- Observation Office for Drugs and Drug-related Addiction Illnesses (ODT)
- Department for Supporting the Commissions for Developing Views on Drug-related Addiction Illnesses (DACDT)
- Office for International Relations (GRI)
- Office for Legal Studies (GEJ)
- Office for External Relations (GRE)
- Office for Education/Training (GRE)
- Advisory Commission for the IDT's Administrative Council (ACA)

As the IDT's decentralised services, the regional services have the task of implementing the activities at the regional level (within the context of the IDT's objectives), and consists of the following 'health regions':

Already formed are the

- Delegation for the Northern Region (DRN)
- Delegation for the Central Region (DRC)
- Delegation for Lisbon and the Vale do Tejo Regions (DRLVT)
- Delegation for the Alentejo Region (DRA)
- Delegation for the Algarve Region (DRAL)

The following local services, which are specialist facilities, are responsible for implementing the IDT's remit in the areas of prevention, education, treatment and social reintegration of drug addicts:

- The care centres for drug addicts (CAT). They are responsible for the general overall care of drug-addicted people. The outpatient care services provide tailor made therapeutic measures at the individual and group level;

- The detox facilities (UD), under medical control, are responsible for developing inpatient care for treating withdrawal symptoms;

- The therapeutic communities (CT), under psychiatric control, are responsible for treating and caring for drug addicts who require long-term inpatient treatment with social and psychotherapeutic support;

- The prevention units (UP), which conduct the measures in their districts required by the regional delegations and the central services, develop programmes and projects for primary prevention, intensify the inter-institutional discussion at the district level and, in addition, support the inclusion of local institutions in developing primary preventive measures.

There are currently 18 of these prevention units, one for each district. Their responsibilities include:

- implementing preventive strategies at the local level;
- providing advice and initial consent for project applications;

- technical and financial help for projects in the following areas:
  - family
  - school
  - leisure facilities
  - school truancy
  - prisons
  - and implementing the 'School Programme', which aims to prevent youth crime in the cities of Lisbon, Setúbal and Porto.

There are currently 73 local prevention programmes. The aim is to establish 308 by the end of 2004 (covering entire Portugal).

6. Participation in the 'SEARCH II' project

Migration to Portugal

Portugal, which until the 1980s was predominantly an emigration country, has in recent years seen an increasing number of immigrants, mostly from Africa, Brazil and also Eastern Europe.

- In 1974, the first wave of migration occurred from the former Portuguese colonies in Africa,
- in 1990, increasing numbers of people from Brazil started arriving in Portugal,
- in 1998, a large influx began of immigrants from Eastern European countries.

Whereas in 1981, only 54,000 migrants came to Portugal, in 1990 it was already 107,000. According to official estimates, in 2004 around 450,000 immigrants were living in Portugal (of these around 350,000 with legalised residence). This corresponds to around 5 % of the entire population of Portugal and around 9 % of the working population. At some schools in the larger cities, as many as 92 different languages are spoken. The immigrants are generally concentrated in the areas of Faro, Lisbon, Setúbal and Porto, the largest conurbations in Portugal. However, there are increasing signs that particularly immigrants from Eastern Europe are also trying to establish themselves in the rural regions.

In recent years policies have increasingly focused on immigration. The budget of the 'High Commissioner for Immigrants and Ethnic Minorities' (ACIME) grew in the years 2001 – 2003 by around 331 %.

This relatively new development has brought with it a series of problems in the social, political, health and legal areas. There have been increasing xenophobic tendencies within the population that have hindered the integration and partial legalisation of immigrants. According to a study by the Catholic University of Portugal from 2002, the following answers were given to the question "Do you believe that we should allow more immigrants into our country": Africans: 74.4 % no, Brazilians: 71.7 % no, Eastern Europeans: 73.4 % no. At the same time, accord-

Example: A survey in Montijo in 2003

A survey from the migration centre in Montijo / Setúbal region in 2003 showed that the registered immigrants are mostly from Brazil, Romania, Moldava, Angola, Ukraine, Russia, Poland and Lithuania (in this order). They are registered in the GAI [Gabinete de Atendimento ao Imigrante da Câmara Municipal do Montijo].

- 40 % were 18-30 years old,
- 26.67 % were aged 31-40,
- 23.33 % were aged 41-50,
- 10 % were older than 50.

Of the immigrants surveyed here, 60 % were unemployed, 23 % pursued a legal occupation, 17 % an illegal occupation.

ing to more recent studies on the average age of the population, Portugal would considerably profit from an active integration policy – as would a large part of the social system. (in the demographic pyramid, there has been a considerable expansion of the age groups 20/25 to 40/44!)

Participation in the 'SEARCH II' project

This relatively new phenomenon of increasing immigration to Portugal is reflected in many structures that are attempting to understand the complexity and dimension of this new development and to offer intervention strategies. The IDT is monitoring these developments with its own initiatives and is supporting institutions that work directly with migrants, with the aim of developing measures for drug prevention for these target groups.

As, however, this work is still in its infancy, it was considerably beneficial to participate in the 'SEARCH II' project: this enabled expertise to be shared with colleagues from other countries and research and intervention strategies to be further developed at the internal level.

In view of the short period of time available for developing the project approach, it was only possible to conduct a survey of information on the phenomenon and, within this context, to establish contact and stabilise relations with privileged informants (key persons), i.e. people who, because of their professional work or access to migrant groups, also possess considerable knowledge of the addiction developments and any culturally sensitive drug prevention projects. A focus group was established.

The following persons took part in this conference that was held within the offices of the Setúbal local authorities:

- representatives from the Montijo City Council (1 official representative, 1 psychologist)
- representative from the Setúbal City Council (1 psychologist)
- SEF (= national border police) (1 inspector who is also an anthropologist)
- the regional CARITAS representative (1 sociologist)
- RAR team (1 psychologist, 1 sociologist)

Furthermore, it was possible to conduct an interview with a member of the board of EDINSTVO (Organisation for Eastern European Immigrants), which revealed relevant information and led to the establishing of an organisation for developing joint initiatives.

This meeting led to considerable material and data being collected, which still needs to be conclusively evaluated. Nevertheless, we have already been able to establish the following relevant points on which to base our work.

1. The country of origin determines the type of integration process in the reception communities.

   The level of education of the migrants coming from Africa is less academic than that of the migrants from Eastern Europe, who frequently have high academic qualifications although they often have jobs that require clearly lower school leaving qualifications.

   In terms of the living situation, the new migrant groups have broken the tradition of building illegal slums around the large cities, which was started by the Africans and has been maintained for years. They want better accommodation and live in small dwellings that they share will other compatriots.

As has already been mentioned, the traditional concentration of migrants around the large cities is changing as a result of the large influx of migrants from Eastern Europe into the rural regions of the country. This circumstance has had the effect of repopulating the interior parts of the country. This has also brought about a certain degree of economic recovery here since these areas, which are predominantly agriculturally structured, have traditionally belonged to the poorer regions of Portugal.

2. In a similar way, the situations and backgrounds for using psychotropic substances differ according to the various migrant groups. The large African population has already lived in Portugal for a long time and uses substances to a much larger extent, particularly in the second and third generation. The youths from these communities are often caught between two cultures – African and Portuguese – and have considerable problems integrating.

   Studies still need to be conducted on use within the migrant communities from Brazil and Eastern Europe. However, there seems to be a greater and more risky use of alcohol within the latter group. The culturally integrated or at least tolerated use in the countries of origin is taking on problematic dimensions in Portugal. This is deemed to be a result of the social disorientation, in particular caused by the difficulties adapting to the new migration situation and the lack of social connections and unemployment. However, other factors have also been identified that can lead to problematic use, such as the constant availability of alcohol and the low prices.

   There are many reasons why many migrants find it difficult to become socially integrated, such as, for example, because of the aforementioned cultural factors. The most important factor, however, is the difficulty that these people have in finding a suitable profession with a secure income that enables them to live independently and to create their own home. In view of this, many migrants hardly look for legal ways to secure a suitable existence but turn instead to small-time crime and 'living on and from the streets'. Many of them, for example, offer guard services for protecting individual cars in large public car parks. The car owners, fearing for the safety of their cars, pay them directly.

Some information on drug use among Eastern European migrants:

- The alcohol consumption is clearly higher than in the Portuguese population;
- This seems to be culturally rooted, i.e. there seems to be no individual awareness that there is a problematic amount of alcohol use;
- It takes place at weekends without showing any leisure character;
- The fact, however, that they can lose their jobs when arriving at work inebriated or drunk, serves as a protective factor;
- With the unemployed immigrants, there is a tendency to turn to minor criminality ('parking helpers'). It is particularly this group that appears vulnerable to drug misuse;
- 13-14-year-olds are often misused as drug couriers;
- there are generally no well-defined networks for these immigrant groups.

If the information received and the conclusions drawn by the team are taken into consideration, it will be possible to create a framework for establishing intervention strategies for addiction prevention in these populations. Here, in brief, are some points concerning the future measures/strategies that are being taken:

1. Bearing in mind that the migrant communities from Eastern Europe and Brazil use the Internet both for reading their native newspapers and for communicating, strategies for preventing substance misuse should be used that make use of the new information and communication technologies.

2. With the African community, priority should be given to prevention approaches that are oriented to the second and third generation.

3. In Portugal there are a large number of organisations representing the migration communities. They should be involved in developing prevention programmes.

4. Likewise, priority should be given to using local cultural mediators, whether they belong to these organisations or not.

5. At the level of the street worker teams (outreach work), we need to consider introducing cultural mediators in these teams with the aim of having an impact on the specific migration-dominated scenes.

6. Because of the difficulty in gaining access to information and the initial difficulties in learning Portuguese, brochures should be developed in different languages (Help Line). These brochures should be oriented to the native culture of the target groups in terms of their design, language and aims. Otherwise there would be too great a risk of only 'paying lip service', without actually reaching the people.

7. Specific research approaches must be intensified to achieve a secure basis for interventions and to evaluate the quality of the interventions.

8. In summarising, we can say that we have embarked on a long journey. Participating in the 'SEARCH II' project, however, has provided a dynamism that has already enabled, at an early point in time, first steps to be taken in migrant-related community work, which will be completely implemented in 2004.

7. Sources

Council of Ministers Approval No. 46/99 from 26 May 1999
Council of Ministers Approval No. 30/2001 from 13 May 2001
Approval (majority) of the Council of Ministers from 30 May 2001
Approval of the summit (city of Maria da Feira) from June 2000

Some Internet links:

http://imigrantes.no.sapo.pt/index.html (*Imigrantes Somos Todos*)
http://www.acime.gov.pt/ (*Alto Comissariado para a Imigração e Minorias Étnicas*)
http://www.sef.pt/ (*Serviço de Estrangeiros e Fronteiras*)
www.oim.pt (*Organização Internacional para as Migrações*)

16. 'SEARCH II' in Spain

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Fundación Salud y Comunidad (FSC), Barcelona, Spain

Helga Gabarró-Nuñez
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1. Brief description of Fundación Salud y Comunidad:

The Fundación Salud y Comunidad (FSC) is a charitable organisation that seeks to improve the health and social welfare of the community by developing activities for promoting health and living quality. Since 1980, the Fundación has been developing programmes tailored to the special needs of specific target groups and has been promoting integrative care systems. The projects are developed with the aim of providing support and prevention, social and professional integration and counselling and applied research.

Specifically, the FSC has a considerable range of experience in the areas:

- Prevention, care and support for persons with drug problems
- Interventions with problems related to HIV/Aids
- Care for (ex) prisoners
- Residential projects and domestic care services
- Prevention programmes against domestic violence
- Residential projects for battered women
- Programmes for health promotion and professional integration of immigrants
- Developing prevention materials
- Conducting applied research projects
- Developing instruments for social and health project problems using new information technologies
- Developing plans for communal health promotion
- Work with volunteers
- Evaluation of services and projects

Since the prevention and care services within the Fundación Salud y Comunidad's social and health areas were coming into increasing contact with migrants in risk situations, we took the opportunity in October 2000 of conducting the project „'SEARCH' – Drug prevention with refugees, asylum seekers and immigrants in risk situations" together with other organisations and professionals from the European Union. The main aim of such collaboration lies in the necessity of increasing our knowledge of the prevalence of addiction among the immigrant population in risk situations in order to develop suitable prevention services. FSC's involvement in 'SEARCH' provided the initial spark for developing specific prevention approaches for the project's target group. Moreover, acquainting ourselves with the Rapid Assessment and Response method in the field of immigrant addiction problems has enabled us to get closer to the reality faced by immigrants in risk situations and has supported us in designing and developing suitable prevention activities. Within the framework of the 'SEARCH' and 'SEARCH II' projects, we have concentrated our work on one of the most vulnerable groups in Spain affected by social exclusion: juvenile immigrants from Morocco who live in Spain without papers and are not accompanied by their families.

2. The transition from 'SEARCH' to 'SEARCH II':

The phenomenon of unaccompanied juvenile foreigners without papers (called MEINAs in Spanish) first became apparent between 1997 and 1998 and is a relatively new phenomenon in Catalonia, Spain and other European cities such as Marseilles and Amsterdam. The Catalonian authorities first began to take it seriously in 1998. Since then, many approaches have been developed to counter this precarious situation, which is experienced by many youths who have started their migration process alone and are frequently minors. This is a more recent social phenomenon (1997-1998) that is difficult to quantify as

there are various related factors that hinder its control. According to the study "Unaccompanied juvenile foreigners without papers (1998-2002)", which was conducted by the "Centre d'Estudis Jurídics i Formació Especialitzada" on behalf of the Generalitat de Catalunya, the Direcció General d'Atenció a la Infància i Adolescència (DGAIA) recorded 1659 unaccompanied juvenile foreigners without papers from the beginning of 1998 until the end of May 2002, of whom 262 were still in Barcelona in May 2002.

Using the RAR research method, in 2001 the Fundación Salud y Comunidad made an initial analysis of the situation concerning drug use among young and juvenile Moroccans living in the city of Barcelona, who are without papers and are unaccompanied by families. Based on the results of this first pilot analysis within the framework of the 'SEARCH' project, we reached a series of conclusions about drug use within the aforementioned target group that can be referred to in the handbook "Drug prevention for asylum seekers, refuges and illegal immigrants"(p. 114). Based on the results of this study and the fact ascertained by other professionals that the primary drug problem with this target group is solvent use, we developed a "Pilot Guideline for Professionals on the Misuse of Inhalants". The first phase of the 'SEARCH' project was completed with the distribution of these guidelines among the most important organisations in Barcelona and Madrid that have combined to form the "Working Group for Defending the Rights of Juvenile Immigrants Unaccompanied by Families" (Plataforma en defensa de los derechos de los menores inmigrantes sin acompañamiento familiar). After a pause of several months, we continued the work in October 2003 as part of a second phase within the framework of the 'SEARCH II' project. Using a light version of the RAR, we again ascertained which immigrant groups in Barcelona are most vulnerable to drug use. Since, as before, we considered young and juvenile Moroccans unaccompanied by families to be the group most at risk, we decided to research their situation in order to determine whether it had changed since the previous initial analysis.

3. Re-examination of drug use among young and juvenile Moroccans unaccompanied by families: Most important factors and ascertained changes in comparison with the first analysis.

The second analysis confirmed most of the information from the first survey while providing some added detail concerning several aspects and introducing some news elements. Above all, however, it confirmed that specific Moroccan youths continue to misuse substances as a consequence of their living conditions and the failure of their immigration plans. The verification analysis was conducted using the RAR's Monitoring Module and the following analysis techniques:

- Analysis of the existing information
- General focus group (helicopter perspective)
- Specific focus group
- Interviews with youths from the target group.

The following information sources were used:

- **First focus group**: 6 addiction professionals who work in specific harm reduction centres and drug care facilities in Barcelona.

- **Second focus group**: 4 professionals from various areas who all have (professional) contact to the juvenile youths in the target group: a cultural mediator of Catalonian origin working in the prison; a Catalonian anthropologist who wrote her doctorate thesis on the subject of juvenile immigrants in Barcelona who are unaccompanied by families; a Moroccan social worker and a Moroccan cultural mediator.

- **Semi-structured interviews** with youths from the target group: From the target group, 2 groups of 5 youths were interviewed – each time by a Moroccan social worker, while a further group was conducted by a Moroccan cultural mediator.

Based on the updated information, the following section identifies the most important factors relating to drug use among youths from the target group and the changes in relation to the first analysis.

3.1. Most important factors

We concentrated the analysis on male juveniles and youths living in Barcelona who were without papers, were not accompanied by families, were aged between 14 and 18 years old and were mainly of Moroccan origin. The following assessments essentially refer to youths who have contact to educators, i.e. they are – or are supposed to be – cared for by the Catalonian youth authorities. However, the clearest cases of misuse are generally associated with those youths who are not cared for by the youth authorities, either because they have eluded them or because they have never had or wanted to have access to the youth authority services.

3.2. The most important substances used

The drugs used most of all by both the adults and juveniles are tobacco and hashish, which the vast majority of youths have already used in the country of origin and are familiar with. The information that we received indicates that the use of alcohol has increased relative to the first analysis. Alcohol use currently appears to be very widespread, although most youths had not consumed alcohol in their homeland. There seem to be various reasons for this growth, including trying to assimilate to the patterns of use in Spain to show their degree of integration in the host culture and to discard the values of their original culture. In each case, the youths in the target group consider alcohol to be a dangerous substance ahead of hashish and tobacco (which they in turn consider not to be so dangerous).

The use of solvents, which was ascertained in the first study both with adults and youths, seems to have become more apparent among younger juveniles, who initially use it with playful, socialising intentions shortly after their arrival in Barcelona. Over time, and to the extent that they are in contact with other, older youths, they change their consumption habits and eventually give up using solvents because of the connotations associated with its use. A further reason for changes in the use behaviour is the fact that the use of this type of substance is very 'visible', both for the educators as well as for the police. The youths begin to view the use of this substance negatively because it draws them to the attention of the police and the authorities: when the youths reach adulthood they find themselves in an illegal situation; if they are minors and are unaccompanied by families they must be placed into the care of the Catalan youth office. Both in the former and in the latter situation, the use of solvents can easily be determined and therefore places their immigration plans at risk. In addition, as has already been mentioned, the use of very cheap solvents also has connotations associated with the phenomenon of 'street kids' in Morocco. Therefore other substances are increasingly preferred that have less negative connotations. The youths themselves still consider solvent use as clearly harmful and dangerous.

Thus, during the new RAR it was determined that:

- solvent use occurs particularly among youths aged between 13-14 and 16-17 who are spending their first months in Spain, although there is also occasional use among older youths due to its cheapness.

- the vast majority of youths from the target group have not used solvents in their homeland as most of them were not street kids.

One reason why solvents carry a negative connotation is because they are associated with extremely poor and marginalized street kids in the Moroccan cities, with whom the youths themselves do not wish to be associated.

We continue to register occasional use of synthetic drugs with the oldest youths in the target group, which is linked to alcohol use and the assimilation of their use patterns to that of the native youths during leisure activities. It is still not quite clear whether sedatives are still used, since in the first study its use was determined among youths who use solvents more or less habitually, whereas the information received in the second study was somewhat vague, thus making it impossible to draw any conclusions. Since synthetic drugs are known as 'pills', these are easily confused with sedatives (Trankimazin, Benzodiazepine, etc) which are also described as 'pills'. This is an aspect that must be considered in future, since the last study was unable to clarify this.

We ascertained the occasional use of cocaine, but only from older youths who have more money than the younger ones, either through their links to drug dealing or the pickpocket mafia.

3.3. Consequences of problematic use:

Physiological problems: The problems mentioned most frequently, particularly in relation to solvent use, were breathing problems, catarrh, dizziness, nausea, mouth wounds and infections of the respiratory tracts.

Psychological problems:
- The drug use is a reaction to the fears related to their living situation, and serves to cope with these.
- After using solvents, the youths mention feelings of fear, anxiety and depression, and, to a certain extent, hallucinatory problems
- They use the initial euphoria after taking solvents and alcohol to give them enough courage to steal or commit other crimes.
- They also describe drug use as a way of combating boredom.

Legal and economic problems: In some cases, the drug use brings them into contact with drug dealing or networks of thieves, but in many cases they also have legal and economic problems that are not connected to drug use. Although their original aim was to migrate, find work and send back money to their families, their age and illegal status in the country prevents them from working legally to obtain money, which is why they resort to illegal means. In the end it is their financial situation that determines which drugs they use. Solvents are, for example, very cheap, whereas cocaine is very expensive.

Social problems: The use and misuse of drugs distances them from their original community, creates problems with the neighbours, with the police and with the educators and the education dynamic in the centres.

3.4. Factors influencing problematic drug use

After observing and assessing the patterns of use displayed by the youths, we considered with them the factors that are connected to their drug use or could influence this. The following are aspects identified by the youths and the professionals:

- Easier access to drugs in Barcelona.
- The use is encouraged and maintained through the precarious living conditions that they experience, and in which some of the youths from the target group are still living (basic needs such as a permanent home, food, affection, safety, etc. are not covered).
- Use with the intention of relieving fear of the immediate future.
- Alcohol use is influenced by the normalised and socially accepted alcohol use in Spain.
- Drug use is influenced by their bitter experiences during the migration process.
- Drug use is influenced by the complete loss of contact to their own families, to key persons in the homeland and by the lack of positive, affective relations to adults.
- Drug use is influenced by the drug use of their peers who are also on the streets, but have already been living in Barcelona for a longer period of time.
- It is connected to the crushed hopes arising out of the differences between their original migration plans and reality.
- According to those youths who misuse drugs, they use them to counter an ‘abstinence syndrome’.
- The use is influenced by imitating the patterns of use for (legal and illegal) substances shown by local youths and adults, as well as by misunderstood integration into the receiving culture.

4. Description of the local prevention activities and their implementation: developed actions and products

4.1. Evaluation of the "Pilot Guidelines for Professionals on the Misuse of Inhalants”:

Of the facilities that had received the pilot guidelines developed during the first part of the project, a total of 8 facilities from Barcelona and Madrid sent us replies with their assessments. After analysing the assessments, we can confirm the necessity of having support material for professionals for providing drug prevention within the target group. Although the information offered in the guidelines was assessed very positively as far as their practicality, usefulness and clarity is concerned, the professionals also requested more precise information on the cultural reality of the homeland and on the social, cultural and religious views of the population regarding drugs. The proposed prevention measures were assessed very positively, as was likewise the guide’s sensitising approach regarding the necessity to network drug prevention within the target group. Emphasis was also given to the importance of training professionals in contact with the target group, particularly in view of such a complex phenomenon with its many implications regarding, for example, drug misuse in the intercultural context.

After these observations and the results of the RAR verifying the situation, we began developing a new version of the guide as a handbook for supporting and instructing professionals, not just on the subject of solvents but on the various drugs determined and on the differences in their use between the country of origin and the host country. The main aim of the handbook is to help to understand the complexity of the phenomenon in terms of drug use, in particular the effect on the health of youths in the target group, and to offer concrete tools and instruments so that the professionals can begin the prevention work with the youths.

4.2. Conversion of the pilot guidelines into a "Handbook for professionals in drug prevention working with young Moroccan immigrants unaccompanied by families”

The new version of the material was started with the support of a Moroccan cultural mediator and experts working with unaccompanied juveniles and young Moroccans in Barcelona, who also work

closely together with the "Platform for Defending Juvenile Immigrants Without Papers".
Together we developed the conceptual framework of the handbook by working out a series of initial, fundamental recommendations for professionals working with youths in the target group, so that they can begin with the drug prevention work and, where sensible, with harm reduction work relating to problematic drug use.

Objectives of the handbook:
As a first step in dealing preventatively with the problems of misuse, the handbook is intended to help understand the social use of each individual substance and their importance for the youths. In addition, it offers important specific information on every individual substance determined as well as providing general aids and special educational and preventive tools for professionals working with the target group on the following substances: cannabis, alcohol, tobacco, synthetic drugs, inhalants and medicines.

Features of the handbook:
The handbook has been published as a 64-page PDF file in DIN A5 size and as 30 hardcopy editions self-printed in colour. In terms of content, the handbook is divided into four chapters than are identified with different colours,

PART I:
YOUNG AND JUVENILE MOROCCANS UNACCOMPANIED BY FAMILIES IN BARCELONA
1.1. The phenomenon of youths and juveniles of Moroccan origin unaccompanied by families in Catalonia
1.2. Study of the drug use among the youths and juveniles of Moroccan origin unaccompanied by families in Barcelona
1.3. About the 'Handbook for professionals in drug prevention working with young Moroccan immigrants unaccompanied by families':
1.4. Most important observations on drug use among juvenile and young Moroccans without papers and families

PART II:
INITIAL CONSIDERATIONS ON DRUG PREVENTION
2.1. Priority measures in the area of prevention and harm reduction
2.1.1. Approaches to prevention and drug misuse
2.1.2. Approaches to harm reduction

PART III:
HEALTH EDUCATION BASED ON THE INDIVIDUAL SUBSTANCES THAT HAVE BEEN DETERMINED
3.1. Cannabis
3.1.1. Basic information on cannabis which the educators should know
3.1.2. The effects of cannabis
3.1.3. Advice that the educators can offer
3.1.4. Arguments that can be used to say NO
3.2. Tobacco
3.2.1. Basic information on tobacco which the educators should know
3.2.2. Preventive activities for tobacco
3.2.3. Preventive dialogue
3.3. Alcohol
3.3.1. Advice that the educators can offer

3.4. Synthetic drugs
3.4.1. Basic information on synthetic drugs which the educators should know
3.4.2. The effects of synthetic drugs
3.4.3. Advice that the educators can offer
3.5. Inhalants
3.5.1. Basic information on inhalants which the educators should know
3.5.2. The effects of inhalants
3.5.3. Aspects that should be taken in to account in crisis situations
3.5.4. Harm reduction with solvents users
3.5.5. Every day harm reduction
3.6. Medicines

PART IV:
ACTIVITIES FOR PREVENTING THE USE OF INHALANTS AND OTHER DRUGS
4.1. Aspects to be taken into consideration when planning and conducting activities
4.2. About the prevention activities
4.2.1. Drug counselling
4.2.2. Sport as a leisure activity and for making new contacts

Content of "Handbook for professionals in drug prevention working with young Moroccan immigrants unaccompanied by families":

4.3. Distribution of the handbook

To distribute the handbook, the intention is to use the network of organisations that work with and on behalf on young and juvenile immigrants in Madrid and Barcelona, the two conurbations where the phenomenon of juvenile immigrants unaccompanied by families is most apparent.

A total of 58 organisations, facilities and institutions have received the handbook, 46 of them by e-mail in PDF format and 12 by post as colour hardcopies in the DIN A5 format. The organisations have received the handbook together with a letter that describes the 'SEARCH' project and the handbook, and requests that they distribute the handbook further within their own local networks.

The following organisations have received the handbook:

- Facilities and professionals in Barcelona and Madrid that have worked together in implementing the 'SEARCH' project;
- Facilities affiliated with the "Platform for Defending Juvenile Immigrants Without Papers";
- Facilities belonging to the Comunidad de Madrid's platform of child protection organisations;
- Facilities from Ceuta, Malaga and Cordoba that were contacted during the development of the handbook.

4.4. Training professionals on drug prevention with young and juvenile immigrants of Moroccan origin unaccompanied by families:

After completing the development of the handbook, an initial ten-hour training session was held (with street workers, volunteer workers, cultural mediators and responsible persons from educational projects for juvenile Moroccan immigrants).

Profile of the participants:
13 participants; 1 coordinator and 4 street workers from the project "Support for youths from the old city", 5 voluntary workers and 2 Moroccan cultural mediators from the "Espacio de Inclusión y Formación del casco antiguo de Barcelona EICA", 1 coordinator from the social vocational training project for juvenile immigrants and the responsible person from the EICA-Youth project.

Content of the training:
- The situation of Moroccan juveniles and youths unaccompanied by families in Catalonia: Reflections on an unsuccessful migration project
- Description of the drug use in the target group
- Reflections on prevention and harm reduction. Prevention: When and how? Harm reduction: When and how?
- Training session on the substances: tobacco, cannabis, alcohol, inhalants, synthetic drugs and sedatives
- Description of the youths' relations to the substances in Morocco and Spain
- Basic information on the substances, effects and risks
- Preventive proposals and dialogue
- Development of preventive activities with the youths
- Work on cases from practice

Aims of the training:
- Initiating contacts between professionals from the different centres and facilities which work with young Moroccans unaccompanied by families
- Sensitising professionals to the importance of drug prevention and harm reduction
- Providing up-to-date information for professionals on the situation of drug use within the target group and on the substances used
- Providing communicative tools for preventing drug use within the target group
- Advising and supporting the professionals on dealing with situations concerning drug use among juveniles and youths
- Encouraging the sharing of information, experience and strategies concerning drug use among youths and juveniles from the target group

4.5. Evaluating the training

We decided to conduct a brief evaluation of the training with the aim of getting some feedback from the professionals regarding the usefulness and appropriateness of the developed handbook on whose basis the training was carried out. For this purpose, each participant was provided with a semi-structured questionnaire with ten questions, on the basis of which we analysed their assessment of the training. The analysis of the answers led to the following conclusions:
- The participants believed that the training gave them a better understanding of the features characterising drug use (type of substances, use patterns, influential factors) among the juvenile and young Moroccans.
- The training enabled the participants to deepen and re-examine their existing knowledge on the effect and risks of specific drugs (x = 7 from 10 points)
- They received new information on preventing drug use among juveniles (x = 7.5 von 10 points)
- They confirmed that the information which they received was useful (x = 7 from 10 points)
- The information provided during the training was clear and understandable (x = 8 from 10 points)
- They are able to use what they have learned during everyday work with the youths (x = 6.5 from 10 points)

Positive aspects that were mentioned included the integrated approach to training, the information on drug use by youths and juveniles, and in particular, the educational and preventive recommendations for dealing with the target group.

Negative aspects that were mentioned included the necessity for more intensive training, the need for information on the legal situation concerning drug possession, dealing and use, as well as the necessity to work using examples from practice.

It is interesting to learn from the FSC professionals that coherent and efficient prevention work with youths and the target group is hindered by both the professionals' level of experience and knowledge in the area of drug prevention as well as by the different positions (attitudes and behaviour) regarding drug use. In this regard we became convinced that future training will need to focus on the professionals' attitudes and behaviour regarding their own use or non-use of drugs, and how this can determine the efficiency of the drug prevention with young Moroccans.

5. Conclusions

As part of the prevention activities carried out within the framework of the 'SEARCH' and 'SEARCH II' projects, the Fundación Salut i Comunitat has developed tools for drug prevention that have been evaluated and, based on the RAR results regarding the drug use situation within the target group, have then been developed further. In view of the fact that we do not consider drug use as something static, but as something that is constantly changing, it must also be understood that the preventive tools that have been developed (handbook and training) will also need to be adapted to meet this permanent transformation.

6 Future activities

The Fundación Salud y Comunidad plans to continue working at the local level in order to be able to offer technical support (using the handbook and training) to professionals who work with and for the target group at the regional and national level. In this regard, the Fundación will establish contact with the Catalonian local authorities and with Spain's national authorities in order to suitably present the material and results of the SEARCH II project and to find sufficient financial means to be able to continue implementing the training measures efficiently.

17. 'SEARCH II' in Sweden

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Centralförbundet för Alkohol och Narkotikaupplysning (CAN), Stockholm, Sweden

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1. About CAN

„CAN“ is the Swedish center for information on alcohol and other drugs with 40 non-governmental organizations as members. Many of them are temperance organizations, but parent-, sports-, client-, and youth organizations are also represented.

The council receives financial support from the Swedish government. The chairman of the board is government appointed. The member organizations appoint the majority of the board members.

CAN’s mission is to prevent alcohol and other drug abuse through the provision of facts, documentation and information. It aims to circulate objective information, serving people and organizations involved in drug prevention work.

For this purpose CAN produces information resources, runs a library service and arranges training courses, seminars and conferences.

CAN also monitors trends in the drug use and abuse, carrying out its own surveys and studies such as annual surveys on drug use among students and military conscripts. It is also compiling and summarizing survey findings, statistics and other data sourced from external researchers. CAN provides a link between research and the community.

CAN arranges a series of conferences in a number of Swedish counties every year, in cooperation with local organizations.

CAN has a staff of research secretaries charged with keeping abreast of the latest research findings and with producing popular scientific publications and reports.

There are also consultants who support organizations in their prevention work. The press secretary supplies the media with basic facts and the latest results.

CAN produces fact sheets and guides, reviews and popular scientific publications. The main publication "Rapport" (Report) contains a review of the alcohol and drug situation in Sweden, including statistics on consumption and new trends in the use and abuse of alcohol and other drugs.

Another periodical is issued once a year. It contains popular scientific articles and follows the debate on alcohol and drug policy, treatment and other issues.

A large number of lectures arranged by local organizations receive financial backing from CAN.

CAN has a representative in each county in Sweden, 28 all told.

2. Alcohol and drug abuse among asylum seekers and immigrants

Sweden as an immigration country

People have been immigrating to Sweden for many centuries. The main motive for immigration has been the need for labour. German tradesmen settled in a number of Swedish cities as early as the 13th century. They were accompanied by skilled craftsmen. In the 16th century immigration was stimulated by state initiatives. The state showed particular interest for Dutch, Scottish and German tradesmen and industrialists who brought with them large groups of skilled workers. In the 17th century the importation of workers intensified in connection with the establishment of an expanding textile industry. However, the number of immigrants remained very low in Sweden until modern times. For example, in 1860 there were fewer than 8,000 "foreign born", of whom most came from Germany and the Nordic countries.
The war years represented a turning point in Swedish immigration history. Sweden transformed itself from a nation of emigrants to a nation of immigrants. In the 1950s this strong immigration (primarily workers) and the number of foreign born reached 300,000 by the end of the decade. Finnish immigrants represented the largest group, but many also came from Italy, Greece, Turkey and Yugoslavia to work. Among refugees, Hungarians predominated. Sometimes immigration occurred in organised forms, through the involvement of the labour market authorities. But most immigrants found their way to Sweden on their own.
At the end of the 1960s a Riksdag (Swedish Parliament) resolution introduced regulated immigration. This meant that those who wanted to immigrate should acquire their residence permits before the journey. For those who wanted to work, it was necessary to have a residence permit in hand or else for the immigration authorities to have carried out a labour market analysis together with the labour market side. Permits were only approved if the country needed foreign workers. If there were unemployed persons in Sweden who could perform the work, then no residence permit was issued. In the meantime, exceptions were allowed for citizens of the Nordic countries, refugees, and for immigrants who wanted to reunite with relatives in Sweden.
In the 1970s non-Nordic labour force immigration declined while the Nordic, particularly the Finnish, grew dramatically. The non-Nordic chain immigration also increased. Refugees came in surges, often immediately following wars or crises. One important event was the military coup in Chile in 1973.

2.1. The 1980s – the decade of asylum seekers

In the mid-1980s asylum seekers claiming refugee status from countries outside of Europe grew in number. They came from Iran, Iraq, Syria, Lebanon, Turkey and Eritrea. At the end of the decade many persons from Somalia, Kosovo or several of the former eastern European states joined the ranks of asylum seekers.
The influx of asylum seekers led to refugee centres being established in many towns. Since Swedish society was not prepared for the new situation, waiting periods also grew longer. Many asylum seekers saw their applications rejected when the "classic" motives for immigration did not apply. Aside from persecution and war, poverty, a lack of faith in the future and dreams of a better life in the new country became increasingly common motives for immigration.

2.2. The 1990s – the period of ethnic cleansing

During the 1990s many trouble spots vanished, but from the point of view of refugee policy they were "replaced" by the emergence of the Balkan Wars. Sweden became home for around 100,000 former Yugoslavs, mostly Bosnians and Kosovo Albanians. At the same time, the stream of Iraqis, particular-

ly Kurds, and also asylum seekers from the Middle East and Somalia continued. Various Russian speaking peoples from the republics of the former Soviet Union saw themselves as being discriminated in their "old-new" homelands.

2.3. The situation today

Census data shows that at the moment some 500,000 foreigners are living in Sweden. The number of foreign born persons makes up circa one million individuals, which corresponds to eleven percent of the population The number of second generation immigrants is around 800,000. Taken together, the two aforementioned groups make up almost twenty percent of Sweden's population. (Ekberg p. 25)

2.3.1. Asylum seekers – general reception and living situation

For many people immigrating to Sweden today it takes a long time to integrate into Swedish society. Two very important aspects of this are education and work/welfare. This applies to young and old people, asylum seekers and immigrants who have received residence permits. "Work for everyone" has been the most fundamental political vision in Sweden for more than half a century. To have work and to be able to take care of one's self not only entails economic freedom for the individual but also gives him/her self-respect, self-confidence and the opportunity to lead a meaningful life.

Many immigrants received a poor education in their home countries. When a young asylum seeker attends a Swedish school, language is not the only hindering factor. The fact that he/she had a sporadic school education makes it impossible to place him/her among students of the same age. This can be experienced as frustrating and underscores their outsider status. But it should also be emphasised that many young people are receptive and learn both languages and adapt considerably more quickly than the older generation. Older immigrants with poor school education often end up in a vicious circle where unemployment alternates with low status jobs or undeclared labour. Unfortunately, education does not always help. Studies show that many highly trained immigrants do not receive the qualified jobs which persons born in Sweden with the corresponding education receive.

According to a state study, the reason why so many immigrants remain outside the labour market (to name just one irrational trait in Swedish society) is as follows: employers, personnel directors etc. have not been mentally conditioned to hire people with exotic names and different educational backgrounds. That can be seen as both inhuman and negative for Swedish society, and in order to change this it will be necessary to take an honest look at the new situation and to institute thorough changes in the relevant institutions, laws, regulations and routines. Most systems – both social systems and those within the private sector – are largely based on and oriented toward a native population which has grown up and been educated within the country.

The goal of Swedish integration policy, at least on a purely theoretical level, is both to adapt general policy to a multiethnic population and to develop and offer special measures to new immigrants so that they can quickly become able to live under the same conditions as the native born and contribute to the same extent to the development of their own and society's development. This applies both to asylum seekers who have often had to put up with long waiting periods before they were informed of a potential residence permit and to those who have received one.

Behind the difficulties encountered by new immigrants in recent years lie both long-term structural changes in the Swedish labour market and the profound economic slump. A growing number of refugees and new nationalities with different backgrounds and expectations have also played a role in organising and implementing the reception of refugees. According to the report "Settling in Sweden. SOU 2003:75", the existing organisation and the tasks it was given in the first phase did not function as the goal-oriented and effective "kick-off" which had been intended. "All too many newcomers have spent all too much time sitting on (school) benches waiting until they are 'cleared to play', even though we knew that we can only learn the game's rules and become good players if we are out there on the field

and playing.” (SOU: 75 p. 35) Research shows that perhaps the most important factor for the adaptation of refugees to the conditions of Swedish society is early contact with the Swedish labour market. Other factors such as age, nationality, education in the homeland, education in Sweden, waiting period in the reception system and one’s marital status appear to have less importance. It is worth noting than an asylum seeker is not prevented from working during the waiting period if it is anticipated to last longer than four months. In some cases the waiting period is considerably longer.
The authorities in charge bear a high responsibility for the conditions described above. It is clear that the outcome of this must be to try to improve and intensify early efforts and to create a clear and unambiguous labour market institution so that "new recruitment” to unemployment and welfare dependence can be prevented. Experience shows that foreign born persons who become dependent on welfare more frequently remain dependent on a much longer basis with, among other things, risks of negative psycho-social consequences than native Swedes.

A number of failures in the reception of refugees have been demonstrated, including:

- The waiting period in the reception system has not been used for goal-oriented, integration-oriented measures;
- The responsibility which local communities have assumed for asylum seekers has come to be regarded as a comprehensive rather than co-ordinating responsibility;
- As a result, other players have not felt responsible for the newcomers, nor have they been given a clearly defined mission;
- The duties of local communities have been unclear and vary from community to community
- A "one thing at a time” philosophy has been disastrous and is built into the regulatory system which has contributed to the prolongation of introductory periods;
- The entry of newcomers to the labour market and future welfare possibilities have not been placed into a self-evident focus for all affected parties;
- The goal of the introductory period has been too general and comprehensive to function in a guiding fashion. (SOU 2003: 75 p. 36)

If the path to work and welfare is to be shortened in an orderly fashion for those who will stay in the country, it is important to pay attention to the time they spend in the asylum phase. That is why officials have started redesigning this period to make it more preparatory for immigration and more labour market-oriented. Even if the asylum seekers receive a negative response, this "education” can benefit them when they return to their home countries.
There is no advanced knowledge of how society’s efforts affect an individual’s qualifications for integration. Few studies have been made of former refugee seekers’ viability and adaptation to the conditions in their new homeland in relation to the duration of, the conditions during and the content of the asylum period. However, there are a number of mass media reports on individual asylum seekers who have fared very badly during the asylum period. The authorities now hope to shorten the waiting periods during the asylum examination as much as possible.
If waiting periods nevertheless continue to be protracted, the goal is now to give them as much content and make them as energising and useful as possible for both individuals and society. The traditional sharp dividing line between asylum seekers and persons who have received residence permits has gradually begun to fade. While in the 1970s and 1980s it was the express intention not to offer asylum seekers anything other than the bare necessities during the waiting period, the growing number of asylum seekers and longer waiting periods have led to an increased need to make waiting periods more meaningful. Among other things, this has led to the development of so-called organised activity. But until today the difference between asylum seekers and persons with residence permits has, for example, been characterised by the fact that Swedish language instruction has been less advanced for asy-

lum seekers than for other groups within the framework of the Swedish for immigrants programme in the schools.
The activity occurring during the asylum period has so far been motivated by the need to create meaning and structure in a waiting period which otherwise risks being purely destructive for the asylum seekers. Limitations in the efforts aimed at asylum seekers have been motivated by the desire:

- Not to invest large resources in persons who might leave the country soon
- Not to give the asylum seeker false hopes that his or her application for a residence permit will be approved
- Not to give the asylum period such an attractive content that it attracts persons to Sweden who have no grounds for asylum

Thus these activities now have the double goal of providing support for a continued life in Sweden or else as a form of meaningful content in case a return to one's home country becomes necessary.

2.3.2. One's own residence or refugee housing
One issue of interest is the possibility asylum seekers have of choosing their own residence. The possibility was introduced in 1994 because the government believed that this could be a way to encourage asylum seekers to seek their own residence and that the goal must be to make the reception system promote the opportunity for asylum seekers to live outside of the refugee centres as a first choice. Underlying this position was the wish to come out of the "caretaker trap" in the asylum system, to treat asylum seekers like adult, mature, responsible human beings. In mid-2003 some fifty percent of asylum seekers had their own residence.
Very soon after the introduction of one's own residence, critical voices began to be heard. People said that those who chose to live outside of the asylum centres fared badly and needed some sort of support from society. The question was tested again in the Riksdag (Swedish parliament) in 1997 in conjunction with a debate on integration policy. But no changes in the system were suggested. The individual's right to choose his/her residence during the asylum period was given great attention. The critique against one's own residence remained all the same.
The major reason for asylum seekers choosing their own residence is the desire to be close to family, friends and fellow citizens. The disadvantages include:

- The asylum seekers and their children often fare badly during the asylum period. The children experience no stability in their schooling, and being passed to and fro between different foster families means having to change schools and frequently a long way to school. The foster families' own incipient integration is delayed and is made more difficult when they are confronted with the asylum seeker's restlessness during the review period, and the asylum seekers have difficulties in participating in organised activities.

- Tight living conditions, conflicts with the foster family and with subtenants, evictions by foster families because they disturb the neighbours or damage their flat.

- Those who live in their own residence contribute to their own outsider status and to growing ethnic segregation, which also represents a social problem.

It is especially important that children do not fare badly. When this occurs, it is the local communities which have the legal means to examine the circumstances and to intervene as necessary, even if they are formally included in the Migration Board's reception system. A study of thirteen communities shows that such interventions have occurred in many cases.

The problems related to finding one's own residence should also be balanced by the many positive experiences which have been shown to accrue from living on one's own. The fact that there is always a free choice and that the possibility to move to a refugee centre is always available probably should also be interpreted as showing that asylum seekers appreciate having their own residence. "To be able to choose for one's self whether one wants to live in refugee housing or perhaps share a flat with strangers or with relatives or friends whom one knows makes a contribution to the experience of being able to influence one's life situation and thus one's well-being." (SOU 2003:75 p. 45)

In order to carry out a co-ordinated transformation work aimed at strengthening and enhancing co-operation between the affected authorities and regional and local players who work together in the introduction of asylum seekers, an agreement has been made between the Labour Market Board, the Integration Board, the Migration Board, the National Agency for Education and the Swedish Community League in April 2001. An example of this effort is the fact that the Integration Board concluded an agreement with seven employment organisations concerning co-operation for the sake of promoting ethnic variety in working life and to counteract xenophobia and racism. The point is to develop more effective co-operation in bringing about a successful introduction. (KORTNYTT, 2 Jan 2004)
The Swedish system for refugee reception with the possibilities of appealing rejection which exist often means that asylum seekers spend years waiting for a decision on their residence permit, a period during which they in practice are provided for by state support. This is followed by the introduction into the communities which can also extend over several years - a long time during which they do not have to think about their support. (Rapport 2001)

In psychological terms, the asylum period can be a very trying period because of the long wait and the insecurity. Upon their arrival and in the immediate period thereafter a certain elation can be observed among the new arrivals. They have achieved their goal, a difficult and thorny path has been completed. Many have great expectations of being cared for and they also experience it as such. But soon they are confronted with everyday life, which is characterised not only by monotony but also by disappointment over not receiving a decision. Mental health deteriorates, sleeping problems and psychosomatic symptoms begin to appear. There is reason to suspect that many people in such situations begin to ease their restlessness or else flee from a pitiless reality with the help of alcohol and drugs.

Although an asylum application can be processed after only a few days of active work, for most people it takes months or years. In 2001, the auditor of the Riksdag examined how long it took for the authorities to give asylum seekers an answer in the period from 1996-2000. The goal set by the government is six months of processing for an asylum examination by the Migration Board and the same amount of time at the Foreigners Commission, i.e. a total of one year.
In reality it often took much longer. Among those seeking asylum in 1998, half of them had to wait longer than eleven months and a quarter more than fourteen months. Among those seeking asylum a year earlier and who were finally approved by the Foreigners Commission, half had to wait more than twenty-two months and a quarter more than twenty-seven months. Of those who were rejected in 1997, half had to wait more than fifteen months and a quarter more than twenty-two months.
There is very little in the literature about the hardships of the asylum period. There is a dearth of information concerning the relationship of asylum seekers to alcohol and drugs. By contrast, in the media there are regular reports of varying quality. In some cases they even discuss drug abuse. Most segments discuss "Kat" abuse among Somalis.

3. Asylum seekers and substance abuse

Assuming that the asylum period is a time of mental hardship, the suspicion that various types of substance abuse are being employed to help reduce inner tensions or as an escape mechanism cannot

be rejected out of hand. ANTONOVSKY (1997) has described physical and mental health as a feeling of connection constituting a dynamic process in which the individual strives to understand, deal with and find meaning in his/her life. Of special importance for healthy behaviour are social networks and socio-economic factors. Many asylum seekers lack these preconditions.

3.1. The incidence of alcohol and drug abuse among asylum seekers

In order to find out about the incidence of alcohol and drug abuse among asylum seekers, I first surveyed the literature. My research shows that there are no scientific studies on this issue. However, there is some material dealing with immigrants and substance abuse. This group mainly includes immigrants who receive residence permits and who thus are not asylum seekers. By the same token, there is material in the mass media which takes up the problem, but they rarely distinguish asylum seekers from immigrants.

The next step in my investigation was the interviews/conversations I carried out with some fifty key persons. These were persons who, whether through their profession or through volunteer work come into direct contact with asylum seekers and immigrants or else who encounter immigrating persons in the course of their general activity (e.g. general practitioners, social secretaries).

3.1.1 General personnel in refugee centres

I conducted interviews in three large refugee centres in central Sweden: Gimo, Carlslund and Flen. I met with supervisors, desk officers and health care personnel in both the adult and juvenile departments.

Despite the fact that the personnel and the asylum seekers are in the same area every day, the personnel stated unanimously that they did not have any great understanding of the asylum seekers' daily lives. The asylum seekers live for themselves in individual flats or in corridors where they attend to their own cooking and practical affairs. None of those interviewed had seen any sign of alcohol or drug abuse. At the youth department in Gimo, where contacts between personnel and school-age youths is more intimate than in the adult departments, there was no indication of alcohol or drug abuse.

3.1.2 Health care personnel in refugee centres

When the asylum seekers arrive at a refugee centre, they are offered a general medical examination. Many take advantage of this offer and receive adequate care. As far as the asylum seekers' mental health is concerned, they are frequently "on top of the world". The experience of having achieved one's goal, having "the whole thing over" permeates the new arrivals, making them experience a profound satisfaction with their lives.

It is only after a while, for example three or four months, that their mood starts to change. The new arrivals had expected to receive attention for their case and their concrete concerns. Instead, nothing visible happens at all. Disappointment sets in, often leading to anxiety. The new arrivals realise that they can take nothing for granted, that they are at risk of receiving a negative answer. This realisation, combined with inactivity, occasionally causes a restlessness which in some cases can only be eased through artificial methods. The nearest solution at hand is to request psychotropic drugs from the care personnel, subduing their restlessness and/or easing sleep. Judging from my interviews, this represents a high consumption of medications which often borders on abuse. If the responsible physicians attempt to reduce their prescriptions, there is a danger that a black market will develop for these substances.

3.1.3 Officials

Interviews with employees in various authorities, police, social administration, the correctional system, the mental care system, and the narcotics system have resulted in general formulations nearly identi-

cal to those among the personnel in the refugee centres. These persons have chance encounters with immigrants, but no one has any special opinion or knowledge of asylum seekers.
I followed the work of the social secretaries at the Outreach Unit in central Stockholm over a long weekend. During this weekend we also did not encounter any asylum seekers suffering from substance abuse.

3.1.4 Voluntary associations and volunteer workers
In Flen there is a voluntary association, "Solidarity House", which concerns itself with refugee affairs. They hold office hours on Thursdays and try to support asylum seekers in case they require help with appeals or other bureaucratic matters. They also give advice on help with psychological issues and whatever else comes up.
According to the staff at "Solidarity House" there is no evidence to show that their clients abuse alcohol or drugs. However, they remark that there is a demand for sedatives and sleeping pills.
There are also voluntary associations which work secretly, for example because they support illegal immigrants with advice, funds and health care. A central figure in these associations has stated: "I see no substance abuse among our clients. But they might well drink a glass or two, thinking about how badly they are being treated by society."

3.2. Immigrant associations

There are many immigrant associations in Sweden, many more than the number of ethnic or national groups. The explanation for this is that the associations sometimes place their emphasis on different areas of interest. In addition, there are conflicts within groups coming from the same country. That can be caused by the fact that they come from different geographic regions, or that they have a different political or ethnic base. Clan tensions within the same ethnic group have been imported to their new homeland and it is difficult for the antagonists to belong to the same association. For example, there are five different Roma (gypsy) associations in Sweden.
One umbrella association which can be found in many locations is called SIMON, Swedish Immigrants Against Narcotics. It is more or less active from time to time and is intended to stand above national and ethnic boundaries.
There are various estimates of substance abuse among one's fellow citizens within the different immigrant associations. But the question is sensitive and its existence is denied by some. This denial may, of course, also arise from a lack of knowledge. Six immigrant associations seeking funds from the Social Administration to combat alcohol and drug abuse evaluated the situation among their countrymen in the following way:

➠ *The Turkish Youth League*
"One issue which the Turkish Youth League takes very seriously is that of drug use among young people of Turkish background. Within the Turkish Youth League, we have in recent years become more aware of the fact that the use of various drugs is common among young people. Leaders, parents and young people have expressed their concern over the reality which they see and experience in segregated towns, particularly the dramatic increase in drugs, as well as the consequences which this has brought about among young people of Turkish background." In addition, the league has taken up the problem of tobacco smoking, which they see as the first step towards the use of other drugs. A survey shows that almost seventy percent of girls and seventy-three percent of boys of Turkish background say they have tried smoking and that over thirty-five percent smoke regularly.

➠ *Somali Association in Malmö*
Abuse of the drug "Kat" is common within the Somali immigrant group. According to the Somali Association, social and economic problems are associated with Kat abuse. Here is a quotation from

the association's programme:
"In itself, the use of Kat is relaxing and leads to passivity. Smuggling is a fact and represents another problem. Smuggling occurs in such a way that adults make use of young people. Both adults and young people are affected, although in different ways. Adults, women and men, who use drugs often become passive and neglect their family responsibilities, resulting in the break-up of the family by divorce. Young people neglect school and education, which can lead to exclusion and involvement in the drug scene."

➠ *Greek Youth League*
The Greek Youth League says that studies pointing to a series of risk factors for alcohol and drug abuse are also strongly affected by areas of high immigrant density. *"In our contacts with parents and young people, we in the Greek Youth League have seen that this also affects young people of Greek background. After having met many of our young people of Greek background, we can state that in nearly all cases they have the possibility of turning to someone in their circle of acquaintances who knows how to get hold of alcohol and drugs."*

➠ *Roma Associations in Malmö*
Romano Trajo, Roma Life, is an association which has been working to resist substance abuse and social decay among the Roma (gypsies) in Malmö. A large part of the Roma groups live isolated from other social groups. Unemployment is high and many feel discriminated. Alcohol and narcotics abuse is considered to be widespread. The abuse pattern resembles that of Swedes, i.e. high alcohol consumption and a very high incidence of amphetamine abuse.

➠ *Bosnians Against Drugs*
"We, Bosnia-Herzegovina's Muslim Youth League (BeMUF), believe that one can observe a growing abuse of narcotics and growing alcohol consumption among Bosnian young people who are members of the BeMUF and among young people with whom we come in contact in the BeMUF. It is our opinion that the increase we have noted among the young people with whom we come in contact is part of a general increase in the consumption of alcohol and narcotics which is occurring in Sweden.
"The increasing abuse of alcohol and narcotics which our members in the local Bosnian youth associations have noted among Bosnian young people is believed to derive from social problems, family discord, very poor adaptation in Sweden etc."

➠ *The Kurdish Youth Association*
The association begins by noting that drinking among young people has increased in Sweden in recent years. They have added the following description of the situation:
"Young Kurds have also been affected by alcohol in recent years. In a study by the 'Kurdish Radio in Gothenburg' it was shown that the drinking of alcohol among Kurdish youths has become more common. Abuse is hidden among the Kurdish young people because they do not talk about their problems in front of parents or relatives. Some of them began drinking because of the tensions and social problems in Kurdistan, others became abusers because of the same reasons in Sweden. There are many Kurdish girls who begin drinking alcohol because of pressure from their families or conditions at home or the clash of cultures. Some girls turn to sexual clients to get money for alcohol."

3.3. Independent survey

In an attempt to gain concrete knowledge of the field, I recently circulated the following survey at "Solidarity House" in Flen. The personnel posed these questions to its visitors. It is still too early to say

to what extent this has provided any deeper knowledge.

1. In general terms, what in your view is the state of alcohol abuse among the asylum seekers whom you know or whom you have heard of?
   ❑ don't know ❑ very little ❑ somewhat widespread ❑ very widespread
2. Are there any special age groups or ethnic groups who, in your opinion, have problems with alcohol consumption?
   ❑ don't know ❑ very little ❑ somewhat widespread ❑ very widespread
3. What is your view of the use of sleeping and/or sedative tablets among the asylum seekers whom you know or whom you have heard of?
   ❑ don't know ❑ very little ❑ somewhat widespread ❑ very widespread
4. What is your view of the use/abuse of drugs among asylum seekers?
   ❑ don't know ❑ very little ❑ somewhat widespread ❑ very widespread
5. Are there any special age groups or ethnic groups who in your opinion have trouble with drugs?
6. If drug abuse occurs: do you know which drugs are being used?

Commentary on the question of drug abuse among asylum seekers:
To a large degree, this problem is a hidden problem. No one wants to volunteer such information, among other reasons because they believe that this will diminish their possibilities to stay. Representatives of ethnic groups do not want to present their own group in a bad light.
It is also possible that the problem is generally more limited than with other groups.
Asylum seekers have little money and many do not know where to find drugs.
The problem varies in prevalence according to ethnic group, personality, the content of the asylum period etc.
It appears clear that the consumption of psychotropic drugs is generally high.

4. Preventive measures

4.1 Direct measures

This section will examine the measures which are directly aimed at preventing or reducing substance abuse among asylum seekers. Today, with the exception of various projects by the immigrant associations, there are few or no special programs for this group. Within the Swedish social welfare system measures are being carried out in order to help people with their problems and not to divide them into categories such as asylum seekers, immigrants and Swedes. Some examples from the immigrant associations' programme are examined below. Note that they are not aimed solely at asylum seekers.

➠ *Turkish Youth League, TUF*
The objective of TUF's preventive work is expressed in the association's own words as follows:

- To identify the causes of drug use among young people of Turkish background.
- To present a programme of measures and new work methods to counteract drug use in co-operation with young people on the local level on a long-term basis.
- To inform young people and their parents about the consequences and side-effects of drug use.
- To launch a debate and dialogue with politicians, government authorities and the media concerning drug problems among young people of Turkish background.

➟ *Somali Association*
A quotation from the programme of the Somali Association:
"The primary goal is to change Somalis' attitudes and behaviour toward drugs and in this way to prevent the abuse of Kat. The project shall also increase Somalis' understanding of the harm the drug does in social and economic terms. The project shall develop effective action plans for both target groups.
The secondary goal is to activate the Somalis' involvement in society, increase their participation in Swedish society and to take responsibility for their own and their families' situation. This means transforming an entire lifestyle and getting these groups involved in society.
Schools may be interested in using the results from the project to stop alcohol and narcotics abuse among students."
The project used the methods of roll playing, discussion, conversation and information.

➟ *Greek Youth League*
From the league's programme:
"We are identifying the alcohol and drug habits of young people of Greek background. Opinion-forming and information efforts are being adapted to different communities. Education and native language teachers can function as a link between young people, their parents and school. Local Greek associations are working closely with social authorities and other organisations in order to discover young people in risk zones early on."

➟ *Romano Trajo*
A brief summary of the association's activity. The association works with emergency response and crisis management. It visits parolees, institutions, supervisors etc. Here the members serve as mentors, ombudsmen and contact persons. "*Because of our background, young people have an easier time identifying with us, which eases contact and leads to the conditions necessary for attitude-promoting work,"* says one leading member. The preventive work includes visiting schools, hostels, institutions etc. They carry on discussions with both parents and young people and try to activate the youths in order to make their leisure time more meaningful. In connection with meetings, they show an information film called "Grofo", which is a good way to get the debate going. Another good way of coming into contact with and influencing young people is to take excursions together where they stay over in another town and take part in a programme which is both entertaining and informative.

➟ *Bosnians Against Drugs*
The target group is young people between age fifteen and twenty. The association believes that it is possible to reach and influence young people in other ways than, for example, through parents or the authorities. It also uses popular education, such as conferences, study circles and lectures as a method. Current plans are aimed at organising seven regional conferences. From all of this they plan to put together workbooks, CDs and similar materials. All participants at the conference are invited to check out the association's anti-drug network on the Internet.
By means of these conferences, a number of interested members will be "skimmed off" to receive special training in alcohol and drug issues.

➟ *Kurdish Youth Association*
"Less alcohol – better health" is the heading of the association's project. They are attempting to motivate young people to become involved in meaningful activities while giving young people and parents information on alcohol and drugs. "*Through this project we shall help Kurdish young people deal with their problems and strengthen their social competence in order to reduce their desire for alcohol. – We*

want to influence Kurdish girls to become more independent and make use of their rights in society instead of trying to solve their problems with alcohol and drugs. Through this project we want to achieve these goals:
1. Reduce the drinking of alcohol among Kurdish young people.
2. Form networks between parents and the association."

4.2. General measures

Here we shall look at some types of measures that are not directly related to substance abuse but which are directly aimed at the asylum seekers and that, if applied in the refugee centres, can have a restraining effect on its development against different types of abuse behaviour.

4.2.1. Activity project in Flen
In co-operation with the private company Management Mind UK Ltd (Swedish branch), the Migration Board in Flen has launched a project called "Organising activities for asylum seekers in project form".
Here is a quotation from the project's programme declaration:
"The Board shall offer the asylum seekers organised activity – all asylum seekers who have the opportunity to participate shall do so forty hours per week, i.e. a normal work week. – By organised activity we mean activity which develops the individual and either accelerates integration in society or else eases the return of those persons who do not receive a residence permit."
There is a solid understanding of how important it is for asylum seekers to become active and how little is being done to address this problem. According to a study from the Riksrevisionsverket (Swedish Government Accounting Office, RRV:19), there have been great deficiencies in organised activity. Among other things, the study criticised that the asylum seekers spend too little time in organised activity and that practical activity and work are not practised to the extent that this would be desirable. Particularly activities which can improve the individual asylum seeker's financial situation are important so that the time the asylum seeker spends waiting for a decision can be experienced as meaningful.
In today's situation, organised activity mainly consists of Swedish language instruction which is conducted in groups of around twenty persons for four hours a day. At the refugee centre in Flen, some also perform caretaking activities.
The new project is thus aimed at full activity. There are a number of examples of activities which can be seen as being meaningful. In the budget planning, resources have been distributed to activities in the following main groups:

- Health, with activities aimed at lifestyle, nutrition, personal care and the popular health education which we conduct in Sweden;

- Household skills, with activities aimed at cooking, shopping, handicrafts, home economics, the cost of living, economics;

- Technology, with activities aimed at plumbing, electricity, construction, cars and opportunities to develop one's abilities while participating in activity programmes;

- Information in general, with activities aimed at the gathering and use of information etc.

4.2.2. Educational project in Uppsala
The community of Uppsala has recently initiated a project designed to promote the linguistic competence of immigrants (and to some degree of asylum seekers) in order to ease their integration into society. Their programme states: "The combined language and culture shock affecting many new arri-

vals in one way or another requires conscientious strategies and increased co-operation between Swedish language instruction and labour market-oriented introduction. The working methods and models used so far have not been sufficiently effective in dealing with the needs of individuals and the demands of the labour market. Too many new arrivals have never entered the labour market. New forms of practical training need to be developed in order to open the labour market for newcomers."

5. Closing remarks

As shown by the examples above, our understanding of the situation and needs of asylum seekers and immigrants has increased significantly in recent years. Sweden has taken in a very large group of asylum seekers every year while the nation's economy has lagged. A decisive question is whether these good intentions will remain mere words or else be transformed into actions. But this is not only a question of money. It is also a question of attitudes. Employers and authorities must dare to approach people whose background, language and culture is different from that of ordinary Swedes.

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Guidelines

for Drug Prevention with Asylum Seekers, Refugees and Illegal Migrants

Prologue

Recipe for 'intercultural competence'

Based on the book: 'Multikulturelle systemische Praxis '[1]

You take:

Rp.

3 tablespoons of empathy
2 glasses of fresh sympathy
70 g of affect recognition
5-7 pinches of sensual experience
5 bags of lateral thinking
4 pieces of pickled astuteness
a hint of friendly curiosity (it can be a bit more)
one portion of wisdom
a large dash of forbearance
and of course loads of anamnesis

M. non sterilasa!, cave too much Latin
Dosis as you need - no stereotypes

User Info:
Adding foreign aromatic spices can be beneficial
Reflect on own cultural heritage (e.g. granny's cooking secrets) as flavour corrigent
Use: not superficial, sensitively

(Fikret Çerçi)

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Project Coordinator 'SEARCH' and 'SEARCH II''

1. Preliminary remarks

During the entire project period of 'SEARCH', the globally discussed subject of 'intercultural communication'[2] touched both the conceptual-methodological as well as the practical level of our work. Everybody who has dealt with this subject quickly learns that it is not a simple, straightforward and easily learned concept that, supported by global consensus, can be rapidly implemented in practice, rather that these terms conceal complex cultural and theoretical discussions, ideological conflicts, different approaches and even continent-specific approaches (for example, Europe <-> America). Extensive literature has been published for more than 20 years, practical approaches have been tested worldwide and ideas defined and further developed. –

Interesting and certainly meaningful is the fact that in the field of globally operating industries, internal training of personnel in 'intercultural competence' is these days standard practice and highly developed. Communication in the 'business area' between members of different cultures does not function as a matter of course, and is therefore often the cause and starting point for misunderstandings, cooperation blockages and other factors that can slow down production. For the global player, ethnocentric thinking, beliefs in dominant cultures and inherently racist delusions of superiority are a thing of the past, as is the reduction of encounters and communication to the bare minimum required for a smooth production process. Therefore it is even more astonishing that particularly in European countries that are 'immigration countries'[3], it is expected that practical educational skills must generally be acquired first in the fields of social work and learning (e.g. schools, universities) before communication can be further developed to become 'intercultural'. And hardly has this happened, the practitioner is faced with the obvious quandary: Who uses the wrong or right 'cultural term'? Which ethnocentric and/or culturally dominant thinking structures exist implicitly or explicitly in the respective approaches…? It is precisely the fact that communication between people of different cultural and ethnic origins is so difficult that it makes the discussion as how this can be improved or developed all the more complicated, complex and divergent.

It was not our task to document this discussion – which is even conducted highly differently in the various European countries! – or even add a new approach to the many ones that already exist. Instead, in the bibliography we refer to important publications on the subject of 'intercultural communication' in the field of migrant health (services). If the interested reader enters 'intercultural competence' or an associated term in a search machine on the Internet, he will come up with thousands of hits. This fact alone illustrates that the hidden concepts used when encountering people of different cultures today belong more than ever to the most discussed themes of our time.

The purpose of starting the 'SEARCH II' project was to help practitioners improve the planning of drug prevention projects for our target groups. 'Improve' here means: to provide advice based on our experiences with both the 'SEARCH' and 'SEARCH II' projects for the conceptual and practical planning. Therefore, the reason why we also have to provide several methodological and cultural-theoretical reflections in advance is so as to remain comprehensible at the points where we draw conclusions and offer suggestions.
The aim of our efforts in the 'SEARCH' project was to recognise health risks with specific groups of immigrants better, more comprehensibly and, above all, at an earlier stage, in order to be able to develop suitable prevention and intervention measures. Besides the numerous detailed aspects that will be described later, a prerequisite is that the health care systems in the European target societies become accessible and transparent for migrants, which on the other hand also means that these systems must face up to this task. The restructuring of the social systems in most European countries, which to some

extent entails enormous cutbacks and reductions in care facilities and quality, implies that the humanitarian aspects when ‘improving’ health and social services increasingly take a back seat in favour of ‘cost factors’ which tend to stand in the way of further developing and implementing improvements. This applies even more for out target groups.

On completion of ‘SEARCH’ we also received the response that, in the end, ‘SEARCH’ "did not find out anything new”. We share this criticism. There was nothing new to find out, provided you define ‘new’ as the discovery of previously completely unknown developments. But according to our point of view and experience, there was quite certainly further development at two levels, which should be emphasised:

- *Although ‘intercultural addiction care and drug prevention’ approaches certainly ‘exist’ as theoretical concepts at the European level (via the Internet and at specialist conferences), in the various European countries there are highly differing levels of perception towards these approaches. The contribution that ‘SEARCH’ has made is to introduce these approaches to 12 European regions and to have raised awareness of the problems and methods at the European level.*

- *Our assumption that we would ‘discover’ something completely new in terms of our target groups in the field of ‘culturally sensitive’ drug prevention proved not to be the case. Finally, the concepts of intercultural drug care and drug prevention need to be extended with the element "…for asylum seekers, refugees and illegal migrants…” (see below).*

2. Experiences in 'SEARCH'

As has already been described in Chapter 2, refugees and asylum seekers mostly leave behind all their possessions as well as family and friends. They flee from military conflicts, from persecution, repression, and they seek security, shelter and stable living conditions. Here, any migration, in particular that of refugees and asylum seekers, can be described as traumatic . Although the process of migration itself brings with it an enormous number of different burdens, by no means do most of the people in our target groups find refuge in stable, secure and, at the relationship level, 'benevolent' societies in the target countries.

GRINBERG/GRINBERG (1990), p. 28:

"Migration represents a change of such immensity that the identity becomes not just more distinct but is also endangered. The massive loss affects the most important and valuable objects: people, things, places, language, culture, traditions, climate, sometimes professions, social and economic positions, etc. Memories and intensive emotions are associated with every loss. With the loss of these objects, the relation to them, and sometimes even to yourself, is likewise threatened with being lost."

In contrast to 'economic migrants', they encounter, for example:

- frequently years of uncertainty concerning the status and duration of their residence;
- they are cut off from normal, everyday life in their host countries (e.g. imprisoned and interned, forbidden from working, extremely little financial means, no obligations for their children to attend school);
- they receive very little psychological, medical and social support;
- they are often subject to xenophobic and/or racist discrimination;
- they do not understand the language of the host country and receive little opportunity to learn it.

The 'SEARCH' workers established that asylum seekers and refugees had no experience at all of health organisations (such as drug counselling centres, drug prevention facilities) in their own countries, either because such services do not even exist or because they were part of the repression they experienced (state services as part of the repressive state organisations). It can be easily appreciated that what we take for granted in Western Europe, such as the obligation to maintain confidentiality, discretion, data protection, voluntariness, autonomy, self-determination etc, cannot be conceived of by people who have fled to Europe from dictatorial regimes and might even create more suspicion than trust.

The situation is, of course, even more drastic for people who have entered European countries illegally. They are generally denied access to medical and social services; they live in constant fear of being discovered; they may be able to work but only illegally, and this fact is misused to unscrupulously exploit them; they do not have any rights; in fact they effectively do not exist any more.

According to the project experiences, these are the 'basic factors' on which all other processes of communication are built. They clearly distinguish the living and day-to-day experiences of our target groups from those of economic migrants and other immigrants: An Indian computer specialist who is brought to Europe by a leading German software company for a top salary will live in a completely different situation than people from our target groups. Although he will also experience discrimination (for

example, because of his skin colour), he will be spared the fundamental marginalisation, discrimination and migration trauma experienced by the target groups.

These differences may not always be so significant in terms of the basic communication with these groups. They show, however, that concepts that, for example, have been collected and discussed on the basis of prevention experiences with economic migrants in European countries can only be transferred to a limited extent to the target group of the 'SEARCH' project[4]. For example, the removal of barriers to the various psychosocial care services will have to be organised differently in terms of

- the institutions (legal regulations which will have to be changed)
- the access to the target groups
- the transparency of the corresponding services

This in turn raises the complex issue of behaviour and relation-oriented drug prevention. After the 'SEARCH' experience, it will remain illusionary to believe that people living under the circumstances described can be permanently protected from addiction risks (and other health risks) just at the level of behaviour and relation-based drug prevention.

The comprehensive psychosocial health that the WHO describes in its pioneering basic definition of health[5] is aimed in the broadest sense at 'health promotion'. With this in view, D. DOMENIG rightly comments:

"As well as integration measures to enable migrants to fully participate in all social areas [...], health promotion for migrants should also be aimed at adapting and developing the health care services for the needs of migrants while taking concrete measures to remove existing barriers that, in particular, prevent migrants from making appropriate use of psychosocial facilities. As well as measures at the institutional level, this also requires an increase in the transcultural competence of practitioners in the health sector."[6]

3. Methodological Guidelines

3.1. „Starting with yourself“

1.

An excellent competence concerned with 'intercultural competence' is the ability to communicate with members of other cultures in such a way that mutual understanding is achieved that provides the basis for all other interactions.

"Intercultural competence is the ability to communicate suitably and successfully in an alien cultural environment or with other cultures“ (HINZ-ROMMEL 1994, p. 20)

Disruptions to this communication generally occur through deviating ideas and role expectations, values and standards, linguistic rules, i.e. when there are different situation definitions.
Here, differences at the content or subject level are less fraught with consequences; they can be successfully explained and solved – with the limitations that we already described in the introductory chapter. Much more important are differences at the relation level.

2.

The necessary prerequisite for any kind of open intercultural encounter is mutual cultural sensibilisation, whereby it is to be assumed that, in this process, your own culture and cultural experience initially form the starting point for the intercultural learning. Ethnocentricity that implies belonging to the superior culture, xenophobic attitudes and projective attributions in your own culture, etc, should also be starting points for the learning process.

3.

Cultural sensitisation enables you to culturally analyse. The cultural-analytical abilities create an interpretation framework for understanding the reasons for your own culturally determined actions and those of members of other cultures.
Reflecting on your own culture – the rituals, habits, perceptions, but also the attributions and images – forms part of the complex task of intercultural learning. Reflecting on the culture of the opposite person seems at first much easier because you reflect, i.e. project, their culture in the (unspoken) images of your own culture. Intercultural competence always develops through the interaction between self-reflection and reflecting upon others. Here it should be noted that superficial knowledge of your own culture inevitably leads to superficial reflection upon others.

4.

According to the experience had in the 'SEARCH' project, this first step often fails to occur even where the 'desire to help' and the good intentions are undoubted. At least in the area of therapeutic work, however, it has long been known that in order to deal with (the problems of) others, you must first of all come to terms with yourself.

Therefore, in the following chapter we will deal with several aspects concerned with organising intercultural learning.

3.2. Various dimensions

There are various dimensions of intercultural *communication* that need to be distinguished[7]:

• ***The power dimension***
Migrants in general, but particularly the target groups in the 'SEARCH' project, are subjectively and objectively 'right at the bottom' of the 'power scale' of the host country. This is expressed in the actual availability of influencing and involvement instruments, but also in the subjective perception of situations. Here, individual life experiences of helplessness play a role, such as experiencing the host culture as inscrutable and frequently not acceptable (but nevertheless not changeable). Frequently, people from our target groups find themselves as petitioners, their possibilities for influencing their living situation being minimum.
Besides the different availability of resources and possibilities to exert influence, an important role is played by the unequal power distribution in the area of discursive power (the ability to define which themes are, or are not, relevant, through the context of the encounter and the linguistic dominance)[8].

• ***Mutual perceptions***
We have already mentioned in the introductory chapter of this collection of material that there are no 'simple' levels of encounter between members of different cultures; rather there are only ever ones that are reinterpreted and projected through the life experiences of the actors. In the project, we have been able to ascertain a specific dimension (initially at the level of self-reflection!): the (mutual) perceptions that (help to) determine the encounter. For instance in Germany this can be ascertained in the discussion on characteristic attributions, e.g. 'the Poles'. However, there are examples of this in many other countries (e.g. the use of 'gypsies' in Italy, Spain and Portugal when what is meant are the Sinti and Roma; 'the Africans', etc). The migrants whom we encountered also have specific perceptions of people in the host countries that have been created on the basis of pre-conceived images and not (necessarily) through concrete empirical perceptions.

In the encounter situations, these mutual perceptions create a certain meta-level that strongly influences the relation level, although we were unable to examine this in more detail.

• ***The cultural dimension***
All the perceptions already described in the intercultural encounter are based against the background of different enculturations and on the patterns of thinking, feeling and action acquired in this process.

3.3. What are the 'cultural differences'?[9]

'Perception'
Perceptions are very much characterised by the importance of the objects for the perceiving person. However, it is precisely this perception that varies from culture to culture (symbols, concepts, physical contact, hygiene, even colours and smells....) Even the term 'health' is in itself a conceptual term that conceals very different ideas about life in general, its risks and how to deal with them. In our culture, health is increasingly defined as an active part of every individual's life-style, whereas in other cultures health is regarded as a destiny that can hardly be influenced by the individual.

'Concept of time'
In intercultural encounters, problems and misunderstandings can occur owing to differing concepts of time (past- vs. future-oriented culture, conflictive points such as punctuality, etc.)

'Concept of space'
Problems might occur when people with differing concepts of space and ways of dealing with space meet ('private sphere', 'closeness vs. distance' in direct contact, 'distance due to respect' etc.). When should you shake hands when greeting somebody? When shouldn't you? Can role games be produced interculturally or must the special characteristics of culturally determined space concepts be taken into consideration?

'Thinking'
It's easy to 'think' that our form of thinking is the only possible one. This is a supposition. If you look more closely, there are very different forms of thinking in the various cultures of the world: Abstract – concrete thinking, inductive – deductive thinking, rational – religious thinking, thinking in complex cognitive concepts or in affectively anchored perceptions, etc.

'Language communication'
Generally speaking, the main problem for a migrant living in an alien environment is understanding and communicating. Language expresses more than the pure lexical 'supra-culturally' defined meaning of the word (owing to differing systems of concepts and meanings). Each linguistic usage reflects the speaker's 'connotative' environment (emotions, association, values etc.), which, similar to perception, bestows even apparently 'intercultural' concepts with highly different culturally bound meanings.

'Non-verbal communication'
Certain non-verbal expressions that have a certain meaning in our culture (laughing, crying, silence, talking, etc.) may have a completely different meaning in another culture. Gestures, actions and corresponding demands may not only lead to misunderstandings but provide the spark that leads to rejection, insecurity and disagreements.

'Values'
Values that are taken for granted in our culture (diligence, ambition, punctuality, time, importance of faith/religion, orientation toward the future etc.) may have a differing or even contradictory meaning in other cultures. This is of special importance for the preventive messages: such concepts as health, risks, responsibility for oneself, self-reflection should be assessed for the preventive context.

'Behavioural patterns'
The considerable differences between the behavioural patterns (customs, allocation of roles, rites, etc.) of different cultures increase the readiness for misunderstandings, reservations, distancing and prejudices on both sides (while incidentally also providing an important basis for xenophobic attitudes). In the preventive context, migrants might perceive group sessions, for example, as threatening, ridiculous or challenging – attitudes that, on the other hand, might be treated with lack of understanding or anger from 'our cultural side'...

'Social relations'
Each culture has its own specific form of organisation for social relations. Intercultural encounters bear risks such as projective attribution in the context of 'interpersonal attribution' – which means that alleged or presumed characteristics of the interlocutor easily might turn into 'facts' by losing their projective character and obtaining normative force[10]. In this context, the allocation of certain prestige values to certain roles (e.g. gender), professions and formal hierarchies may also play a major role.
In the drug prevention context, this might lead to (unexpected) implications (role of men/women, professions, appearances, hierarchical organisation, etc.)

Language barriers play an important role in the work with the 'SEARCH' target groups. It is precisely these target groups that mostly have insufficient knowledge of the host country's language[11]. Especially in prevention work, which of course is based not just on the cognitive level of knowledge and learning but is also strongly embedded at the affective level, the lack of adequate linguistic communication is a particular hindrance. Although in other migration-specific contexts interculturally trained interpreters provide a decisive bridge to improved understanding , according to the 'SEARCH' experience, interpreters here are of limited help. With the exception of linguistic/cultural problems, affective-based learning processes cannot be 'interpreted'.

The 'SEARCH' concept has shown that it is essential to focus on key persons. These should originate from the homelands of the target groups ('peers'), speak the language of the target group and be able to understand the native culture of the target group so well that they are able to interpret not just at the level of the immediate language but at the level of cultural mediation[12].

The use of 'foreigners' in addiction work, which is being increasingly demanded in several countries, is according to our experience of little use in such abstract terms. For instance, an Italian social worker in Germany will not necessarily be able to work, for example, with Iranian asylum seekers in a way that is any more culturally sensitive than Austrian colleagues. This already indicates that, in the field of intercultural drug prevention, there is an urgent necessity to develop other forms of cooperation that will be new in many European countries. This will be looked at in more detail in the next chapter.

In view of what has been described, 'culturally sensitive' drug prevention work is not only a moral requirement but also a necessity to ensure not just abstract 'broadcasting' but also the 'reception'. However, in many areas of current drug prevention this predict in turn means that the methods used must also be based on the native culture of the target groups, not on 'professional standards'.

> *Using, for example, the salutogenic concept developed by Aaron Antonovsky as a basis is only then helpful if this concept can be translated in terms of the reception possibilities of the target groups' native cultures. The idea that concepts should not be based on what makes us ill but on what keeps us healthy presupposes – nolens volens – traditions and orientations of thought that will at best lead to misunderstanding with, for example, asylum seekers from Eritrea or Liberia[13].*

On the other hand, 'culturally sensitive prevention', with all its described implications of tolerance and respect for being different, does not mean levelling out the cultural differences or even adopting the alien culture. This applies, however, for both communication directions (although in many European countries it is one-sidedly directed at migrants as an imperative of integration).

4. Practical Guidelines

4.1. Developing competence

Finally, special competences must be developed in every area of social and health-oriented work. An essential prerequisite for this is acquiring knowledge about the target groups, their behaviour patterns, their social and cultural background, their previous and present living situation, etc. In this context the RAR proved itself in practice. (We would also like to just point out here that we have also produced a guideline/manual that was supplemented in 'SEARCH II' with the monitoring module).

However, the RAR only records data and material and specific indications for the practical implementation; it is no replacement for acquiring specific implementation competence. The following levels of competence must be differentiated (and acquired):

• ***Self-competence***

As has already been mentioned, most important is the ability to recognise your own cultural standards, values, perceptions of people and their cultural-historical relativity. As this is an extraordinary complex ability (cultural and sub-cultural analysis!), it is absolutely essential to complete a corresponding self-reflective curriculum before being able to take the following competence (and communications) steps.

• ***Factual competence***

According to our experience, any form of drug prevention work with our target groups requires knowledge: about your own cultural relatedness, the manifestation forms and the communication structures of your own cultures and those of the target groups(s).

• ***Social competence***

First and foremost it should be mentioned here that basic empathy for the people from the target group is a prerequisite for any further (preventive) work. This also includes the ability to develop discursive competence, i.e. the ability to so develop contact and communication that no other (additional) barriers are created, with the communication being conducted in a 'culturally adequate' fashion. This is particularly difficult when fundamental differences in the perception and assessment of specific values collide with one another.

> *Example: The events of 11 September 2002 in the USA have further exacerbated communication with people from Islamic countries. Workers from the 'SEARCH' project report that the encounters on both sides have become more antagonist and fundamental, and it was sometimes difficult to even begin communicating because both sides had to overcome fixed preconceptions of one another ("Islamic people have no respect for human right" vs. "Western and Christian people think and behave in a colonialist fashion towards Islamic countries and people"). It requires social competence to re-establish respectful and emphatic communication.*

• ***Action competence***

Action competence results from developing the previous competence steps. Here, the knowledge and ability to analyse both your own and the alien culture is implemented in practical steps; it is also concerned, however, with shaping the contact and communication.

4.2. Example: *When designing an educational flyer on the risks of specific substances that, according to our RAR results, were predominantly used in the target group, we initially approached this with lots of commitment but rather voluntaristically due to a lack of experience (direct transfer of the contents of a domestic flyer for the target group, literal translation).*

The following steps were taken:

1. *Production of a basic layout for the flyer;*

2. *Failure with the target group (no interest, lack of understanding, criticism);*

3. *Feedback from persons from the group who had already been in the host country for a long time (key persons: development from their own target culture), 'culturally adequate' correction of the contents based on the background and culture of the target group: language, connective associations of the terms, checking the images and symbols (including online);*

4. *Culturally adequate new version of the educational brochure, publication, distribution and monitoring of the results in communication with the mentioned key persons.*

➠ *Cf. illustration on page 196*

4.3. 'Intercultural competence' curriculum[14]

• Step 1: 'Cultural sensitisation'
It has proven worthwhile to use game-like simulations on the central themes as a didactic means for achieving the initial sensitisation. There is material available in almost all the countries (e.g. for role games and plays) that are aimed less at the rational-cognitive knowledge processes than at the affective, emotional ones.

• Step 2: 'Methods for cultural analysis'
Here, methods for cultural analysis are applied that initially also use game-like and affective-oriented forms of intercultural concepts based on 'misunderstandings' that can arise from not knowing 'what is actually the cultural difference' . Our experience is that humour can be successfully used to portray the typical intercultural encounters that everyone knows. It is not only necessary to actuate the abstract terms but to reflect on your own, possibly still subconscious experiences: It is first the integration of experiences that leads to understanding.

• Step 3: 'Starting point: your own culture'
As has been mentioned several times already, this should be followed by a phase of analysing your own culture to prevent there being an ethnocentric bias to intercultural encounters[15]. Here, learning forms and contents mix that tend to be affectively and cognitively-oriented. We assume that insufficient knowledge of your own culture (and of your own culturally-determined understanding and behaviour) will inevitably lead to only a superficial understanding of the target culture.

• Step 4: 'Analysis of the target culture'
Once you have examined your own culture you can begin to analyse the target culture. This includes examining evidence of this culture as well as the observer's pre-conceived images. It is precisely this latter level that complicates the analysis: the colourful variety of a target culture is soon reduced to con-

ceptions about it. We experience a particularly graphic example of this when studying Islamic target cultures: thanks to their portrayal in the mass media, in Western Europe it is practically impossible to develop an image of Islamic societies and cultures that is not influenced by images of terror and suicide attacks on the one hand and headscarves and burkas on the other. Ultimately, however, it's not about examining the political values of the target culture but about understanding it as a way of finding a starting point for drug prevention. According to our experience, these two levels are frequently confused: this results in (mutual!) projections of specific attributions that hinder open communication.

• Step 5: 'Checking'

Here, it's essential to implement the acquired knowledge and experience and to test it in contact with the target culture and, if need be, change it. It's essential to check your own knowledge in practical contact with the people of the target culture and to combat the stereotyping of perceptions.

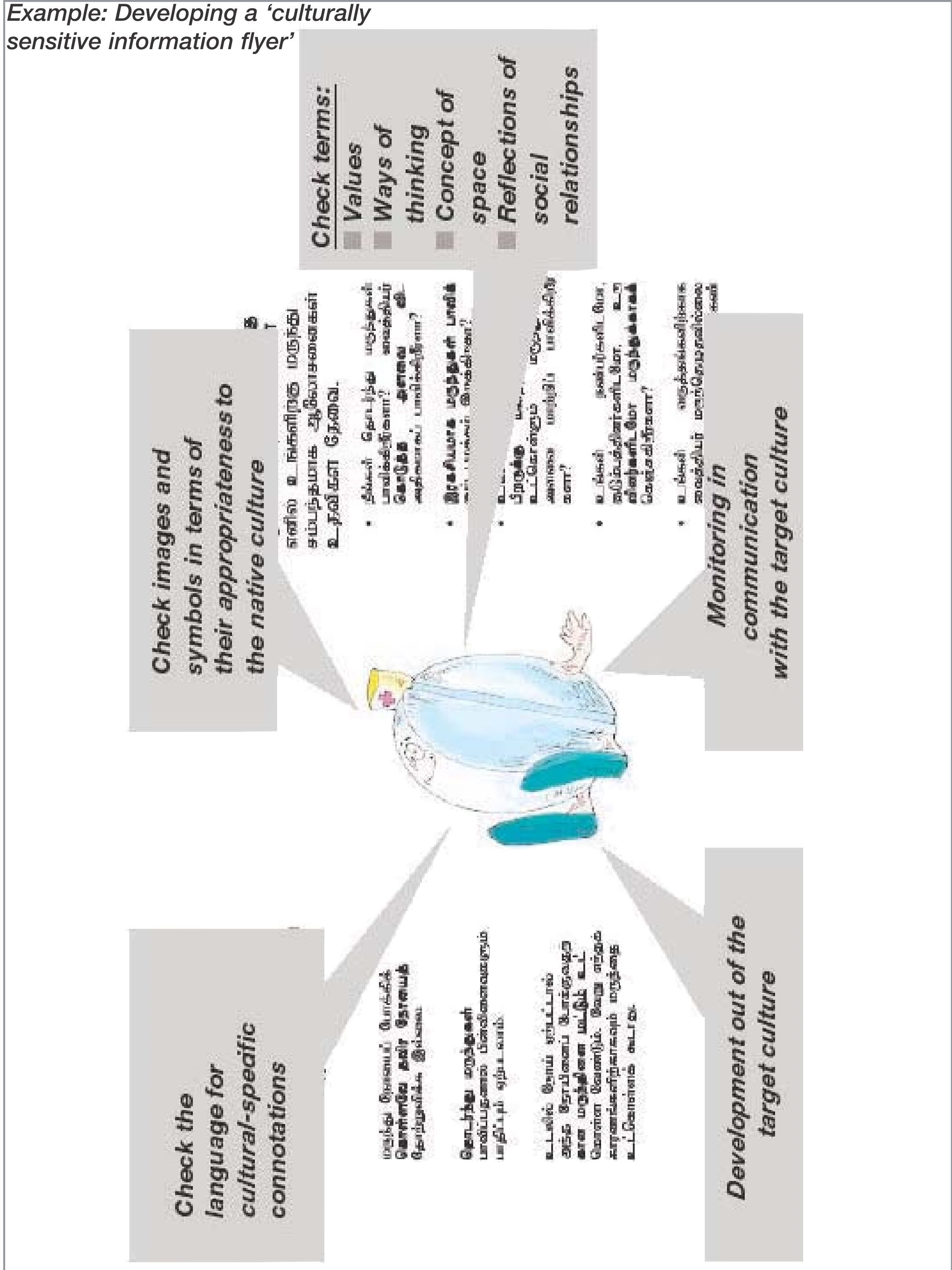
An important experience here was that the experience of alienation varied considerably from group to group. 'SEARCH' was a project from practitioners for practitioners, it was not a scientific project. Whereas one group (e.g. in contact with people form the Balkan States) ascertained that "the cultural differences are not so great" and that it is "only the risky use of alcohol, which is apparently not viewed at all critically by these people," which differentiates them from the standards of the host country, others found the contact to non-European asylum seeker groups to be ultimately completely incomprehensible; they complained that they were unable, or hardly able, to build up contact.
Our experience has shown that, in the end, even your own 'trained' interpretation and comprehension processes reach their limits. It is important to be aware of this, particularly in view of an 'information society' that gives the impression that everything is understandable and comprehensible as long as you have sufficient information. Our experience in the 'SEARCH' project, on the other hand, clearly shows that in intercultural contact with foreigners, many cognitive things are actually comprehensible but that this understanding reaches its limits precisely at the level of affective-controlled processes.

When looking back at the three years of the project work, such difficulties are typical for intercultural health work. Incidentally, they once highlight the fact that the groups must be encouraged to be active on their own part, even though at the same time it cannot be denied that this is extremely difficult precisely for our target groups.

- *The living conditions in the host countries often do not allow for any free organisation of their own interests,*
- *Self-organisation presupposes good knowledge of the cultural, social and political conditions of the host country.*

Those acting with intercultural competence should avoid negatively assessing differences, respect the target culture and have lots of empathy and tolerance. It is essential to include people from the target culture. However, whether and in which form 'peer education' concepts can form the basis of the work in turn depends on the target cultures: This approach is also influenced by central European culture!

Example: Developing a 'culturally sensitive information flyer'



Flyer from the 'SEARCH' phase: For Tamil asylum seekers

4.4. What constitutes 'INTERCULTURAL COMPETENCE'?

Summary

The quotation at the beginning of this chapter described what constitutes 'intercultural competence':

- ***Empathy.*** People who see the migration of people from 'alien' cultures as a threat to their own culture ("downfall of the Occident...") may have plausible arguments for their view but they're very unlikely to have intercultural competence!

- ***Sympathy.*** Behind every flight, behind every asylum application is a dramatic, often tragic story. That calls for our sympathy!

- ***Recognition of emotions***. Much of the communication with foreigners happens at the level of emotions and perceptions. Our 'intellectualised' Western European society tries often enough to 'rationalise' this dimension, these roots of our actions and feelings: This is something typical only to us!

- ***Sensual experience.*** This means not just relying – as already has been mentioned – on the rational dimension when encountering strangeness but including the sensual dimension – an encounter with all senses.

- ***Lateral thinking.*** This is often difficult in societies that would so very much like to prescribe their views and thoughts.

- ***Astuteness.*** Without doubt this belongs to the basic necessities of intercultural communication: recognition, interpretation and understanding are prerequisites for astuteness!

- ***Curiosity.*** Without this nobody will find meeting people from other cultures interesting, exciting and enriching.

- ***Wisdom.*** This confronts the short-lived clichés of the present time with historically developed culture.

- ***Forbearance.*** This is no less important than wisdom because it allows you to put up with much and recognise it for what it is.

- ***Anamnesis.*** Behind each flight, behind each migration there is a story that one must know in order to be able to understand.

- ***Stereotypes.*** These prevent us from seeing (and encountering) the real people, so that we only see the images that we make of them.

4.5. Several methodological and organisational aspects of drug prevention: One size fits all?...

In most European countries, the following **methods** are used in the field of drug prevention:

- *Peer education*
- *Life skills training*: Includes approaches such as conflict management, violence de-escalation, social orientation, frustration and ambiguity tolerance, etc and the differentiation between affective and cognitive-oriented approaches. A specific sub-form is
- *Risk competence orientation* ("autonomous dealing of subjects on the basis of trained risk competence").
- *Fear appeal techniques* ("establishing knowledge of harmful effects in the affective area").
- The following always applies: most European countries have no "state-prescribed rules, structures and contents for drug prevention". Accordingly, each individual support body chooses the method of approach that is preferred by their workers.

One methodical basis that can be taken as certain is that with all the specific methods, the communication cycle takes place between the cognitive dimension ('knowledge') and the affective dimension ('attitudes') in each specific learning and training technique (combination of knowledge and attitudes in concrete drug prevention action).

At the **organisational** level in Europe this results in a colourful variety of different alternatives:

- Drug prevention in networks as a task of specific, independent specialist institutions or as part of addiction care organisations (but also connected to youth services and companies).
- Drug prevention as a voluntary activity is the exception (e.g. parents' self-help groups); it is mostly professionals who take on the responsibility for the tasks.
- Monitoring and, in particular, the evaluation of the results of drug prevention activities is rarely included in the standards. In recent years the EMCDDA has produced several publications on the theme 'evaluation in the field of drug prevention'[16] and, with reference to the whole of Europe, has ascertained that the specific evaluation of results and effectiveness is still very much in the early stages of development.
- 'Evidence-based drug prevention' (analogue to evidence-based medicine) is seen in some countries as a future area of drug prevention. However, because there is no central collection and evaluation of suitable methods (see previous point), this still remains a theoretical discussion at the moment.

For the drug prevention work with our target groups, however, there is also no 1:1 transfer of drug prevention approaches. Whereas in central Europe, for example, 'fear appeal' approaches are no longer considered as lege artis, they can still be highly effective with some asylum seekers and refugee groups. A second dimension is also decisive here (which in Europe tends to be forgotten): namely who is to convey the drug prevention messages and not just how they are to be conveyed.

Example: People from countries/cultures with highly defined prestige hierarchies are more likely to accept preventive messages from people whose occupations are regarded with high esteem in the country of origin (e.g. doctors) than from social workers (and vice versa).This also applies to peers. Peers cannot and are not allowed to accept any "You should not..." messages without losing face; a clear hierarchy (knowledge, role, social position etc) must exist in the contact. Group work is in many cultures a completely unusual environment for such 'message-filled' encounters, especially when the hierarchy in these groups does not correspond to their own norm and values structure.
People from other cultures, however, can react very differently with the examples described: they would consider messages from their 'superiors' as being somewhat humiliating, or at least very didactic, whereas they would be approachable at the level of their peers.

These examples have shown us that the previously described cultural analysis is an indispensable prerequisite for choosing a method or methods in prevention work. Caution and culturally sensitive tact are also necessary at the level of the organisations that offer drug prevention. If the context of the drug prevention action is felt to be potentially dangerous[17], the methodical considerations should take second place!

A further comment needs to be made in view of the frequently dramatic and traumatic reasons for fleeing: the massive disorganisation of the personality caused by the processes leading to fleeing, or the flight itself, generate mental and/or physical disorders that are expressed in diverse symptoms, including drug use and drug addiction. Although our experience has shown that (psychotherapeutic and other supporting) measures for trauma work should belong as a matter of course to the canon of drug prevention services, they are in fact only implemented in some countries and, even here, it is often only NGOs that take on this responsibility. There is knowledge of the dramatic traumata that persons experience before, during and after the flight, and about the treatment methods, but there is often a lack of resources and political will to let them lead to action and services[18].

5. Organising the practical process

5.1. Preliminary remarks

We are presupposing with the further comments that, at the local authority level, two essential factors exist or can be attained:
- Interest of those politically responsible in improving the health care of refugees, asylum seekers and, if need be, illegal migrants, and thus also providing the
- means and resources to take the necessary steps for this.

It seems to us that in most European countries neither factor is automatically given in the current development of social systems. In this respect our 'SEARCH' project was 'privileged' to have been given EU funding. However, at many of the locations where the 'SEARCH' project was run, the evaluation of the results and the further planning were being directly fed into work to convince political bodies.

5.2. 'Knowledge'

We have already explained that acquiring knowledge on the target groups belongs to one of the indispensable prerequisites for the project work. Conducting an RAR seems to us to be a particularly suitable method in terms of the costs/expenditure<->related benefits for collecting comprehensive data on the target group(s) while at the same time monitoring and assessing the process, making corrections and re-evaluating the results.

The first step is to collect information on the ethnic background of the target groups (Internet, publications, newspaper reports, etc) and establish contacts on location (key persons, if necessary from the target community).

Mapping the available information enables a 'knowledge landscape' to be developed while making the knowledge acquisition reproducible.

5.3. 'Access'

According to our experience, it is essential to develop a 'competence pool' of people from the target group (e.g. recognised asylum seekers from the target group).

'Multiple access' to the target groups is achieved through regional migration organisations (professional and voluntary), self-organisation of the target group(s), drug care organisations and health services – but also through diverse individuals.

The part played by interpreters must also be mentioned here: Interpreters must also be 'interculturally trained'; they must be able to reflect on the social-cultural dependence of their own values as well as those of the target groups.

5.4. 'Action'

According to our experience, drug prevention action for our target groups can be best conducted by including key persons[19]. In ideal cases these are accepted persons from the target group who enjoy

respect and acceptance[20]. They have a common basis with the persons in the target groups and can achieve a 'we-feeling' much more honestly and convincingly. At the same time they provide a bridge to the world of the host country and can explain the structures while appearing credible ('cultural mediators'). This concept of culture mediators has already been developed in some countries and is successfully practised in all possible aspects requiring mediation between migrants groups and the persons and institutions of the host country.

A culturally sensitive selection of the means and media used is a further prerequisite for acceptance. The use of media "must be so designed [...] that it ensures acceptance in terms of the media content (i.e. of the symbol system)."[21]

The drug prevention methods implemented must likewise be checked to see whether they tend to encourage or hinder the process (cf. previous chapter).

5.5. 'Sustainability'

The project experience has shown that it is only possible to develop drug prevention care for the target groups if it is conceived on a long-term and sustainable basis. In most cases, it was possible to incorporate the project activities into existing migration and health-specific networks; in many other cases, however, such networks or working alliances developed out of the focus groups for the RAR processes. To keep such alliances permanently active, requires institutional responsibility: An institution must be permanently responsible for this task. It is not possible here to give any advice that is applicable throughout Europe; the organisation of care from country to country is too different. However, it can generally be said that: drug prevention for refugees, asylum seekers and illegal migrants is a sub-theme of general health-oriented migration work. Accordingly, migration and drug work organisations and their networks provide the suitable starting points for sustainable organisation of the 'SEARCH' project aims.

5.6. 'Monitoring'

The project target groups are frequently subject to change.

- This became clear, for example, in the civil war situation in the former Yugoslavia: There was an enormous influx of refugees in almost all European countries. After peace returned to the area, most people returned home very quickly.
- Changes in the national immigration policy change access routes for the target groups; the care landscape changes completely, etc.
- But it is also possible for considerable changes to occur within the target groups (other religious and/ or ethnic composition from the same country of origin, changes in the risk behaviour in terms of drugs, etc).

After the successful testing of the RAR methods during the first project phase, in 'SEARCH II' the RAR-based monitoring was implemented, which was in the position to quickly and reliably record changes in the target group and to evaluate the results from the first project phase.

The inclusion of 'evaluative loops' belongs as a matter of course to the research-based advancement of the drug prevention work for our target groups.

5.7. 'Political sphere'

Under 'Sustainability', we have already mentioned the necessity of firmly establishing the work approaches described here on permanent basis, initially at the professional level. However, this presupposes that there is a political will – a political mandate for this work, since without this no (additional) resources will become available. We are convinced that the European societies that have committed themselves to upholding human rights, the Geneva Convention and Christian and socialist principles are called upon to provide the means and interest in order to provide comprehensive health care for people who arrive within their borders and regions. We learned during the period of the project that many national laws effectively bar our target groups from gaining access to (better) public health care (e.g. to the addiction care system and addiction therapy in Germany). In many countries in Europe, health care for people without secured residence status is largely dependent on private charitable initiatives; frequently, addiction illness among asylum seekers is seen as a hurdle in recognising their asylum applications or at least is treated as such.

Factors that hinder use of existing drug prevention and addiction care services for migrants:

- *"Communication difficulties of a linguistic and cultural kind in contact with addiction professionals;*
- *Hardly any awareness of a problem in terms of using drugs [...];*
- *Insufficient knowledge of the available drug care services;*
- *Lack of services with native speakers, bilingual and culture-specific counselling and therapy;*
- *Mistrust towards [...] institutions and authorities [of the host country – ed.];*
- *Fear of legal consequences for their right to stay leads them to take refuge in anonymity;*
- *Taboos in relation to the drug problem and the desire to maintain individual cultural values."*

(R. SALMAN, J. COLLATZ, Interkulturelle Suchtprävention und Beratung – Qualifizierung von "Keypersons" und Aufklärungsveranstaltungen, in: SALMAN/TUNA/LESSING 1999, p.129)

At the same time, in many European countries asylum seekers live under degrading conditions, sometimes in prison-like accommodation; they often don't have the right to move around freely, to cultivate contact with people from the host country, to work, or to send their children to school. They only have minimal financial resources; they are branded as scapegoats for the increasing difficulties faced by the health and social services in many countries, which in turn encourages or even provokes segregation and stigmatisation as well as leads to xenophobic-based isolation and discrimination. These living conditions create fear and insecurity, and are risk factors for developing addiction.

As we have already emphasised, at this point the project work leaves the field of behaviour-based drug prevention to become relation-based drug prevention. Organisations and supporting bodies for projects that also intend to implement drug prevention for the target groups described here must also be politically active, and form a kind lobby to instruct and inform on behalf of those affected.

Annotations

1. Changed by Dr. med. Fikret Çerçi, Detmold, after:
   Arist von Schlippe, Mohammed El Hachimi, Gesa Jürgens, Multikulturelle systemische Praxis, Ein Reiseführer für Beratung, Therapie und Supervision, Carl-Auer-Systeme Verlag, Heidelberg, p. 18.
2. Some authors prefer the concept 'transcultural competence'. This has effectively the same meaning, but we prefer the term 'intercultural competence' because it is more widely used in Europe.
3. This term refers to the de facto reality of immigration, not to how countries perceive themselves at the political and constitutional level.
4. cf. D. DOMENIG (1990)
5. WHO: Ottawa Charta 1986
6. D. DOMENIG, ebenda, p. 13
7. Cf. Georg AUERNHEIMER, Interkulturelle Kompetenz - ein neues Element pädagogischer Professionalität? Essay. University of Cologne 2002, Internet-Download
8. Cf. on the concept of 'dominance culture': Birgit ROMMELSPACHER: Dominanzkultur. Texte zur Fremdheit. Berlin 1995.
9. The following arguments are closely based on: G. MALETZKE, Interkulturelle Kommunikation, Westdeutscher Verlag Opladen 1996. This text provided in many ways a guideline for our discussion.
10. For example, on the occasion of a training seminar on 'migration and addiction' within the context of in-patient rehabilitation in Germany, a speaker commented: "In the public debate in Germany, addicted migrants from the former CIS states are quickly labelled as dealers with highly criminal tendencies, etc. When these people get together in therapeutic facilities and then speak only Russian or Polish, even experienced therapists are not free from imputing, which is purely projective, that the next crimes and drug deals are being planned... "
11. In some countries such as, for example, the Netherlands, new political concepts for asylum seekers are no longer aimed at easing the acquisition of language skills but, on the contrary, are designed to hinder this until the residence status has been definitively determined. These processes can last for years.
12. Therefore, 'cultural mediators' play a decisive role in most of the project locations.
13. Whereby there is no shortage of critics in Europe who criticise that the development of themes, methods, content and formulations concerning 'professional drug prevention' is oriented to typically educated middle-class people: this drug prevention is alien and incomprehensible for entire sections of domestic society.
14. We are aware that we are arguing here in very 'idealistic' terms; in reality, implementing drug prevention with our target groups would certainly in many ways be much more complicated and complex. Nevertheless, the rather 'abstract' description seems to us to be suitable for stating a basic view that can then be varied more specifically.
15. In the literature, the 'ethnocentric starting point' for intercultural encounters is depicted as normal and natural. What's important is to develop it until it opens up interculturally.
16. EMCDDA (Hg. 1998a, 1998b)
17. We must remember that it is precisely refugees and asylum seekers who are often fleeing from countries where there are no independent health organisations that are not state controlled and censured. They will instinctively react with suspicion to the comparable institutions of the host country.
18. Cf. for example, C. KRUSE, Sozialarbeit und Sozialtherapie mit traumatisierten Flüchtlingen, in: A. BIRCKI, Ch. PROSS, J. LANSEN (Ed. 2002), p.79 - 95
19. Cf. S. TUNA: Konzept, Methoden und Strategien migrationsspezifischer Suchtpräventionsarbeit, in: Ramazan SALMAN, Soner TUNA, Alfred LESSING (Ed. 1999), p. 104 ff
20. However, these key persons must be trained in intercultural competence!
21. S. TUNA, ebenda, p. 121

6. Literature

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