

'SEARCH' in The Netherlands

Drug Prevention for Juveniles Inside and Outside of Asylum Centres

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1 Introduction

As with other European countries, a large number of refugees and asylum seekers live in the Netherlands. It can be assumed that the use of drugs (including the use of alcohol, medication and, possibly, problematic gambling) can be included amongst the health problems of refugees and asylum seekers. Some have been using drugs before they came to Europe, others starting using them during their stay in the asylum centres. TACTUS has observed that, although there has been considerable discussion about drug use amongst refugees and asylum seekers, and about health care in general, few substantial measures have been taken.

We have to assume that in several cases, perhaps even in most of them, the traumatic experiences of the refugees and asylum seekers is the cause for problematic substance use. We have not gained the impression until now that the refugees and asylum seekers are receiving help in dealing with these experiences. Without comprehensive research all current opinions can only be assumptions, but assumptions which are of immediate relevance.

If we assume that the preceding thesis is true, then these problems will continue to grow in the future. This is not only because new refugees and asylum seekers will continue to come to the Netherlands, but more importantly because we have to assume that unless there is proper care, in many cases psychological trauma will only begin to manifest itself after twenty or thirty years.

Until our society starts investing in these matters, many refugees and asylum seekers will try to find their own solutions. The use of psychotropic substances will be a part of that solution. If this kind of solution has no negative side effects, this will present no problem, but the use of alcohol, medication, illicit drugs or gambling as an escape will in many cases lead to problematic use or addiction. Therefore it is necessary that addiction care develops effective prevention measures. It is for this reason that TACTUS took part in the European project 'SEARCH'.

2. Structural aspects

2.1. TACTUS

TACTUS, the Institute for Addiction Care, is a foundation for outpatient and clinical treatment, counselling, care and protection. These services are offered to clients who, through the use of addictive drugs, are in danger, or run the risk of getting into danger. TACTUS is active in the eastern part of the Netherlands.

The aims of TACTUS are:

1. Promoting health care in general and addiction care in particular
2. Offering integrated care
3. Offering prevention measures
4. Providing probation and after-care services.

2.2 Target Groups

In an effort to concentrate our efforts within the framework of the 'SEARCH' project, we focussed on juvenile asylum seekers, and within that group 1) on single juvenile asylum seekers without family (in Dutch: AMAs) and 2) on juvenile asylum seekers with family.

Most of the refugees and asylum seekers are accommodated in asylum centres. In the vicinity of Enschede there is such a centre which provides care for 400 refugees and asylum seekers. Of these,

100 are AMAs, and amongst the rest are a large number of juveniles with family. Most of our interviews were conducted there. In the Netherlands an artificial line is drawn within the group of single juvenile asylum seekers. A single juvenile asylum seeker who is younger than the age of 17 is a so-called AMA, and normally he or she lives in an asylum centre. The moment an AMA reaches the age of 18 he or she is no longer an AMA and he/she is expected to leave the asylum centre. A juvenile leaving the centre goes to one of the small housing units and from that moment he/she comes under the auspices of youth care. At a certain point they leave youth care and live independently. Juveniles with family stay with their parents until the moment they leave the centre and family and live independently.

Summarising, our target groups are:

- 1) Single juvenile asylum seekers less than 18 years old. They live in asylum centres.
- 2) Former juvenile asylum seekers between the ages of 18 and 25/26. They live in small housing units or independently. The difference between target group 1 and 2 is artificial. It is just a case of age.
- 3) Juveniles and youths with family. Most of the time they live in asylum centres.

Our target groups can be found in two communities. Inside asylum centres and outside.

They mostly come from African countries such as Guinea, Somalia, Sierra Leone, Sudan, Angola and the Congo. A small minority come from China. In most cases the parents and family were killed in civil wars or the juveniles were separated from parents and family and have not yet been able to meet up with them again.

List of nationalities and numbers of single juvenile asylum seekers

living in an asylum centre in April 2001

Afghanistan	4
Algeria	3
Angola	15
Azerbaijan	2
China	10
Guinea	17
Guinea-Bissau	1
Iraq	2
Yemen	1
Yugoslavia	1
Cameroon	1
Congo	2
Kirghizia	1
Mauritania	1
Mongolia	1
Niger	1
Pakistan	1
Russia	1
Sierra Leone	17
Sudan	3
Somalia	6
Togo	7
No homeland	1
Total	99

- 2 youths have been in the asylum centre since March 2000
- 2 youths have been in the asylum centre since April 2000
- 95 youths have been in the asylum centre since August 2000
- 14 arrived in the asylum centre after 1st March 2001

2.3. General political and social conditions in relation to the asylum and/or immigration policy

On January 1st 2001 a new refugee law came into effect.

The provisions of the new law:

In the previous law it was distinguished between different asylum seekers. The problem was that the greater the differentiation, the more exceptions that were possible. The greater the number of exceptions then the longer the procedures. Thus the previous law had to be changed. This happened on 1st January.

Since then, only one kind of permission is granted to stay in the Netherlands. This permission is granted for a fixed period. If necessary, after three years permission can be granted to stay for an indefinite time. Everyone who is granted permission to stay for a limited period of time can claim the same rights. There is still one asylum status which provides the same health care and support package of services.

Persons who are granted permission to stay for a limited period of time are allowed to work for money. They can also claim student grants and places in student accommodation.

Asylum seekers whose request for asylum is rejected can lodge an appeal against this decision with a special tribunal (Chamber for Foreigners) or with a higher court, the "Raad van Staten" (a kind of appeal court). The foreigner can stay in the Netherlands during the period of appeal. As always in the Netherlands, there are exceptions. The moment the application has been finally rejected the foreigner must leave the Netherlands. He cannot claim relief or other care. He also cannot lodge an appeal against this decision.

Of course, this law has its advantages and disadvantages, and its proponents and opponents. Some people think it is a good law, others do not. Asylum procedures are always caught up in a area of conflicting interests between those of asylum seekers, the law enforcers, the political parties, the treasury, churches, foundations for refugee care, city councils, pressure groups in neighbourhoods where asylum centres are planned, etc.

The Dutch policy is based on 1. humanity and 2. control. These are also often in conflict with each other.

2.4 Living conditions of the target groups

Generally speaking these are good.

They either live in asylum centres or in housing accommodation for youth care, or when they are aged between 22 - 24/25 (with exceptions), they live independently.

Problems occur when a member of the target group has to leave the Netherlands. Sometimes (how often is not known) they stay in our country illegally. Most of the time the living conditions are poor, but there is no official information on this.

In our opinion addiction care also has a role to play, but it will be difficult to obtain finance for the care and treatment of these groups.

2.5 Presumed elements of their drug consumption (results of our survey)

Kind of use

As "vulnerable groups" we have distinguished between single youths and youths with families as well as between youths who are inside and outside asylum centres.

When the AMAs and juveniles arrive in the asylum centre investigated they are asked to sign a contract. One of the items in this contract is a promise not to drink alcohol or use any other drugs. However; about 30 % of all AMAs and juveniles have a high risk of substance abuse. The AMAs and juveniles themselves deny any use of drugs.

One of the respondents, an AMA counsellor, made an estimate of the prevalence of misuse.

Alcohol: About 15 % of all AMAs drink excessively. They mostly drink in the evening or at the weekend, in the mobile homes. Most drink beer as whisky is too expensive. As usual in the Netherlands this is tolerated, unless or until other people get annoyed. Soft drugs: About 3 % of the AMAs uses marijuana.

One respondent denied misuse.

Tobacco: Few of the AMAs and juveniles smoke. One of the asylum centre's social workers thinks that this is because most of the AMAs and juveniles come from African countries where smoking is not the norm.

Hard drugs (heroin, cocaine, etc.): The employees at the asylum centre have no indications that hard drugs are being used.

Psycho-pharmaceutical drugs: Sedatives are used by almost everyone. The employees have no indications that these drugs are used excessively. In our opinion the AMAs and juveniles do not stay long enough in the asylum centres for this problem to arise.

Problematic substance use

We concluded that for most of the AMAs and juveniles, their stay in the Netherlands has been too brief for physical, psychological or other problems to manifest themselves.

Most of the juveniles will take psychological problems with them from their home country and will use medication to forget these problems or to alter their mood.

Physical: Headaches, stomach complaints, dizziness, sleeping problems.

Psychological: Most AMAs and juveniles have frequent nightmares, sleeping problems and are mistrustful. Only one of the 5 AMAs we questioned was co-operative. Three of the AMAs and juveniles denied having any knowledge or told us that they had not seen or noticed anything. Problems with the language also played a role. The director of the asylum centre assured us that most AMAs and juveniles could speak Dutch quite well. We got the impression that as far as the employees were concerned, the AMAs' and juveniles' knowledge of the language was sufficient for daily use, but we nevertheless felt restricted. However, we chose not to make any new appointments with interpreters present. This was not only because of the noticeable mistrust but because we were also told that it would be very difficult to get a non-biased interpreter. We came to the conclusion that the denials of the AMAs and juveniles confirm the information provided by the professionals and employees.

The employees told us about the severe traumatic experiences in the home countries of the AMAs and juveniles. At the same time they also notice the great flexibility and courage of the AMAs and juveniles.

Social: The AMAs only have contact with other AMAs, preferably from the same country. Those we met were friendly and polite.

Sometimes they cause a nuisance, especially after drinking too much. We doubt, however, that causing a nuisance is a real social problem in the sense that solutions need to be found for this. Causing a nuisance is only a result of the real social problem: excessive use of alcohol. No information was provided about other juveniles.

Legal: No major problems. No exact figures were available, but employees were only aware of some minor shoplifting incidents.

Financial: This is a major cause of problems. The AMAs receive a weekly allowance of 31.81 Euros. With this money they have to pay for all daily expenses, such as drinks, extra food, extra clothing, mobile phones, etc. No information was provided about other juveniles.

One of the respondents told us about a young Chinese woman. She liked to buy new clothing but could not afford them. She then bought a second-hand pullover. Unfortunately it itched. She concluded that this itching was caused by improper cleaning and vowed never to buy second-hand clothing for her baby.

Factors that influence the development of problematic substance use.

Differences between home country and host country

No information.

Traumatic experiences in home country and host country

The employees and professionals are convinced that traumatic experiences play a major role. There is no information about traumatic experiences in the host country. The employees speak about horrible and awful experiences.

Aspects of the refugee and asylum seeker policy

The AMAs have no fear of this procedure. In the Netherlands all AMAs can stay until they are 18 years old. More traumatising, however, are questions like: "Will I ever see my family again?"

Relevant aspects of drug policy, differences between home country and host country

The professionals know too little about this aspect to have a well-founded opinion.

Function and benefit of current substance use

To forget their problems and/or traumatic experiences, or to get into a different mood.

Availability of substances in host country

The employees and professionals assume that this is a significant factor.

Other factors

The AMAs and juveniles are alone too often and for too long. At the same time, most of the employees and professionals noticed that most AMAs and other juveniles refuse to participate in organised activities.

3. Process-orientated aspects

3.1. Access in the field of asylum seekers, care and support

When we started this project, we assumed that it would be important to learn more about the problems of substance abuse amongst juveniles and, specifically, AMAs. Substance use by youths is probably misuse but not yet abuse. Most of the time, as we assumed, use and misuse fulfils a function. In our opinion it must be possible to replace the function fulfilled by substance with something else (by means of prevention and care). In this way we are trying to prevent many future problems.

In the Twente region (the part of the Netherlands where TACTUS operates) there is an asylum centre which provides shelter for 100 AMAs (out of a total of 400 asylum seekers). The managing director of this centre was, after a brief presentation, willing to assist us. The managing director introduced us to the centre and enabled us to interview several people (professionals and AMAs) at short notice.

During the period before 12th December 2000 we began making our preparations and were able to make several appointments with professionals from several organisations that deal with asylum seekers and refugees.

We conducted the semi-structured interviews with these professionals, the AMAs and other juveniles, questioning a total of 13 people.

During this process we discovered that some steps presented us with more problems than we had first imagined. The first thing we ought to point out is the co-operative nature of all the adults we met. When things went wrong, it was certainly not because of the efforts and kindness of all these people. Without exception, everyone intended to make our interviews a success.

We really wanted to conduct interviews with youths, with and without families. We did actually meet some youths but without success. They were very polite and, concerning the questions, they really did seem to make the effort to think about them, but in 90 % of all the answers they nevertheless reacted with: "I don't know". During a discussion after one interview one of the youths asked an interviewer if he was a police officer. When the latter denied this, the youth then said that the interviewer must be the managing director. We considered bringing in interpreters but we learned that interpreters would not necessarily provide a good solution; one could never be sure if the translation would be correct.

We do not think it is exaggerated to use the term 'fear'. Amongst asylum seekers and refugees there must be many who live in constant fear: fear of being sent back, but also fear of being dragged into matters which they would rather not get involved with. The latter particularly concerns juveniles.

The care and support of asylum seekers and refugees is organised rather like a patchwork. There are not many persons or organisations who have an overall view. Moreover, very few persons are employed in this field. The largest organisation is COA - the Central Organisation for Asylum Seekers - which runs a large number of centres for asylum seekers. An autonomous service operating in these centres is the MOA, an organisation providing medical care for asylum seekers.

The moment an asylum seeker leaves a centre he will either disappear into a life of illegality or he becomes a part of Dutch society and is responsible for his own health and welfare. In both cases the existing contacts are very much reduced. This means that there is no extensive knowledge and experience outside the asylum seeker centres, and any knowledge or experience that is gained occurs accidentally.

To find respondents for the semi-structured interviews was not so difficult. To find respondents for the structured interviews took longer. This was partly because it was difficult to find new respondents and partly because it was difficult to make new appointments with former respondents. The composition of the focus group proved to be really difficult. We particularly wanted 'fresh' persons who were not involved with the previous interviews but were close enough to the subject to be able to discuss it in a proper way while having enough distance to be able to provide an overview.

The last remarks refer to the RSA method - Rapid Situation Assessment. We consider it to be very important that long gaps do not appear during the planning. When the process begins to lose momentum then it is very difficult to keep the respondents enthusiastic. In addition, we discovered that it is very important to inform every person early on in the process.

3.2. The RAR team

The RAR team of TACTUS consisted of three persons. The project leader, a prevention worker from the prevention department of TACTUS and the project leader's secretary.

The RAR team formed an important part of the whole process. Its activities started with the preparations of the interviews and ended with the formulation of the final conclusions of the RAR phase. All the results of the interviews were discussed in the RAR team, the grids were filled in together, as were the conclusions that were made.

These joint activities meant that each member of the RSA team gained the same knowledge. We think that this was the reason why all the internal and external discussions were well prepared and of good quality.

A RAR team is a must.

3.3. From ideas to action

We are unable to point out any specific moment when an idea was transferred into action. Because the RAR team discussed everything that was told during the interviews, and because the RAR team prepared and discussed the results of the discussions in the focus group, ideas gradually changed into proposals for measures. Sometimes a measure seemed inevitable.

After phase 1, the phase for interviewing and for reaching conclusions, the ideas and proposals for activities were discussed with the members of the focus group. This was the beginning of phase 2. In this discussion the practical feasibility of the activities was determined.

3.4. Advice for interested colleagues

The first piece of advice which we would give is do not accept any advice uncritically. Other situations cannot necessarily be equated with ours.

What we considerably appreciated:

1. Create a good RAR team consisting of about 2-4 persons.
2. The RAR team should meet each week.
3. Do not let long gaps occur between the different activities.
4. Do not be hasty but continue steadily.
5. Provide everybody with extensive information. The more people know, the more they will co-operate.

6. If you want to develop structural co-operation between organisations, then this needs lots of time (months), and brief, clear information about the form of co-operation (goals, timeframe, finances, etc.) which should be presented to the managers of the organisations approached. (We did not do it. It took far too much time).

4 Result-oriented aspects

In the focus group only three persons came from the world of asylum seekers. It seemed impossible to find any more. Nevertheless we are not disappointed. The persons who joined the discussions all have extensive experience in the field of asylum seekers and all work in situations that enable them to gain an overall view. Each person is used to not only working closely together with asylum seekers but also thinking in terms of policy.

1. Co-ordinator at a youth care organisation called Jarabee in Twente. This organisation provides housing accommodation for single juvenile asylum seekers between the ages of 15 and 18. A counsellor/coach spends 4 hours per day in each housing unit. One of the tasks of these counsellors/coaches is to provide sexual and substance information.
2. Nurse working for organisations providing medical care inside and outside the asylum centres.
3. Managing director of a number of asylum centres in Twente.
- 4-6. Two RSA team members plus the co-ordinator of the 'SEARCH' Project Netherlands who is also the third member of the RSA team.

4.1. Provisional conclusions and items discussed by the focus group

Actual use - misuse

1. The use of legal and illegal drugs by single juvenile asylum seekers and other youths with families in asylum centres cannot be described as misuse or abuse. The use can lead to problems:
2.
 - If Dutch society does not provide education and information on using legal and illicit drugs, and
 - if Dutch society does not organise addiction prevention in combination with possibilities for structured daily activities, and
 - if Dutch society does not organise this in combination with psychiatric care for their psychiatric problems such as fear, mistrust, mental pain, etc., and
 - if Dutch society discontinues providing this care, treatment and prevention after their stay in an asylum centre,
 - then a large group of these youths will become addicts and alcoholics in the near future.
3. The aims of the prevention activities are:
 - A. Establishment of peer groups. Youths must always belong to a group.
 - B. Establishment of a meaningful daily structure that will prevent juveniles from using alcohol as a means to forget or to relax.
4. Medicines are only used during the first weeks of their stay in an asylum centre. After that period their use is reduced.
5. Single juvenile asylum seekers do not use cannabis. Cannabis use does not cause problems.
6. Aggressive behaviour and shoplifting does not represent a considerable problem amongst this group of youths. No further measures are necessary (With this statement we do not want to override the responsibility of the management of asylum centres. The statement only refers to the responsibility of TACTUS as an institute for addiction care.)
7. One respondent denies that traumatic experiences have an influence on problematic substance use.

8. Use of medicines does not lead to social isolation.

Characteristics of single juvenile asylum seekers and other youths

9. Young asylum seekers do not know anything about the use and risks of addictive substances.
10. Single juvenile asylum seekers are unskilled and have little education.
11. Problems in asylum centres have more to do with religious backgrounds than with substance use.

General Remarks

12. The various statements made by the medical staff members, the AMA team members (team working with single juvenile asylum seekers) and the police officer have a lot in common. However, a former asylum seeker who is a volunteer in an asylum centre holds a totally different opinion. He denies any problem in the field of medicine use. He does recognise some problems with alcohol use but claims it was worse when he lived in the asylum centre himself. How should we interpret the information given by members of the target group? Are there any consequences that need to be drawn?
13. Is it justified to no longer focus on the target group of men aged between 18 and 30 in the next part of the project?
14. In some cases it appears as if the respondents are not interested in depicting the asylum seekers as problematic cases. Do they underestimate the problems?
15. It appears that men can deal with uncertainty better than women. If this is true, this means that the combination of addiction prevention and psychiatric care must concentrate on women.

Asylum Centre Staff

16. Education and information should be practical and realistic. This means that education should be integrated within daily life and be provided by employees of the asylum centre. This implies that the employees should themselves be thoroughly trained. They must learn how to recognise misuse and how to contribute to addiction prevention. If this is true, how can this be organised?
17. Addiction prevention can only be performed by addiction professionals.
18. The supervisory and counselling staff must play a part in the overall prevention activities. If yes, then how? Prevention activities and structured daily activities must be combined. If yes, then how?

4.2. Results of the discussion in the focus group

Actual use - misuse

1. *The use of legal and illegal drugs by single juvenile asylum seekers and other youths with families in asylum centres cannot be described as misuse or abuse. The use can lead to problems.*
 - ➡ The focus group did not agree with this statement. There is a lot of use and misuse, but they cannot prove it. During the time in which youths are in the asylum centre or housing unit they are in a situation where they receive daily and continual care, and the problematic use is kept within limits. As soon as the young persons leave the centre, however, use and misuse grows. The focus group also mentioned the fact that the workers in the asylum centre are not properly trained to recognise abuse and misuse, in particular of illegal drugs.
 - ➡ All three members of the focus group mentioned a growing use of sedatives in the asylum centre.

- A number of groups of youths (so-called child warriors) from, amongst others, Sierra Leone, Liberia, Angola and Nigeria, are taking drugs when they enter our country. It is not known whether they are addicted. It is unclear how quickly they are able to find a network to get the drugs to continue their consumption. The respondents in the focus group were of the opinion that as soon as the youths leave an asylum centre, they will find a network to obtain drugs or to traffic.
 - Some boys become so-called 'lover boys'. They let girls fall in love with them, and when they gained enough influence over the girls they introduce them into the world of (illegal) prostitution.
 - Chinese asylum seekers like to gamble, but since they are not seen playing for money, it is difficult to do anything against it.
 - The respondents also agreed with the statement that the problems in the asylum centres are greater than perceived. They therefore asked for more research to be conducted as a precondition for combining care for asylum seekers with addiction care. It is very important to be aware of the different cultural backgrounds.
2. ➤ *If Dutch society does not provide education and information on using legal and illicit drugs, and*
- *if Dutch society does not organise addiction prevention in combination with possibilities for structured daily activities, and*
 - *if Dutch society does not organise this in combination with psychiatric care for their psychiatric problems such as fear, mistrust, mental pain, etc., and*
 - *if Dutch society discontinues providing this care, treatment and prevention after their stay in an asylum centre, then a large group of these youths will become addicts and alcoholics in the near future.*

Most of the Dutch information and education material is unsuitable for AMAs and other youths. The Dutch material 1. makes too greater demands on the verbal skills of the members of the target groups, 2. is based on Dutch culture and 3. takes it for granted that these youths have the same previous knowledge as their Dutch peers.

Our society confuses the (young) asylum seekers. How should AMAs and other youths interpret messages about, for example, not drinking too much, that one should not smoke because it is healthier, that taking pills is not always good for your health, that it is better not to start smoking cannabis, and that a woman in hot pants is not there just for your pleasure, when they are surrounded by 'coffee-shops' and sex shops, and medicines can be bought on the streets. These youths do not believe our message. Non-verbal communication has a greater impact than verbal communication. An example for more effective activities: sometimes it is better to teach youths through family members.

Trauma care: post traumatic stress syndrome - it is better to treat these problems as soon as possible to prevent borderline symptoms. Nobody, however, was able to give an answer to the question as to whether Dutch society needs to combine addiction prevention with psychiatric care. One interpretation of the discussion might be: addiction prevention and psychiatric care are two different worlds - they do not belong together.

Conclusions

- Information and education are very important, especially for former single juvenile asylum seekers living independently (> 18 years old);
- Information and education must be appropriate to the culture of the homeland;
- Information and education must explain the norms applicable in the host land (Netherlands);
- Information and education materials must be more visual and less 'verbal'.

3. Aims of the prevention activities are:

A. Establish peer groups. Youths must always belong to a group.

B. Establishment of a meaningful daily structure that will prevent juveniles from using alcohol as a means to forget or to relax.

Regarding A:

The large cities, such as Amsterdam, Rotterdam and the Hague, appeal greatly to single juvenile asylum seekers living in housing units and asylum centres. A large number of former single juvenile asylum seekers and other asylum seekers live in these cities, most of the time in bad conditions. In contrast to the places where they used to stay, in the cities the youths are able to live in anonymity. In the provinces they feel observed and they do not like being noticed. As soon as they are in the Netherlands they wear the same clothes and accessories (mobile phones) as Dutch youths. The respondents cannot see any other reason for their being in the large cities.

The respondents thought it would be very useful if the youths belonged to networks of peers where they can learn other values. A soccer club is an example of such a peer group. Swimming lessons are scorned by a lot of youths, however, which means that the drowning rate is relatively high.

Regarding B:

It is difficult to motivate the youths to participate in daily activities. In the housing units the youths must wake up on their own but that is very difficult.

Conclusion

The respondents agree with this statement.

4. Medicines are only used during the first weeks of their stay in an asylum centre. After that period their use becomes less.

This observation was made by one of the 24 respondents during the two interviews. However, the focus group were unable to confirm this statement.

Asylum seekers first of all concentrate on survival. As soon as a certain stability is achieved, however, they hit a low point.

The role of the GP is not always clear. The youths do not understand why the GP does not wear a white coat and why he or she asks so many questions. They assume that because a doctor knows so much, he or she does not need to ask so much. What kind of doctor is the man or woman who is asking all these questions? The youths also do not understand why medicines are only available when the GP prescribes them. On the other hand, it is child's play to get prescriptions lengthened. In their homeland they are used to buying them themselves.

In asylum centres the use of medicines plays an important role in the procedure. The logic is that the more (health) problems an asylum seeker has, the better his or her chances are of staying in the Netherlands.

Conclusion

The use of medicines does not diminish over the course of time.

5. Single juvenile asylum seekers use cannabis. Other youths do not. The use of cannabis does not represent a problem.

In the asylum centres youths with families also use cannabis, but to a lesser extent than single juvenile asylum seekers. Exactly how much they do use, however, is not known. The focus group members have not heard about any problems with cannabis use.

6. Aggressive behaviour and shoplifting does not represent a considerable problem amongst this group of youths. No further measures are necessary.

According to the representative from the youth care organisation there are no problems with aggressive behaviour. The respondents in the focus group agreed that useful daily activities are vitally important to prevent aggressive behaviour.

Conclusion

The statement is agreed with in terms of the general extent of the problem. Any further measures should be focussed on providing useful daily activities.

7. One respondent denies that traumatic experiences have an influence on problematic substance use.

The respondent concerned is a former asylum seeker. The focus group believes that many asylum seekers are sensitive about their perceived image amongst the Dutch population. They therefore do not want to harm that image. Moreover, many asylum seekers belong to a so-called 'shame culture'; certain matters are simply not spoken about. This means that you do not speak about your traumas. Finally, experience has shown, both in the homeland and in the Netherlands, that it is better to keep your mouth shut.

Thus the reaction of the respondent concerned is easy to understand.

Conclusion

It can be expected that asylum seekers with problems will deny or trivialise their substance use.

8. Use of medicines does not lead to social isolation

This is correct. Extreme behaviour will meet with disapproval. Anyone who is inactive, lying in bed or hanging around will be looked after. The use of medicines validates the fact that you have problems.

Conclusion

Medicine use does not often lead to social isolation.

Characteristics of single juvenile asylum seekers and other youths

9. Young asylum seekers do not know anything about the use and risks of addictive substances.

All the focus group were in agreement on this.

Many youths have a distorted view of Dutch culture, believing that all Dutchmen use lots of medicines and have sex every night. One of the housing units in Enschede is situated between a video sex shop and a gay bar, on the opposite side from a so-called 'coffee shop'.

For many asylum seekers the body and spirit are indivisible. For this reason they always ask for medicines useful for physical complaints.

Conclusion

Young asylum seekers do not know anything about the use and risks of addictive substances. They have a distorted impression of Dutch society. They think that more is allowed than is actually the case.

10. Single juvenile asylum seekers are unskilled and have little education.

In general this is correct, particularly if the youths come from the region around Sierra Leone. This does not mean they are not intelligent, however, but that they are neither well educated nor skilled. On the other hand, asylum seekers from Iraq and Iran are educated to a higher level and have greater skills.

In general women are better educated and are more skilled.

Conclusions

1. Single juvenile asylum seekers are often semi- or unskilled.
2. This means: information and education must be specially adapted to the different target groups and their cultures. The use of visual languages is very important.

11. Problems in asylum centres have more to do with religious backgrounds than with substance use.

This claim was made by a police officer. The members of the focus group did not agree. Differences between ethnic backgrounds and traditions cause more problems. An example was given about two Chinese girls from two different regions. They came from the same country, spoke more or less the same language, but nevertheless one was envious of the bread which the other was eating. They argued over a kitchen pot, but in such a way that the others did not notice anything much.

Differences in languages can cause problems.

With astonishment it was ascertained that people from war-torn areas (such as Kosovo) had few problems with one another, regardless from which side they came. They came from the same war.

Conclusion

Mutual problems are not caused by religious differences. They are caused by ethnic or traditional differences.

General Remarks

12. The various statements made by the medical staff members, the AMA team members (team working with single juvenile asylum seekers) and the police officer have a lot in common. However, a former asylum seeker who is a volunteer in an asylum centre holds a totally different opinion. He denies any problem in the field of medicine use. He does recognise some problems with alcohol use but claims it was worse when he lived in the asylum centre himself.

How should we interpret the information given by members of the target group? Are there any consequences that need to be drawn?

Many asylum seekers are sensitive about their perceived image amongst the Dutch population. They therefore do not want to harm that image. As has already been mentioned, many asylum seekers belong to a so-called 'shame culture'; certain matters are simply not spoken about. See also question/conclusion to No. 7.

Conclusion

Because of the circumstances which have already been mentioned, asylum seekers often deny or trivialise their substance use and/or misuse.

13. Is it justified to no longer focus on the target group of men aged between 18 and 30 in the next part of the project?

No, the group between the ages of around 18 and 24 forms a risk group. They start living independently, are not required to attend school and still do not have a job. They are therefore not accountable to anyone.

14. *In some cases it appears as if the respondents are not interested in depicting the asylum seekers as problematic cases. Do they underestimate the problems?*

No, the focus group members did not have the impression that the problems were underestimated. Nevertheless, it is certain that not every asylum seeker is a problem case and therefore a certain amount of caution is appropriate. They also recognise, however, that more research is necessary. If addiction prevention is to be effective then it is advisable to start with research based on the conclusions derived from the focus group discussions.

15. *It appears that men can deal with uncertainty better than women. If this is true, this means that the combination of addiction prevention and psychiatric care must concentrate on women.*

The members of the focus group consider this statement not to be true. Girls and young women show less problematic behaviour than boys and young men. Girls and young women appear stronger and can cope better. For boys and young men the Netherlands appears more threatening. In their homeland they had a certain status. In the Netherlands they have lost their status.

The use of medicines by girls and young women is lower than the use by boys. According to the nurse in the focus group, the ratio of male to female youths lies at 80:20.

For girls and young women there is another danger. The scale can tip in the other direction and they can have too much freedom. Becoming pregnant is then a common 'problem'.

Through their housework, adult women create a daily routine. Single boys and men seldom cook, do not eat healthily and thus develop more physical problems.

Conclusion

No, the reverse is true.

Asylum Centre Staff

16. *Education and information should be practical and realistic. This means that education should be integrated within daily life and be provided by employees of the asylum centre. This implies that the employees should themselves be thoroughly trained. They must learn how to recognise misuse and how to contribute to addiction prevention. If this is true, how can this be organised?*

The managing director of a number of asylum centres is clear about this: this statement cannot be true. The goal for an asylum centre is to provide accommodation. Nothing more. All other services must be brought in from outside.

The nurse in the focus group sees a lot of possibilities for co-operation between the Medical Care Service (MOA) and the addiction prevention department. But there is no money to pay for the addiction prevention activities.

The youth care co-ordinator mentioned the existing co-operation between youth care and addiction prevention. But there is a problem in that there is a lack of good folder material and leaflets. It is all based on verbal communication (see also question 2 and 10).

It is desirable to have some information material for asylum seekers when they come to live in an asylum centre or housing unit. But it must be based on visual languages.

Beside effective information and education materials, individual counselling is of great importance.

Conclusion

- Co-operation between asylum seekers relief and addiction care is important.
- (The development) of effective information and education material (extensive use of visual language) is of great importance, as is the need for individual counselling.

17. *Addiction prevention can only be performed by addiction professionals.*

Conclusion

This is not true.

18. *The supervisory and counselling staff must play a part in the overall prevention activities. If yes, then how? Prevention activities and structured daily activities must be combined. If yes, then how?*

Because of the previous answers this statement is no longer relevant. It is superfluous.

4.3. Final overall conclusions

Staff

1. The employees of asylum centres have not sufficiently realised the extent to which there is problematic substance use. Employees of asylum centres need to be trained to recognise substance use, misuse and abuse and how to react. Problematic use occurs more frequently than is recognised by the employees.
2. If there is to be co-operation between care services for asylum seekers and addiction care, more research is required. In particular, this includes investigating the cultural background as well as the substance use amongst asylum seekers, both previously in their homelands and now in the Netherlands.

Information and education must explain the norms in the host land (Netherlands);

3. (The development) of effective information and education materials (considerable use of visual language) is of great importance, as is giving individual advice to those employees charged with providing information and education.

Target group

4. The group of single juvenile asylum seekers form a risk group. In this group special attention needs to be given to the so-called child warriors from countries such as Sierra Leone, etc.
5. The group of asylum seekers between the ages of 18 and 24 (former single juvenile asylum seekers) forms a risk group. They start living independently, are not required to attend school and still do not have a job. Thus they are not accountable to anybody and therefore they need more guidance, information and education.
6. Boys are more likely to start using problematic substances than girls.
7. Single juvenile asylum seekers are often semi- or unskilled.

Substances

8. The prevention measures need to be oriented to alcohol, illegal drugs and medicines, and gambling.
9. The use of medicines does not diminish over the course of time.

Prevention

10. The prevention measures which can be offered by TACTUS, the Institute for Addiction Care, are not suited to the target group of refugees and asylum seekers. They are too oriented to the Dutch, are too verbal and make too little use of visual material.

11. Information and education materials must be developed which are adapted to the cultural background of the different asylum seekers and make extensive use of visual language.
12. Structured daily routines, the development of a social network and individual counselling are important prevention methods.
13. One needs to be aware that when members of the target group become part of the prevention activities these persons form part of the so-called "shame culture". At the moment it is not possible to judge how these people would react when they get involved.

General

14. Mutual problems are not caused by religious differences. They are caused by ethnic or traditional differences.
15. Not every asylum seeker is a problem case and therefore a certain amount of caution is appropriate in depicting the extent of the problems. More research is necessary. It could prevent prejudices from developing.

5. Concrete practical projects

5.1. Introduction

With the overall conclusions of the RAR method, phase 1 came to an end.

To begin the second phase, concrete projects need to be formulated which will be carried out in practice.

On the basis of the results of the RAR method and the results of the discussion in the focus group, TACTUS formulated the next ideas to be explored in practice:

Group 1 (AMAs and other juveniles and young people in asylum centres)

- Education and information about the risks of medicine and alcohol, conducted by professionals
- Guidance and counselling on the same subject
- Daily structured activities

Group 2 (AMAs and other juveniles and young people outside asylum centres)

- Education and information (alcohol, cannabis, medicine).

We need to develop new materials which take into account the following three aspects:

- They must be adapted in accordance with the culture of the homeland
- They must explain the norms of the host land
- they must be more visual and less 'verbal'

Information and education activities can never provide the solution alone. It is necessary to provide a social life and support for a daily structured routine. As part of the information and education activities, adults (or others) from the same cultural background should be asked to help since youths listen more to such persons.

More abstractly formulated: one needs to be aware of the degree to which a message from a messenger is accepted.

- Training of professionals - but refresher courses are necessary. Since this does not form the focus of their daily work they must be kept attentive and involved. New workers must undertake a course. They need to learn to recognise the use of substances and to know what to do.

- Establish peer groups for the single juvenile asylum seekers. This is an important aim, but only when the peer group imparts desirable norms and values.
- Provide assistance in developing a meaningful daily structure. This can only be effective together with other activities. TACTUS, as an institute of addiction care can only be successful when it aims at co-operation. TACTUS needs the people from the asylum centres, from the youth care housing units, but also from medical care. Only then can we prevent our efforts from being a waste of time.
- Rapid completion of the asylum procedure. As has been mention previously, this aspect is not a task for addiction care.

5.2. Implementation as concrete projects

After a period in which there were no activities as a result of the summer holidays, the definitive aims for Phase 2 were established. The execution was planned to last for about 12 months. This meant that it would take more time than was planned for by the project.

Aims

1. Establishment of a steering group. The intention was to ask the members of the former focus group to participate. With a steering group we can begin to develop a network.
2. Discussion on the organisation and planning of the intervention measures, as formulated in the focus group
3. Development of a basis course for workers in asylum centres and youth care
4. Organising funds

In the overall conclusions more possible aims were formulated. Trying to make all of them aims would have been too optimistic, so we made a strategic choice. First, we thought it very important to find partners. With co-operation we could be stronger and more effective (Aim 1 and 2). Second, in our opinion it is very important that more people have knowledge and experience about prevention measures (Aim 3). Addiction care cannot do all this alone. Third, it is necessary to develop new prevention materials, suited to this target group, but without extra money it will be a very long-term process. The moment we have established a network we can start trying to obtain funding. At the moment we feel that we will need to discuss this with the local authorities.

5.3 Process

So steady and successful as everything went in phase 1 before the summer holidays, so slowly everything started in phase 2.

Aim 1 - Establishment of a steering group to start a network

Inviting the former focus group was simple and starting the discussions about the plans as described in 5.2 was not difficult at all. The discussion was as lively as the discussion in the focus group. The aims were evaluated as being very important and co-operation was a must but...

Two persons from the intended steering group felt that they were unable to promise anything. They had to discuss it first with their managing director. From that moment we lost control. From outside an organisation it is impossible to influence policy-making within that organisation.

We discussed this aspect with the other international partners in the 'SEARCH' project. There we

established that by developing co-operation and a network we had created a split in the course of the project. Phase 1 consisted of activities which concentrated on prevention in practice. Co-operation and starting a network are activities which are intended to ensure that the work is continued. Looking back we have to accept the possibility that we made a mistake. When we invited these people to join in the focus group (phase 1), the invitation was only for a short period. Each person could make his or her own decision. For long-term co-operation, however, two of the three persons required the agreement of their management. Instead of letting these persons discuss future co-operation with their management on their own, it would have been perhaps better if the project leader had introduced the subject to the management in the other organisations. The moment this was arranged, the steering group could have then returned to concentrating on the content of the work.

Discussion on organisation and planning of intervention activities as formulated in the focus group

The discussions have been completed and there has been a large degree of consent. Without the fulfilment of aim 1 (co-operation and starting a network), however, the results were not able to be carried out in practice. Nevertheless, there was considerable enthusiasm, the importance of giving priority to these aims was recognised, and everyone wanted to continue.

Development of a basis course for workers in asylum centres and youth care

TACTUS intended to join in a project with different organisations to develop such a course. The project organisation applied for a grant. Unfortunately the application was not successful.

That meant we had to develop our own basis course. By the end of December 2001 we were ready to start the first trial. What we wanted to find out is: Do we need two, three or four days? Or even more? What will be more effective, but also realisable in practice: consecutive days or with intervals in between? Will the given subjects be appropriate to what is required?

5.4. Limits and future prospects

The future prospects of our activities in the field of asylum seekers will be determined by the limits which we have been learning now.

Limits

During the course of the whole project we discovered that the problems of asylum seekers and refugees are not recognised in society. This does not mean that the press (newspapers, television, etc.) do not pay attention. On the contrary. The asylum policy is a burning issue, not because of the individual problems but because of finances or the problems caused by an asylum centre in a neighbourhood, etc. For a lot of people, including many politicians, it is a matter of control.

We therefore assume that finding funds to fulfil our aims is going to be a difficult job, although we do get the impression, however, that things are beginning to change for the better - albeit slowly.

With regards to juvenile single asylum seekers (AMAs), things are also changing. It is increasingly becoming the policy to send them back to where they came from. How things will develop cannot be said at this moment in time. This policy is new.

Future prospects

We think that the RAR method has a future, even in the field of asylum seekers. At this moment we are discussing this method with a national organisation (COA = *Central Organisation for Asylum seekers*). The experiences of TACTUS will be possibly used to introduce it to the whole country.

Furthermore, we are convinced that we have developed a solid basis for co-operation in Twente, and the results of the 'SEARCH' project (RAR method) have been widely disseminated. In the field of

asylum seekers and refugees, the results have been judged to be useful and reliable. The future will consist at first of a series of small steps. We will continue slowly but steadily.