SEARCH
Suchtprävention
für Flüchtlinge und Asylbewerber

GESUNDHEITSABTEILUNG

Suchtprävention für Flüchtlinge, Asylbewerber und illegale Einwanderer

Drug Prevention for Asylum Seekers, Refugees and Illegal Immigrants

Ein Handbuch

A Manual

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Note:
On the enclosed CD rom you will find the texts of this manual as well as some examples for prevention material which were made within the context of 'SEARCH', in the pdf-format. You can open the files by using the "Acrobat Reader" from Adobe. If you don't dispose of the "Acrobat Reader", you can download it from the internet: www.adobe.com

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A Manual

Drug Prevention for Asylum Seekers,
Refugees and Illegal Immigrants

"The passport is the most noble part of a human being. It is also not so easily made as a human being. A human being can be created anywhere, in the most careless of ways and without due reason, but never with a pass. For this reason it is also recognised if it is good, whereas a person can be just as good and still not be recognised."

in "Conversations Among Exiles" by Berthold Brecht

Table of contents:

Dear reader,

first of all we would like to briefly introduce the supporting body for the 'SEARCH' project, the Landschaftsverband Westfalen-Lippe (LWL).

North Rhine-Westphalia is the most populated federal state in Germany with more than 18 million inhabitants. At local authority level it is divided into two regional organisations, one of which is the LWL, which with 8.5 million inhabitants represents almost half of the overall population. The LWL is a municipal umbrella organisation and represents the towns and districts of Westfalen-Lippe.

The basic responsibilities of the LWL include regional social care, the duties of the Youth Authority in Westfalen-Lippe, the psychiatric clinics, forensic psychiatry and other responsibilities within the public health service.

The department responsible in our organisation for conducting the 'SEARCH' project is the "Co-ordination Office For Drug-Related Questions", a section of the health department. It is involved in various core activities such as, for example, training and further education, advising local bodies responsible for addiction care, documenting addiction in the federal state, and providing quality management in outpatient addiction care. It also participates in other model projects and has extensive experience working in European-wide projects such as, for example, euro net (with 12 European countries), euro peers (with 11 countries) BINAD, European Workshop on Prevention (1992 and 1994) and the project described here: 'SEARCH'.

Before the LWL made an application to the EU Commission for funding for this project, there was a long run-up which we would like to briefly outline here. By the end of the 90s the "Co-ordination Office For Drug-Related Questions" had become very much aware that in Westfalen-Lippe (and this certainly also applies nationally) the relation between scientific research and practice in the field of addiction had become increasingly characterised by a feeling of mutual reservation: it is commonly believed in addiction work that scientific research is long-winded and not very practically oriented, whilst critics from addiction research claim that practical work often ignores the results of addiction research. Both points of view had and continue to have a certain plausibility: scientific research needs results which are as precise as possible, validated and secured in a database. This requires a correspondingly comprehensive research structure and a sufficiently long enough period of time to conduct and assess the research. Addiction care practice on the other hand, must be quick and flexible in recognising the need to act in areas that are subject to rapid change, turning ideas into action, i.e., the planning and implementation of interventions. Although there is no intention of acting superficially or even "speculatively", it nevertheless needs an action-oriented database - but has clearly little time.

In 1998, the "Co-ordination Office For Drug-Related Questions" called into being a working group consisting of practitioners and addiction researchers in order to reach a mutual understanding and to foster co-operation by means of various meetings and discussions. Out of the dialogue arose the idea to test out a research method which could forge a link between the methodically structured recording of relevant data on the one hand and the up-to-date, practice-oriented and relevant implementation of the gained results on the other. As a field of research, the working group decided to investigate the addiction problem amongst asylum seekers and refugees where very little consolidated data and plans for action have previously been available. The intention was to test out the "Rapid Assessment and Response" (RAR) method.

The reason it was decided that this should be the project aim has in turn its own precedents: particularly in North Rhine-Westphalia the proportion of foreigners relative to the overall population is very high,

and the proportion of refugees and asylum seekers who are distributed throughout the federal state is considerable. We have continually received reports from the outpatient addiction facilities in our catchment area about addicted asylum seekers and general substance abuse amongst this group. The question which needs to be answered is: How can we reach these people with addiction prevention messages when apparently they appear to be very difficult to reach with the strategies developed in Germany for addiction prevention. We did not have any immediate answers to this and put this on our long list of issues to be dealt with. However, at various conferences and discussions with addiction care organisations in other European countries this issue was picked up as a central theme and we heard in unison: these problems are also increasing with us and we also do not have any satisfactory answers.

The idea of the project was born, and together with 6 European partners we conducted the 'SEARCH' project.

We do not wish to leap ahead as far as the report and results are concerned, and will limit ourselves here to expressing what the modesty of our partners prevents them from mentioning in their reports:

While participating in the workshops for the project, as well as during various further meetings and contacts, we were able to observe the enormous energy, thirst for knowledge, vigour and drive - but also the curiosity for previously non-researched unknown areas - with which our project partners approached the work! Particularly during the initial "RAR phase" the workload was enormous and demanded a great deal from all those involved. At the same time, with the Trimbos Institute and the CVO Institute in Utrecht in the Netherlands, we were able to gain the help of research establishments and the scientists within them, who with great expertise and experience, but also with enormous sensibility and patience, were able to provide supervision and guidance in what was for all project partners a new way of dealing with the RAR instruments.

The results are respectable, both as far as the research *methods* are concerned and in relation to what we, the authors, are continually emphasising: "culturally appropriate" addiction prevention for refugees, asylum seekers and illegal migrants. All have broken new ground with this project and have developed a pool of knowledge and methods that will provide a starting point for further planning and activities across Europe. Our results are already being used as the basis for further planning in the field of "migration and addiction" in several European countries.

If we may comment on behalf of the project supporting body, however, we would qualify this by saying that the 18-month project period not only created an enormous workload for our project partners but was simply far too short. The results need to be consolidated, evaluated and spread on a much wider scale, including at European level - perhaps a worthwhile task for a follow-up project?

Last but not least, we were also witnesses (and in all modesty co-initiators) to another process which we consider to be very well worth mentioning: not only have those responsible for heading and co-ordinating the projects in the various countries worked very well together during the course of these 18 months, there has also developed an extremely friendly, loyal and open working atmosphere. The European concept has been expressed not only in the results of the work but in the *atmosphere of co-operation* between people from six different countries!

We would like to thank all those involved who are mentioned in the text, as well as those who could not be explicitly mentioned, for their committed, competent and highly esteemed co-operation which in the end made possible the remarkable results of this project.

And of course we would encourage you to discuss with us the results, experiences and any background information by post, e-mail, phone, or whatever. This will also be an important part of the further development of the project results!

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2. On the initial situation behind the 'SEARCH' project

2.1. Asylum, flight and the risks of addiction

All the European countries are target countries, not just for immigrants who for economic reasons want to live there for a short or longer period of time, but also for refugees. These people are fleeing from war or acute crisis situations (such as has recently occurred in the former Yugoslavia) and return to their homeland as soon as there is peace or the overall political situation has changed. Many people, however, flee their homeland to escape persecution, torture and suppression, and ask for asylum somewhere else in the world in order to find peace and refuge. In the EU Member States, around 387,000 people applied for asylum in 1999, 390,090 in 2000, and 384,310 people in 200[1].

However much these migration movements in Europe are discussed in politics, asylum laws are drafted (and discarded) and elections are taken up with this theme, all in all we know very little about the people who are concerned. In particular there is very little research into their health problems and certainly not into the problem of drug addiction[2].

The Co-ordination Office For Drug-Related Questions of the Landschaftsverband Westfalen-Lippe (LWL) 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 German 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.

In particular the 'SEARCH'[3] project was established to gain further knowledge and to find the first answers to the questions:

- How extensive 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?
- What should be the first steps?

At the same time: almost all European countries have similar experiences and questions, as has been confirmed by addiction care bodies from many countries in response to our enquiries. In the age when Europe is coming together it seemed appropriate to organise a project across the EU to research these questions.

Together with 6 (regional) bodies responsible for facilities involved with addiction in 6 European countries[4], the LWL applied to the European Commission (SANCO G2) for funding from which the 'SEARCH' project grew.

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1 Source: UNHCR Press release, Berlin, 11th March 2002

2 An exception in Germany is: 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] Düsseldorf 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.)

3 The project received this name after a suggestion from our Belgium project partner: It expresses the idea of research (research) by us, but also the "search" for security, dignity and protection by the asylum seeker and refugees.

4 Project partners, see Annex

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[5]. However, in both countries many immigrants live who come from the north-western regions of North Africa (Maghreb region). Most of them are illegal and many of them live under conditions which are similar to those of asylum seekers and refugees in the aforementioned countries. We therefore 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 substance abuse among the target groups and**
- **to develop suitable addiction prevention for these groups**

We do not deny that there is a "political dimension" to this undertaking, which we would like to say a few words about as the project supporting body:

After the collapse of fascism in Europe, and as a result of the wide-spread suffering through poverty, flight and expulsion, all European states have agreed to receive refugees (Geneva Refugee Convention). Nevertheless, the influx of these people has led to wide-spread political debate, and much political opinion sees in this influx considerable risks: political, financial, moral and legal. With this project we do not want to take sides on such fundamental issues of this kind. Our aims are very specific: to help people who are at risk and vulnerable in a foreign country, to help them cope better and differently in a new culture, to help them protect themselves from health risks and to minimise harm, and to advise local communities and bodies who care and shelter them on the sort of care that provides effective protection against the risks of addiction.

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

Many problems within the field of public health demand rapid answers which, on the other hand, are difficult to provide. How do you proceed when you only wish to "speculate" on the extent of the problem? How do you plan when you do not have any reliable database? On the other hand, how do you achieve this when there is no or very little time available?

With the application to the EU Commission we decided to incorporate a further aim, namely to field test the "RAR" method (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 which 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 that "scientific preciseness".
Particularly with the use of addictive substances (and in turn especially with *illegal* drugs), the rapid

[5] Asylum applications lodged in EU Member States in the year 2001 (= 100 %): In Italy 9,760 (2.5 %), in Spain 9,220 (2.4 %), in Austria 30,140 (7,8 %), in Belgium 24,550 (6.4 %), in Germany 88,360 (23.0 %), in the Netherlands 32,580 (8.5 %). Source: loc. cit., UNHCR 2002 / http://www.unhcr.de/news/pr/pm020311.htm

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.

As with most empirical research, RAR makes use of interviews, and to be precise so-called "key persons", i.e., people who have extensive knowledge about the problem being researched. This process is described in detail in the RAR Handbook, and in the next chapter we will be looking at out concrete "RAR design". In terms of the origins of the 'SEARCH' project, of great significance was the fact that the Co-ordination Office For Drug-Related Questions at the LWL had called into being a working group of addiction researchers and addiction care practitioners which in particular intended to examine the often very problematic transfer of knowledge and competence from one area to another.

Practice-oriented and relevant addiction research: the RAR method appears 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 area of work described in the last chapter - addiction prevention among refugees, asylum seekers and illegal migrants - with the RAR instruments.

Therefore, our second project aim was:

- **The effectiveness and practice-relevance of the ”Rapid Assessment and Response” method (RAR) shall be tested out in regard to the theme of ”substance abuse and addiction prevention among refugees, asylum seekers and illegal migrants in Europe”**

It can already be said in summarising the result 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[6]. This is covered in more detail in Chapter 3.

2.3. Why a European project?

We have already commented that during numerous contacts with addiction care organisations in Europe, of whom some have already worked together with us for many years[7], the subject of "migration and addiction" has constantly been discussed. In all European countries this area is presenting addiction care with (new) challenges - although these are different depending on 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"[8] for any one country. 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

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[6] 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. As we write this, we are ourselves thinking about how a qualified "RAR" training module could be implemented.

[7] For example, in the European network "euro net ", see http://www.euronet-prevention.org

[8] We are also emphasising this to protect our research work from political misuse through parties and opinion leaders!

"common denominators" that make our results interesting at EU level. This applies not only to addiction prevention work with select groups of migrants, but in particular to the RAR method which, as a planning and research method in the field of public health and addiction care, represents a considerable advance in planning interventions.

3. The work involved in the 'SEARCH' project

3.1. The duration of the project

The project lasted from 1st October 2000 to 31st March 2002, i.e. 18 months, and it goes without saying that this proved to be far too short in many ways. Many prevention projects were only able to be designed in conceptual terms, or were started but not completed. On the other hand, a wealth of results were provided which were 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 RAR training for the project workers, which was held on the occasion of the first workshop in Münster, Germany, in December 2001. Our research institute provided not just basic material for this training but special questionnaires ("grids") and other materials[9]. 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). This did not occur entirely without problems. 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[10]. During this time, the project supervisors and coordinators 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 2002. 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 the countries, 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, had already begun to be established.

These activities were presented and discussed at the third workshop in October 2001, where it was possible to present a huge variety of different 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

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[9] See R. BRAAM/H. VERBRAECK/F. TRAUTMANN: Handbuch 'Rapid Assessment and Response' (RAR) on Problematic Substance Use among Refugees, Asylum Seekers and Illegal Immigrants. Ed. LWL, Münster, 2002 (Handbook for the 'SEARCH' project available on the Internet: http://www.projekt-search.de)

[10] One project partner, for example, began with great zest to investigate a target group which in actual fact was only pre sent 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!

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 to apply for a follow-up project with the EU, which the project supporting body LWL has also done.

In Phase 4
beginning in October 2001, the prevention activities continued to be implemented in the regions while work was started on the reports. Both the Trimbos and CVO institutes completed their RAR Manual during this phase, which they presented to all project partners. Stock was then taken at the concluding workshop in Barcelona/Spain in March 2002. The handbooks were then edited and went to press.

3.2. RAR - A brief introduction to the "SEARCH-RAR"

As has already been mentioned, the "Rapid Assessment and Response" (RAR) method was chosen as the research and recording method for the 'SEARCH' project.

Scientific addiction research needs results which are highly precise, validated and secured in a database. This requires a correspondingly comprehensive research structure and a sufficiently long enough period of time to conduct and assess the research.

Addiction care practice on the other hand must be quick and flexible in recognising the need for action and turning this into activities, i.e., the planning and implementation of interventions. If it is not going to act speculatively, it needs an action-oriented database - but has clearly little time.

The "RAR" is a scientifically-led rapid survey method for recording the type, origin and need for action in respect of a recognised or presumed problem (e.g., in the field of addiction work)
- within a short period of time
- with limited expenditure
- and with high practice relevance

It can thus be regarded as forging a "link" between the needs of practice and the methods used by scientific research.

"Rapid Assessment (...) means identifying the extent and nature of health risk behaviours and associated health consequences, to identify existing resources and opportunities for intervention, and to initiate appropriate and timely interventions"[11], quoted from G. Stimpson, one of the developers of this method.

However, although RAR makes considerable use of the individual elements or "tools" of empirical (quantitative) social research (such as, for example, estimation techniques, observations, etc), it is essentially *qualitative* research. From the results you can expect that it will provide a clear and relevant depiction of a problem and thus be adequate for the further planning of interventions, but not that it will provide quantitatively precise results (i.e., up to two decimal places so to speak): in our project it is irrelevant whether 23.7 or 28.9 % of a certain subpopulation from the group X use a substance, what is important is whether there is (problematic) use at all of addictive substances, in what way, for what reasons, and what are the possibilities for suitable and successful addiction prevention appropriate to the specific cultural characteristics of the individual target groups. Of course, here there was also a need for data which had to be recorded, compared and checked, etc., and the instruments which were developed for this project will be briefly described below:

[11] The Rapid Assessment and Response guide on psychoactive substance use and especially vulnerable young people, WHO 1998, S. 15 (EVYP-RAR), WHO 1998, p. 15, translation R.L.

The most important instruments in our RAR were:

- Semi-structured interviews (SSI), which use questionnaires ("grids") that, apart from using set answers, provide considerable opportunities for giving freer answers (narrative technique). They should be carried out with 10 - 15 persons who can be expected to possess a high degree of knowledge about the problem being investigated (so-called "key persons"). These should include not just "professionals"[12] but of course those affected. The aim is to get as many different standpoints as possible to create an "overall picture".

- Structured interviews (SI), which provide answers which can be crossed off in the grids and estimation scales. These should be conducted with up to 30 persons, and in particular with people with (assumed) extensive knowledge, but if possible not the same people used with the SSI. The aim is to recheck the initial "picture" gained in the SSI phase and to ascertain (or discard) it.

- Focus groups, which are assembled from the group of SSI and SI respondents. Here the results and contradictions that have been gained are checked with experts and then evaluated. Two focus groups were convened: the first was concerned with assessing the results in the first phase, the second - already looking to the future - was concerned with the possibilities for prevention.

- Country reports were produced on completion of each phase according to a given framework and, step by step, the confirmations or amendments were documented. These reflect the development of knowledge throughout the research process.

In order to structure the RAR process, our research institutes developed key questions consisting of elementary questions for gathering information on substance use amongst our target groups as well as suitable prevention measures. The questions form the basis and framework for the information collection stages. During the course of the RAR process they were subdivided into more detailed questions which were formulated on the basis of the findings of previous phases of information collection.

A: Questions on substance use

1. Who uses substances in a problematic way?
2. Which substances are used in a problematic way?
3. What is problematic substance use?
4. Which factors influence the occurrance of problematic substance use?

B: Questions on addiction prevention

5. What does the target group know about substance use and the associated risks?
6. What effective preventative measures/conditions do currently exist?
7. What are the preventative interventions/conditions needed by the community?
8. What are the priorities in giving the prevention?

It can be easily appreciated that in practice these questions must be further subdivided:
Target group 1, Subgroup 1, Substance 1, Question 1 ...and so on.
An enormous volume of paper had to be processed and evaluated. After each phase the country reports had to be produced, which from report to report gradually closed the gaps in knowledge. In the

[12] The term "professionals" here certainly does not just refer to those in the field of addiction care but all those who on the basis of their (paid) work can provide impressions, observations and experience.

focus groups any open questions that still needed clarification were then finally put to the experts, who had to be first of all found .... which means taking a few steps backwards:

Finding key informants proved to be very time consuming. Who is a "key informant"? There was no other choice than to start "somewhere", and that meant mostly with social workers, the police, and the authorities responsible for asylum seekers and refugees as well as those providing accommodation for the target groups. Each respondent then knew of other competent people who could possibly provide information; thus a snowball system was put in place. Naturally, most difficult of all was getting access to those affected themselves, but this was able to be achieved via street workers or social workers in low-threshold contact centres.

Of course, the information from the informers also sometimes began to be repeated, regardless of their own respective viewpoint: an indication to the interviewer that here the breadth of answers had been exhausted, the problem sufficiently thoroughly researched and that no other interviews were necessary. In this respect the predetermined number of interview partners was not deemed to be a "fixed" number, it was possible to fall short of this figure (however, it was also possible for it to be exceeded when constantly new information appeared from one informant to the next...).

The final reports and evaluations provided a differentiated, comprehensive and very vivid picture, both of substance abuse among the target groups as well as the proposals for target group-specific addiction prevention - and therefore provided the starting point for further project activities.

3.3. RAR in practice

As far as the practicians in addiction care were concerned, they were not used to dealing with this type of questioning and researching. Of course they were familiar with the concept of "being researched" by some research institute or other - suddenly however they had become researchers themselves! A lot of rough edges needed to be sanded down: the different cultural backgrounds of many respondents, for example, often did not allow for a concise answer with the "SSI"; it was sometimes answered in a flowery, polite, long-winded and therefore indefinite way. And when the "SI" phase was reached things really began to fall apart: only a cross when there is so much to say...? Many of the Muslim key persons we asked considered this to be impossible.

Other things also turned out to be very complicated in detail which had seemed so simple when first conceived: The answer, for example, to the question as to "what is problematic substance use" revealed enormous discrepancies between that of our trained estimation profiles in addiction care and that of our respondents. For many people from Kosovo, a level of alcohol use is considered to be normal or inconspicuous which we would certainly consider to be problematic; for many in Iran the use of opium is considered to be a cultural ritual, whilst as far as our narcotic laws and experiences in Europe are concerned it is considered to be problematic *per se*. Owing to their low alcohol tolerance, Tamil men would already consider a level of alcohol consumption to be problematic which we would judge to be unproblematic. On the other hand all these points provided us with important indications that we were on the right track in terms of having the correct *understanding* of addiction prevention: a culturally-appropriate understanding that is not interested in the abstract but sees and advises real people in terms of their cultural, religious, ethnic and spiritual experiences in life.

Admittedly, this was frequently not very easy for the project partners. Nevertheless (or perhaps because of this?), we were all very amazed by the depth and precision - but also the practical relevance - of the data that had been produced by the end of the project. RAR is a method which is suitable for thoroughly examining social problems, for providing qualitative as well as quantitative material within the limits already described, that is reliable and therefore provides a secure basis for further planning and

interventions, and this in a very short period of time! What's more: RAR is not only a method that provides precise "indicators" for realistic practical planning, it informs and supports the practical work, reacts to changes, recognises new needs and describes changed intervention requirements. In this sense it is not only a "reaction instrument" but can also, for example, provide precise monitoring during the process of implementing practical addiction prevention for asylum seekers, refugees and illegal migrants.... but that is another story as far as 'SEARCH' is concerned (and perhaps the subject of investigation for a follow-up project).

3.4. The country reports: A selection of results from 'SEARCH'[13]

3.4.1. Stress of 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?

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 which 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[14] . 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

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[13] 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.

[14] For Germany compare MFJFG (Ed.) Gesundheit von Zuwanderern in NRW, Düsseldorf 2000, p. 16 ff. Also see: Toni FALTERMAIER, Migration und Gesundheit, in: P. MARSCHALCK/K. H. WIEDL, Migration und Krankheit, Osnabrück 2001, p. 93 ff.

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 study - has considerable impact on their self-esteem and courage to face life. 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 sometime 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[15]).

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[16]. 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 Magrheb 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[17].

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

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[15] Compare critically with PRO ASYL (Ed..): G. CLASSEN, Menschenwürde mit Rabatt. Kommentar mit Dokumentation zum Asylbewerberleistungsgesetz (AsylbLG) und zum Flüchtlingssozialrecht, Berlin 2000[2]

[16] "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.

[17] In some of our studies we were able to establish a clearly higher vulnerability with respect to addictive substances for single men.

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.
The actual harm caused by substance abuse amongst 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 *preventative activities*. Nevertheless, we are mentioning this factor here as an indication of the health and social policies of the various countries.

3.4.2 Theses

We would like to very briefly summarise here in thesis form - and so to speak in anticipation of the project descriptions - what we the project supporting body consider to be the essential contents and methods of specific addiction prevention work with refugees, asylum seekers and illegal migrants:

- Addiction prevention is always "health prevention" as well. The very different ideas of our target groups regarding the body, health and health risks need to be considered against this background. Our "Western and Central European" concepts of, for example, "holism" will hardly be understood by them for reasons of their social and cultural backgrounds (for instance with Iranian men), and are therefore completely unusable as starting points for prevention concepts with these target groups.
- Culturally-sensitive and respectful addiction prevention is only possible on the basis of knowledge and understanding. It is apparent (and is also a general experience within addiction and migration research) that without possibilities for communication and meeting in their native language, there is a risk that a well meant approach will lead to nothing, falls flat and remains ineffective. The focus on the "key person concept" is pioneering[18] in its approach, as is the adaptation of the "peer education concepts" for inter-cultural addiction work (which was also suggested in the context of the second focus group in nearly all the project countries).
- Before establishing interculturally-oriented addiction prevention concepts, it needs to be examined which *special* risk and protective factors[19] exist for each specific target group, i.e., related to the homeland, not just in terms of general behaviour harmful to health but in terms of the risk of addiction.

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[18] Compare with: S. Tuna, Konzept, Methoden und Strategien migrationsspezifischer Suchtpräventionsarbeit, in: R. Salman/ S. Tuna/A. Lessing (Ed..), Handbuch interkulturelle Suchthilfe, Gießen 1999, p. 104 ff, here: p. 108 f

[19] The role of the family with people from Islamic countries, for example, is often defined very differently than with us (role of the father, concepts such as marriage, internal family problems must not "get out" into the open; other important concepts are authority, respect, shame, etc.)

- Addiction prevention with asylum seekers and refugees forms part of intercultural *addiction work*[20] Features which distinguish it from existing addiction work in our countries are, amongst others: the organisation of the family and its influence on development; norms and values; thinking, perception and ways of learning; the explanation of the body and illness; the interpretation of situations, dealing with conflicts and thus strategies for coping; the absorption and processing of information, and linguistic requirements and communication[21]". In some European countries fairly extensive experience has been meanwhile gained in the field of "migration and addiction", however, the specific adaptation of this experience to the work with our target groups must still be developed and implemented.
- The differentiation between primary and secondary prevention, as suggested by the WHO, also makes sense for our project: wherever addiction problems or problematic use have still not appeared, many of our "key respondents" presume - for the reasons described above - that there is nevertheless a considerable substance-related vulnerability, so that primary prevention projects are certainly important. In various other groups (the Maghreb youths in Barcelona and Turin), we can find a widespread and problematic use of various substances. Here, for example, secondary prevention measures have been proposed by the Spanish project partners (e.g., interculturally-oriented street work and harm reduction measures within the context of the project "Guide for Solvent Users").
- However much the (inter)dimensional nature of our work should remain to the foreground, we should not ignore the fact that there are many *structural exclusion* mechanisms, which for their part encourage addiction and other health risks. There is a dialectic relationship between *behaviour-oriented* and *relation-oriented* addiction prevention, i.e., not only should the behaviour, the way of acting in concrete situations, be the aim of our preventative efforts but also the conditions under which our target groups (must) live. We must ensure that the perceived need for action is not only concentrated on the individual but takes account of the structures and the changes that are necessary here.

Particularly with the last-named point, local research has demonstrated the practical limits of addiction prevention work. In the area of "relation-oriented addiction prevention" we can only name and describe grievances, stress situations and structurally determined addiction risks, we cannot change them; that is the task of the (social) politicians in the different countries. It is true what Sadako Odaka, the former High Commissioner for Refugees of the United Nations (UNHCR), once said: "Humanitarian actions alone cannot solve any problems which fundamentally are of a political nature!"[22]

3.4.3. The country results

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". For this reason we would like to just limit ourselves here to drawing attention to certain aspects which are perhaps not so immediately evident in the country reports.

First of all it must be stated that our notion that, by the end of the project, all project partners would have a completed addiction prevention project that they could then present and describe as such was not attained.
With our project, however, we opened doors in all countries, brought people and institutions together,

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[20] Compare, for example, with G. Pavkovic, Interkulturelle Kompetenz und Qualität in der Suchtkrankenhilfe, in R. Salman et al. (Ed.), loc. cit., p. 56 ff
[21] See Tuna, loc. cit.
[22] Sadako OGATA, Foreword, in: UNHCR (Ed.), Zur Lage der Flüchtlinge in der Welt, Bonn, p. XI, 2000

and we discovered, or to put it better, illustrated 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' - this is already becoming apparent - is having a sustainable effect:

- In the Soest District in Germany, the working group which developed from the focus groups is conducting further work on the subject.
- In Barcelona in Spain, the handbook which has been developed is being evaluated and implemented for work with "glue sniffers".
- In Turin in Italy, new working alliances have been created for addiction prevention and treatment work with Maghreb migrants as well as projects which, in the context of culturally-sensitive prevention, use very youth-oriented and modern means: pop music.
- In Enschede in the Netherlands, the work of our project partner with single juvenile asylum seekers (AMAs) has received national recognition and is being developed further.
- In Ghent in Belgium, the concepts and materials developed for the target groups of Albanians and Kosovans are being developed further for other ethnic groups.
- In Austria the results will be taken further and disseminated via both symposia and concrete working groups.

As the project supporting body, the LWL has learnt that the RAR method provides excellent instruments for planning interventions in the psycho-social field, but also that 'SEARCH' was "only" able to touch on many things that will need to be further consolidated (such as, for example, the development of the RAR monitoring instruments for supporting the implementation processes in the various countries).

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'SEARCH' in Belgium:

Drug Prevention for Refugees and Asylum Seekers from the Kosovo and Albanian Communities in "De Brugse Poort", Ghent.

De Sleutel, Ghent, Belgium:

Peer van der Kreeft ***Head of the Prevention***
Freya Van den Bossche ***Co-ordinator for European Projects for Secondary Prevention***

1. Structural issues

1.1 De Sleutel: research, prevention, treatment of drug dependency

De Sleutel is a network for treatment, research, employment and prevention of drug abuse and addiction. It is an NGO, being a non-profit (social profit) organisation that is independent of public services. It is recognised as a rehabilitation institute and is financed as such. De Sleutel has several departments throughout Flanders, 200 employees and approximately 2,000 clients annually.

In the field of treatment De Sleutel has established a cure and care network of inpatient and outpatient modules, outreach and harm reduction activities, employment guidance, learning and social workplaces. We have also developed preventative and educational expertise in line with the core mission statement 'maximum reintegration and optimal self-realisation'.

In the field of prevention De Sleutel has played an innovative role in adapting and re-shaping life skills programmes with several European and other international partners in the late 80s and early 90s: Tacade (UK), Lions-Quest (USA), Leefstijl (NL), The Pompidou group (EU), European Centre for Social Welfare (AU).

Prevention combined with research led to need assessment and situation assessment projects in several municipalities, schools and specific target groups. Within this framework we participated in the development of the European Handbook of Prevention from the **Pompidou group**, the Evaluation Guidelines for Drug Prevention from the **EMCDDA** and, within this field, provided reports on several projects located in Belgium. Our research department was also active in the **BIOMED programme** and **COST A6**.

Whilst continuing our efforts in the field of primary prevention, since the end of 1999 De Sleutel has shifted its sphere of activities to **secondary prevention**. We have contributed to activities for specific risk groups in the following EU-funded projects:

- Targeting asylum seekers and refugees in **'SEARCH'**
- Children of addicted mothers in **VULNERABLE PEOPLE**
- Socially excluded young people with low employment chances in **DOUBLE IMPACT** and **GRUNDVIG 2**

De Sleutel participates in the **EURIDICE** and the **PREVNET** networks, is a member of **EFTC** and **ICAA**, and provides training and advisory services for **DRSTP**, **PHARE** and **TWINNING**. Since 1990, De Sleutel has been a department of Broeders van Liefde (Frères de Charité), an umbrellas association for many institutions both in the field of mental health and primary and secondary education. The group has consultative status at the **UN**.

1.2. 'SEARCH' in Belgium: Kosovan and Albanian communities in „De Brugse Poort", Ghent

The Little Castle

The asylum seekers policy[1] started with "Het Klein Kasteeltje[2]", the little castle, a closed centre in Brussels for receiving refugees. This initially dealt with families and single persons from South and Central America, later Ghanaian and other African peoples, followed by Eastern European refugees. It

[1] Peter Neelen, Co-ordinator of heads of reception centres, Federal Ministry of Social Affairs, Op Maat, Ghent, 29 Nov. 2000
[2] Het Klein Kasteeltje has a periodic magazine "Magasiel"

soon became apparent that it was too small and so four other closed centres were established. These were then followed by open reception centres (in 1990 these were all federal centres). Soon this infrastructure became insufficient, and, in addition to the 2,500 places in federal open centres, the Red Cross decided to run open centres for another 2,500 refugees. These numbers were then again exceeded very quickly and the federal government was forced to establish "OCMW[3]" public centres for social welfare, to receive asylum seekers and refugees at city or local level. These city welfare centres also became involved when there was no place available in an open centre because, for instance, the dossier was "not yet acceptable". Over the course of the years this possibility became institutionalised, and today 70 to 80% of the asylum seeker cases[4] are officially sent directly to the city welfare centres.

Three consequences of the direct referral to the OCMW city welfare centres

1. The welfare centres must support the asylum seekers financially with a minimum living standard of approx. 500 Euro/month per person. The control mechanisms for this are not very sound, for instance the planned home visit and personal interview often only takes place long after the first payment. This has created a black market in "welfare centre" dossiers and "stories": the "passeur" (illegal smuggler of asylum seekers) sells the story along with the "correct route" required for a successful application for asylum and temporary accommodation in a social welfare centre. This low-threshold support apparently also attracts mostly people who are "merely" looking for better living conditions, i.e., more than political asylum seekers defined by the Geneva Convention. This group aims to get a job, send money to the family at home or save it, and bring their families over after a while.

2. It causes a chronic delay in handling the dossiers: the procedure time can now vary between 1 and 2 years.

3. It reduces the quality of the care and accommodation of the asylum seekers. The city welfare centres cannot support a higher workload. Currently, a social worker often has 20 to 25 dossiers per day. He cannot spend time providing support or counselling.

Failure of the attempt to disperse asylum seekers across the country

In 1994 the federal government attempted to disperse asylum seekers proportionally across relatively small regions of Belgium. Sophisticated coefficients and formulas were meant to lead to a just division in accordance with the minimum budgets of the cities, but had very little influence on the actual domicile of the asylum seekers. A person assigned to a village in the Ardennes could easily go there once a month to cash his cheque, but in reality live in Antwerp or Ghent. In such cases it is difficult to implement the care services of city welfare centres.

What is the relation to 'SEARCH'?

The federal government has given a particular emphasis to safety and security. The city welfare centres, (which certainly also have strong social dimension), also regard it as importance to maintain the socio-economic conditions at a balanced level. Neither health care nor health promotion are traditionally or structurally part of the federally governed institutions. These mandates belong to the regional governments: the French and Flemish speaking regions and Brussels. The regions are not at all demanding when it concerns the issue of asylum seekers[5]. This means that the issue of health is given very little consideration in this matter. Under the authority of the federal government this is reduced to a minimum obligation to deliver highly urgent medical care. Prevention is only mentioned in a restricted

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[3] = Openbaar Centrum voor Maatschappelijk Welzijn

[4] Belgium has today 47,000 asylum seekers, plus x refugees, plus x illegal migrants. The total number is cautiously estimated at 90,000 people. The Ministry of Justice currently receives 6,000 new dossiers per month.

list of epidemic diseases, with TB given as a priority. The TB screening machines, however, are standing un-used in the welfare centres because there is no personnel, i.e., health care personnel, available. This has already been like this for two years! Within this context it is therefore not surprising that there has been no study or report which has looked into the subject of drug abuse.

Future changes

The city welfare centres are encouraged to organise local support and initiatives, with direct financing for the housing of asylum seekers instead of providing individual minimal income support. These initiatives also include specific personnel for counselling and support.

Assessment of the initial situation: De Brugse Poort, Ghent

Based upon general reports and data, we chose to locate the RAR assessment study in a larger city: Ghent. Why:

- The survey should not be situated in a closed or open asylum centre because 1) the people do not stay there very long and 2) the most vulnerable target group is not linked to such a centre.
- In larger cities, the asylum seekers, political refugees and illegal refugees are mostly living in social institutions (or nearby) which can provide the necessary points of contact or access.
- Within the city of Ghent, the "Brugse Poort" quarter is a main area for our target group.

As has already been mentioned, no reports exist which concern drug problems. According to the police and social welfare organisations, in the Brugse Poort there are mostly Kosovan and Albanian fugitives. Based on the same sources, it is assumed that drug abuse is probably more prevalent here than among other nationalities.

Further information in this area was gathered by interviewing the following persons:

1. The head social worker from "OCMW" (state social welfare centre). The OCMW has a formal obligation to act as the point of contact for refugees and asylum seekers, to give them the minimal payment and to assess any possible need for urgent medical treatment.
2. The social workers from the Transit House[6], which is responsible for the whole city but is (coincidentally) situated at the same site.
3. The doctor and social worker from the local health centre, assigned to the target group of asylum seekers and fugitives. The local health centre tends to promote and implement a preventative approach to health in general.
4. Doctors and nurses working in the academic hospital (coincidentally) situated at the same site.
5. The social service from the integration centre for migrants, specifically working with asylum seekers and fugitives.
6. The 2 street workers from the ambulatory drug services, assigned to the Brugse Poort.

The starting point: Aziza or the story of deportation in Europe

No research reports or reports from health services refer to drug abuse, drug use or potential needs for drug prevention. The studies that come closest to our subject are university dissertations about health care in general. Related reports mostly concern urgent medical care or treatment, whereby drug addiction and drug prevention as such are given very little attention. Media reports have been focus-

[5] Even though the general policy has shifted from legal aspects to a support and care aspects.
[6] NGO providing basic support, with up to 120 counselling contacts per day with 4 workers.

sed more specifically on this issue, but here there have also been no surveys or research done into drug use as such. Contradictory information in the media refers on the one hand to there being very little drug use because of the lack of money and the cautious attitude of refugees and, on the contrary, to there being a high number of drug users because they belong to a socially deprived group. The most relevant report in this regard has been made by the investigative journalist Chris De Stoop[7] in his book, describing the devastating and finally fatal process for the Ghanaian refugee Peter Q., beginning with a totally wrong 'diagnosis' by the police that he was 'under the influence of drugs'. This chapter in the book is, however, only descriptive and of course casuistic, and provides another argument to begin writing reports that give a more objective assessment of the drug use situation amongst asylum seekers and refugees instead of making just prejudicial assumptions.

2. Process issues

- The "snowballing system"
- the RAR team
- how did the idea become reality?
- Advice for colleagues on: What worked well, what should be avoided?

2.1 Snowballing system in RAR

In recent years, De Sleutel has developed adequate know-how and instruments, such as questionnaires and interview training, as part of other research projects. Prevention and research projects that have been greatly significant in establishing a drug policy at the level of a school, community or city, have been conducted in De Blauwe Toren, a community in Brugge (1996); in Sluizeken-Ham-Muide, a community in Ghent (1997); in the city of Beveren (1998), a secondary school in Oostende (1997); the city of Brugge (1995-2000) and the city of Lint (2000). These are all instruments that we wish to develop further and refine using the RAR methodology and in co-operation with several European partners.

We trained confidential mediators in interviewing and other data collecting techniques, who then coordinated a RAR pilot project for one specific district of a city in Belgium. The respective report describes the volume and character of legal and illicit drug use for a specifically outlined population, as well as the background of their drug use and needs for prevention. This situation analysis has provided a realistic formulation of the problem and sets the benchmarks for prevention recommendations and objectives.

An important aspect of our organisation was the dissemination of the know-how gathered within the 'SEARCH' project to other organisations in Belgium so that it could be implemented on a wider scale.

2.2 Co-operation

A centre for asylum seekers, the city council, the Movement of People Without Papers (Beweging van Mensen Zonder Papieren), social services, medical authorities and specific target group-oriented organisations in the field of drug treatment were approached as part of the exploratory phase. Later on they were involved in the "sampling" part of the RAR method, the focus groups and the data feedback process. These institutions were also necessary for a broader implementation of the methodology.

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[7] De Stoop, Chris, Aziza of een verhaal van deportatie in Europa, De Bezige Bij, Amsterdam, 1996

2.3 RAR team

- Project co-ordinator for De Sleutel was **Peer van der Kreeft**, head of prevention. With a background in social education, Peer has worked in De Sleutel on the development of outpatient treatment in Dagcentrum Antwerpen since 1985, as well as on the conception and implementation of primary prevention programmes such as Leefsleutels, Contactsleutels, training both in and outside of Belgium.
- The project assistant was **Freya Van den Bossche**, who is a specialist in press and communication sciences. Freya has been making a substantial contribution to the detox centre of De Sleutel in Merelbeke since 1993, and has gained a lot of expertise here.
- The scientific component of the project was directed by **Veerle Raes**, head of the Scientific Research Department of De Sleutel. Veerle, a social educationalist, has gained broad experience in health care research.
- The team of interviewers consisted of Freya Van den Bossche, **Kresimir Strganac** (a former political refugee from Slovenia) and **Nele Voesterzoons** (a trainee from a college for social work).

The interview training was done with the whole RAR team, including role play. The interviewers were also responsible for the input of data in the Access File, designed by our research department on the basis of the grids provided by the scientific co-ordinators of the 'SEARCH' project.

2.4 Key persons within the city welfare centres

The social workers currently conducting the house visits and personal interviews (not concerning the asylum dossier but concerning financial support) are contact persons who have considerable potential for making a situation assessment and later on carrying out prevention measures. The largest number of asylum seekers, refugees and illegal immigrants are living within reach of these social workers. This group which lives in the city is more at risk of addiction than the group living in open or closed centres (largest proportion of illegal immigrants, less control, greater opportunities to come into contact with drugs). In the larger cities asylum seekers or refugees are often grouped in clusters according to nationalities. The nationality or country of origin can also be a factor that influences the probability of drug abuse.

2.5 The Red Cross centres

While the federal government open centres (2,500 residents) are mostly situated in former army barracks, the Red Cross open centres (2,500 residents) are often on a smaller scale, situated in former health centres and supported by a more health-oriented network. By coincidence, in a few of these centres some workers already have experience of drugs and addiction problems. Although the length of stay of the residents is rather short (4 months), the workers in such centres can make a valuable contribution to the situation assessment and play a role in prevention measures later on. The headquarters of the Red Cross[8] is also willing to allow the 'SEARCH' questionnaire to be sent to those responsible in its centres so that 'SEARCH' can be provided with information.

[8] Hilde Van Gastel, hoofd & Barbara Janssen, adjunct-hoofd, Rode Kruis Vlaanderen, Brussel

2.6 Additional data gathering in more than 100 municipalities in Belgium

We had the opportunity to design a questionnaire which was sent to more than 100 people within municipal social services (the OCMWs) who are responsible for asylum seekers. This information enables the data from the pilot project to be compared with other settings. At the same time the involvement of these services will make it easier to implement the prevention initiatives developed in the later phases.

2.7 Results of the process evaluation for the Belgian RAR pilot project as a standardised grid

Phase	What went well	What went wrong	Suggestions for improvements
Collecting existing information	Readiness of contact persons to explain their viewpoints by telephone	The initial phase occurred long before the actual interview phase: the context had changed a lot within that time: – The largest group of asylum seekers no longer were Kosovans and Albanians, people vulnerable for drug use now were Slovaks, Georgians, Iranians – Asylum seekers have been required to stay in a centre since January this year and no longer receive money from the government.	One phase should flow smoothly into the next!
Access and (social) mapping			
Identifying key respondents	It was possible to find contact persons from different viewpoints and sectors (press, voluntary services, Red Cross, city, etc).	The assumption that a respondent X represented the police turned out to be incorrect	Standardised characteristics
Mapping the community, gaining access to the community		Community is the most closeknit group of all asylum seekers: suspicious group, very hard to get access to	

Phase	What went well	What went wrong	Suggestions for improvements
Semi-structured interview phase (SSI)			
Sampling respondents	– Introduction to respondents was easy thanks to key respondents – Contact by phone and making appointments was easy – Respondents are very willing to make a quick appointment when they get an explanation about the RSA method. – Respondents are happy there is interest in the asylum seekers: very willing to co-operate	Selection based on time, not always on receiving more extensive information on the target group; Consequence of selecting mediators: the research tells us something about Kosovans and Albanians in contact with care workers. Those who do not have contact may be the most vulnerable group. It narrows the scope of your survey.	Be nice to your respondents: they're important if your investigation is to have any value
Semi-structured interviews	SSI form is a reminder for the interviewer not to forget to ask about certain subjects. We got a lot of good and detailed information about the target group: mediators are happy to be consulted	– Open interviews would have been better, there was lack of space for filling in background information – SSI form gives too much of a forced approach to the interview. – Splitting up products, vulnerable groups and Kosovans and Albanians is too complicated for the respondents. They see a group of asylum seekers, not 'Kosovans or Albanians', and they have little knowledge of products. – Question about relevance of the problems was difficult: respondents did not understand the question, most of the time they did not see problems, so they could not answer this one. Some respondents assumed that De Sleutel was prepared to overrate the drug prevalence in the target group.	Develop several key questions as guidelines for the interviewer and construct the next phase (SI) on the basis of the answers

Phase	What went well	What went wrong	Suggestions for improvements
SSI questionnaires	The grids were structured like the interviews	– The (over) differentiation of some points complicated the filling out – Background information is lost: there is nowhere to write it down!	Provide some instructions on how the information can be collated when the key questions are followed!
SSI report	– Since a lot of information was collated, the structured way of classifying information proved to be simpler for the report, – A good structure makes the report simpler!	Referring to the grids in order to draft the report proved to be useless: there were far more questionnaire pages than interviews (through the "splitting up"): we had to painstakingly collate the information together again afterwards	
Structured interview phase (SI)			
Sample survey	– No lack of contacts: the respondents freely gave us the names of others – The interviewers gradually become experts in this area in terms of differentiating between good and bad respondents – The development of considerable trust during the SSI phase proved worthwhile: many interview persons were willing to bring us into contact with people from the target group and even to interpret!	– Some new respondents did not regard themselves to be 'experts', they did not believe that they could provide us with new or further information – Colleagues from respondents from the SSI phase in a medical centre refused to participate: they did not see any point in the SI – Should we wish to obtain more information from the target group: access is not easy!	– Providing preliminary information on the phone and being prepared to mention some aspects has advantages: The respondent gains trust and the interviewer can judge how much expert knowledge he can expect from the respondent, – contact as many respondents as possible: the time is short, meetings can be cancelled and you can always keep a few "in reserve"!

Phase	What went well	What went wrong	Suggestions for improvements
structured interviews	– We dispensed with differentiating between "products" (= addictive substances) and vulnerable groups, the respondents chose the area which they knew about and were able to answer the questions in a structured way; – We have discovered more concrete facts than "assumptions"; – The interviewer became constantly better at matching the interviews with the respondents (flexibility).	– As far as saving time, there was no great difference between the SSI and the SI: winning the trust of the respondents and explaining the type of questioning needs time. – As far as the language was concerned when interviewing respondents from the target group: the questions were too complicated for them.	
SI grids	The filling out was easier: more structured, less background information	Not enough room for including background information	It is very useful to keep a notebook in which every step is recorded
SI report	Simple to build on the SSI report	The splitting up of information in the grids made it complicated to draft a report	
Focus groups			
Finding participants	– was very easy, the experts were very cooperative	The time was a problem: experts are very busy and therefore it was difficult to make an appointment, or some did not turn up at the last moment	
Agenda of the focus groups	It is easy to derive the agenda from the report		
Head of the focus group	Very good way of getting a lot of information in a short period of time		
Focus group grids	We did not use the grids in the groups and filled them out later		

Phase	What went well	What went wrong	Suggestions for improvements
Final report	It was easy to collate all the information		
The entire RAR process...	– enables a good and quick insight into the problems and their background with a selected population, – is a good system in order to gain a "clear view" of the "hidden population" – better differentiation as to who belongs and who does not	Difficult for very closed and suspicious groups	

3. Prevention issues

3.1 Conclusions from the RAR process

Should we differentiate between substances?
No, the focus group finds it to be more important to consider ways of approaching the target population and the means of communication. Quality prevention is considered to be more general prevention. In talking openly about drug use the aim is to influence lifestyles and culture rather than just provide information about substances.

Is reducing anxiety and insecurity an appropriate preventive measure?
Anxiety and insecurity in general are one of the main causes of drug abuse, but influencing this area is a matter for policymakers and not for health care or prevention workers. Activities which are feasible for them, however, include helping asylum seekers to become better integrated within Western society and providing them with clearer long-term perspectives.

Is the target population effectively reached through mediators and parents?
Parents must also be informed. They are more easily accessible through primary health care than youngsters. Reaching young people would be more effective through the general school classes which they attend than through specific language classes; the latter would have a stigmatising effect.

Would brochures or information sessions be appropriate prevention instruments?
Leaflets or brochures should first and foremost be published in their own languages. It is only then that they are read. Possible distribution channels: at the GP, the emergency services of hospitals, community health centres.
If possible, the brochures should be incorporated within the general information package for prevention, or as part of an existing video programme.

Information sessions are, as with Belgian residents, only attended by people who are already sensitised and engaged.

3.2 General recommendations from the focus groups:

1. Prevention for Albanian and Kosovan youngsters needs to keep up with new youth lifestyles and youth culture. Approach them as developing young people, not as young refugees.
2. Do not only direct the prevention measures at the refugee target population; this will make them feel singled out and stigmatised.
3. Give a light, spontaneous feel to the message and the approach, the target group has a distrust of anything that looks official or formal.
4. Formulate a message that suggests opportunities and potential, i.e., is not just filled with accusations or concerns.
5. Find out how the prevention in the country of origin is organised and why it is so organised.
6. Organise prevention as you are already doing for the Belgian population. Apart from the language, there does not have to be much difference.
7. Qualitative prevention starts with an adequate explanation of the findings of the RAR research.
8. An objective might be: Albanian and Kosovan parents begin discussing substance use; i.e., it has become an issue which can and may be spoken about.
9. An important recommendation for policymakers: if you organise prevention, take care that there is also a treatment facility.

3.3 Reflections on the recommendations in the RAR team

The first suggestions for prevention measures were discussed in the RAR team after the second focus group. We considered:

1. Training of social workers coming into contact with Kosovan and Albanian refugees in De Brugse Poort in Ghent. The subject would be: legal and illicit drug use and the problem description derived from the RAR. Additional subject: To whom can you send possible clients, what happens there, which steps can you take?
2. Training of key persons in the refugee community. The subject of drug use would be embodied within general health care, with specific attention given to how problems can be solved within your own group.

For both considerations we need to detect who and where the key persons are (peer leaders) in order to develop adequate prevention tools. The way Kosovan and Albanian refugees receive and perceive information and care needs to be described before we can implement this stage. We decided to limit the prevention activities within the 'SEARCH' time frame to these activities.
The exchange of ideas at the European meeting in Turin led to the suggestion to include existing training possibilities as part of our activities. This suggestion was supported by several participants in meetings in Ghent, where our options were discussed. We decided to organise meetings with players concerned with caring for refugees.

3.4 Meetings with representatives of refugee carers

We discussed our options with people working in ING-steunpunt-zuid (local integration centre), PICO (regional integration centre), RKJ (inpatient treatment for juveniles); all in close connection with De Brugse Poort in Ghent[9]. We enlarged our RAR team with the inclusion of Sofie Heye (social worker trainee) to organise and report on the meetings.

Further recommendations:
Simply providing information on legal drugs, including the effects and risks, will be the easiest way to gain access to the target groups. The subject of illicit drug abuse will necessarily form a part of written or direct contact. The 'SEARCH' brochure should clearly demonstrate the risks to children within the refugee community and how they should be protected. In this way the dubious and often incomprehensible concept of 'our future' will be given more flesh and blood for the target population.

The 'SEARCH' brochure will need to deal with more than just issues concerning tobacco, alcohol, medication and illegal drugs. Only if it can illustrate the link with the social and cultural reality of the refugee families will it be able to reach the target population.

When employing mediators who have a trustful and confidential relationship with the target group it must not be lost sight of as to the high degree of sensitivity required. Integrity can easily be destroyed if the impression is gained that information is flowing to official authorities.

Even if the content and objectives of the 'SEARCH' prevention activities are specifically based on the RAR outcomes, it does not mean that the activities should remain limited to this specific target population of Kosovan and Albanian refugees. Broadening the target population to other groups of refugees will open up a lot of new communication channels.

It will be most effective if the main efforts are put into developing qualitative materials that can be used and supported by training or communication officers from other agencies. In that case the 'SEARCH' materials (brochures) would also need to contain trainers' guidelines or mediator guidelines. If the guidelines are compiled adequately, a train-the-trainers session will not be necessary. Incidentally, experience has shown that, even if they are very well equipped, such sessions are poorly attended because of the high caseload of the workers operating in this area.

Translators need to be planned for any direct contact with the target group. They could be provided by the regional (provincial) government institutions.

3.5 Concrete possibilities:

1. Together with KOMPAS, ING (local integration centre) organises an orientation course lasting 60 hours targeted to Kosovan and Albanian refugees from De Brugse Poort and another district in Ghent. A 'SEARCH' training or information session could be integrated into this course. This would require the need for an in-depth preparatory contact, however, because the course is introduced within the framework of time consuming home visits where the aims and methods of working are explained to the refugee families. Non-registered illegal residents are also reached by ING, whereas KOMPAS (social orientation education centre) only reaches refugees with restricted status.

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[9] ING = Intercultureel Netwerk Gent
PICO = Provinciaal Integratie Centrum Oost-Vlaanderen
RKJ = Residentieel Kortdurend Jongerenprogramma

2. Steunpunt (supporting point) El-Ele organises food distribution in De Brugse Poort; many refugees are known by the Ele-Ele volunteers and professionals. If these mediators were informed of the aims and intentions of our 'SEARCH' prevention tools (be it by training or using a brochure), they could provide informal support for the initiative and at the same time gather feedback on it.
3. El-Ele organises a series of meetings specifically for women; a one-day meeting could be organised on the issue of children's health, providing important information on heavy smoking at home and the use of sedatives.
4. The Transit House will be an important channel for issuing printed material in addition to providing oral and informal information. It has an interesting status as an NGO which is a well-organised and very busy care centre.
5. Onthaalklassen (orientation classes): There are 4 such classes in Ghent for refugees. Illegal refugees are also reached by these classes. One theme from the current primary prevention material of De Sleutel could be adapted and translated, linking the issue of integration and the use of drugs.
6. The University of Ghent organises language courses which are also available to young refugees between the ages of 18 and 25. As part of theses courses the 'SEARCH' brochure would also be willingly accepted as study material. Kosovan and Albanian students could also act as mediators within their community.
7. The same kind of integration as with the language courses, but on an even broader scale, could be proposed for the Small Castle in Brussels. The six-month stay in a residential centre by each (official) refugee provides an opportunity to provide extra and specific information on substance abuse prevention.
8. City Council of Ghent: Publishes an orientation brochure for all new inhabitants, including refugees. The 'SEARCH' brochure could be successfully distributed within this context.
9. This series of meetings provided us with another list of contact persons who can provide further support for any initiatives which we take.

3.6 Actions

3.6.1 Materials

De Sleutel has developed the following materials:
A 6-page 'SEARCH' brochure with information (in Kosovan, Albanian, Turkish and Arabic languages) on:

- Heavy cigarette smoking and the consequences for small children as passive smokers
- Binge drinking and the relationship between family drinking habits and the early onset of teenage alcohol use
- The way sedative medication is prescribed and taken in Belgium and the long-term effects of such drugs
- The similarities and differences between legal and illicit drugs in Belgium and the onset of cannabis or amphetamine use amongst teenagers and youngsters
- Life skills, social skills and the roles of the community, family and school
- Specific pit holes and opportunities for migrant or refugees concerning addiction and dependency: risk factors and protective factors:
- A 'SEARCH' version of a primary school prevention programme based upon *A hole in the fence*. 5 selected stories about children in their community, welcoming a stranger into their midst, wonder-

ing about a magic potion, learning about life skills and everyday problems. Well illustrated and easy to read or be read out by an adult[10].

3.6.2. Public information

In October 2001, De Sleutel organised a conference in De Brugse Poort which presented the results from the RAR phase of the 'SEARCH' project.
Media exposure included:

- National newspapers: nieuwsblad/standaard/demorgen/hetvolk
- Regional television: AVS
- National radio: Radio 2
- Local radio: Radio Roeland[11]

By the end of March, the close of the project, De Sleutel will have publicised the prevention materials and initiatives together with the 'SEARCH' manual on a similar scale.

3.6.3 Policy recommendations

- The report, together with the manual, will be disseminated to all government institutions involved.

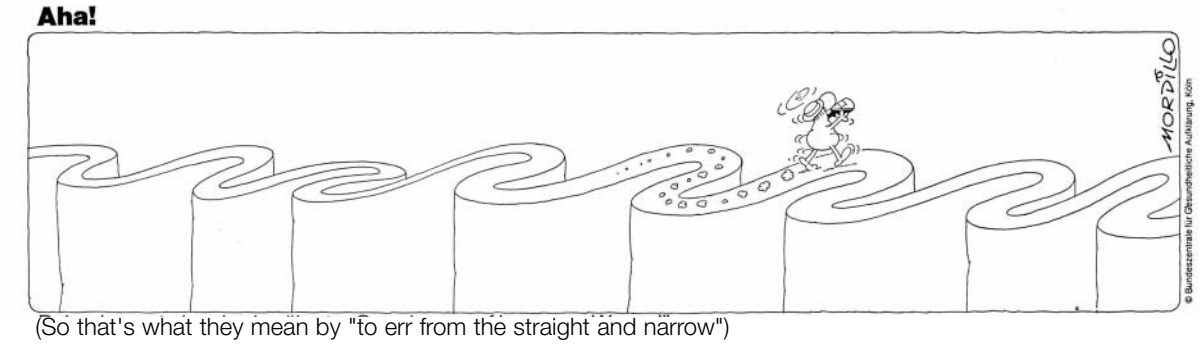
Special meetings to discuss the recommendations will be organised with:

- The Flemish Ministry for Social Integration
- The Inter-ministerial Committee for Drug Policy
- The Red Cross
- The City Council Commission for Refugees in Ghent.

[10] See attached materials in Dutch language. See also www.desleutel.be
[11] see selected article on http://<www.kleinkasteeltje.be/nl/belgie/2001/oktober/druggebruik.htm

'SEARCH' in Germany

Drug Prevention for Tamil Asylum Seekers in the "Kreis Soest"



(So that's what they mean by "to err from the straight and narrow")

Diakonie Hochsauerland-Soest e. V., Soest, Deutschland:

Dieter E. Hauck — ***Project Coordinator 'SEARCH' Germany***
Beate Wolf — ***Research Assistance***

1. The German partner from 'SEARCH'

1.1 Soest District - Hellweg Region

14 The region around Hellweg is characterised by towns, districts and three health resorts. They all have a history which goes back several centuries, but which is very much still alive. The historic trade route "Hellweg" had already attained importance by the Middle Ages in terms of the early economic development. Openness to new developments, a nurturing of traditions and an optimal regional infrastructure have enabled the towns and districts to become lively and important centres.

The Hellweg region in facts and figures

Large towns	Lippstadt	(66,806 inhabitants)
	Soest	(48,561 inhabitants)
	Werl	(31,738 inhabitants)
	Warstein	(29,073 inhabitants)
	(Last updated: 31.06.1999)	
Soest District	1,327.47 qkm	
Population	305,589 (as per: 1999)	

The Soest District Local Authority organises its duties according to the "departmental concept". The organisational structure consists of four departments which are administered in line with the principle of decentralised resource management.

The department mainly involved in the 'SEARCH' project is department 4: Social, Youth and Health Services. In order to realise the research part of the project a co-operation agreement was concluded with the Diakonie Hochsauerland-Soest, a church body providing voluntary welfare work.

1.2 Diakonie Hochsauerland-Soest e. V.

The Diakonie is a church network which provides social welfare. It helps people in social, mental and physical need, and fights for social justice.

The Diakonie is there for all people, regardless of their origin or religion.

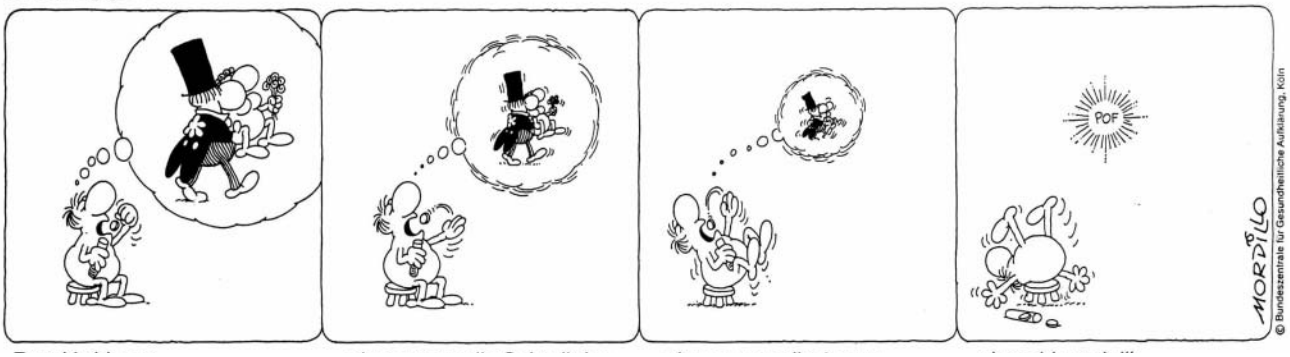
The Diakonie represents closeness, trust, friendship, solidarity, openness and tolerance.

The Diakonie provides areas of work for many voluntary and full-time employees working in parishes, outpatient counselling services and in social and inpatient facilities.

The fields of work include providing counselling for aliens and refugees as well as for people with psychiatric, addiction and accommodation problems.

The experience and resources of the Diakonie are incredibly well suited for conducting research; in the field of addiction risk and dependence the employees have almost 30 years of experience in inpatient and outpatient addiction care. This includes both substance-related and non-substance-related dependencies for Germans and foreign residents in the Soest District and the bordering regions. Moreover, the Diakonie is involved in the structural and conceptual further development of addiction care within the Soest District and throughout the federal state of North Rhine-Westphalia.

That'll do it



„so that everything is OK - one to calm the nerves... ...one for faintness... ...one for anxiety... ...then it'll be OK!"

2. The target groups of 'SEARCH' Germany

2.1 The initial situation in the Soest District

At the start of the survey conducted for 'SEARCH' around 305,000 inhabitants were living in the Soest District, an average population when compared to the rest of the federal state.

The proportion of foreigners was around 6.5 %, consisting of 19,784 people from 95 different nations.

The statistics for foreigners reveal that there are:
– 1,598 asylum seekers
– 125 de facto refugees
– 1,519 holders of short-term resident permits, i.e., there is a total of
3,242 registered refugees and asylum seekers.
(16.4 % of the foreigners or 1 % of the overall population.)

The town of Soest was selected for the observations related to the 'SEARCH' project.

On the reference date of 30th November 2000, 223 refugees and asylum seekers were registered in the town of Soest by the Aliens Authority of the Soest District.

At the beginning of the Rapid Assessment and Response research there was no specific knowledge about drug and addiction problems among the (potential) target communities.

When observing the living conditions of the refugees and asylum seekers in the town of Soest, it was noticeable that the accommodation was concentrated in the so-called "Soester Süden" (South Soest), in the immediate area surrounding the "Britische Siedlung", the former British military base. These are housing blocks which, following the disbanding of the military base there, were made available and now provide homes for a great many foreigners.

In the town accommodation:

"Opmünder Weg"	=	capacity	110	places
		occupancy	50	persons
"Waldstraße"	=	capacity	120	persons
		occupancy	75	persons,

there is stabile occupancy that mostly consists of families with a very low fluctuation rate and where there is very little in the way of conspicuous behaviour that would point to substance use.

The situation was more problematic, however in the all-male hostel in the "Werkstraße", where refugees live who have mostly short-term resident permits. Here, experts and contact persons assume that there is a high proportion of consumers and dealers.

The other registered persons either lived in the immediate proximity of the "Britische Siedlung", or elsewhere in the town, mostly in their own flats.

2.2 Assumed consumption patterns and the definition/narrowing down of the target group for our RAR

At the beginning of our work we received the overriding impression that the voluntary workers concerned - but also the "professionals" from the administrative and social services - were extremely discreet in dealing with information on the subject at hand and certainly did not mention anything at all in public. Although we were unable to find any confirmation of this, there appeared to be a "collusion of silence".

In the course of this report it will become clear how, using the RAR method, it was possible to very successfully break down this "wall of silence" and provide reliable information.

The gathering of information on conspicuous behaviour that would indicate drug problems led to speculation about significant alcohol abuse amongst *Tamils* and drug abuse amongst Kurds. As a result, the study concentrated on persons in the target group of *Kurds* from Iraq, Iran, Syria, Lebanon, Georgia and Turkey, as well as on Tamils who were mostly from Sri Lanka.

Here it has been *presumed* that there is nicotine, alcohol and drug consumption amongst Kurds and nicotine and alcohol consumption amongst the Tamils.

3. Asylum in Germany - a quantity with many unknowns

Comment

At this point we do not wish to make any sweeping comments on, or any general criticism of, the German asylum policy and the procedures used.

In the following report exemplary factors will be mentioned which, as will be shown, effect the conditions which influence the occurrence of problematic substance use. The reader is called on to use his own imagination here.

3.1. Initial situation

"The word asylum derives from the Greek: "Asylon" means place of refuge, "asylos" means that what cannot be captured. In former times "asyle" were mostly holy places which protected the refugees from capture by secular powers.

With the incorporation of the statement

"persons persecuted for political reasons enjoy the right of asylum"

into the German Constitutional Catalogue (Article 16 Par. 2 Clause 2 of the German Constitution) the right of asylum is legally enshrined as an enforceable right at constitutional level.

The Federal German Right of Asylum, which is guaranteed by no less than the German Constitution itself, is the result of the bitter historical experience of political persecution during the period of National Socialism. The authors of the German Constitution granted those entitled to receive asylum with a highly personal, absolute right of protection and thus the fundamental right of asylum. By granting an individual right of asylum the German Constitution goes beyond that of international law, which does not recognise such a right, but in terms of granting asylum gives preference to the right of the State over that of other countries.

The fundamental right of asylum is the only fundamental right to which aliens are entitled. It applies only to those who have been persecuted for political reasons, i.e., persons who as a result of their race, religion, nationality, membership of a certain social group, political conviction, etc, have suffered from, or are immediately threatened by, state persecution. General emergency situations, such as poverty, civil war, natural disasters or high unemployment, are excluded as grounds for granting asylum[1]*."*

> "The growing number of asylum seekers in Germany (1987 - 57,000, 1992 - 438,000 persons) led to an amendment of the fundamental right of asylum in 1993. The main elements of this constitutional amendment are the "third country regulation", the list of "safer countries of origin" as well as the "airport procedures". These regulations can be considered both as measures against possible illegal entry as well as, de facto, as causes for creating new illegality. Together they have the aim of limiting the number of asylum seekers entering Germany. Many refugees who are neither able to receive asylum through the German embassies nor get visas are therefore forced to travel illegally to Germany and the EU. Refugees become aliens without any right of residence, seeking protection while being completely at the mercy of others.
>
> Since the amendment of the fundamental right of asylum, there has been an increase in the discrepancy between registered entry and asylum applications made in Germany. One explanation is that the asylum seekers enter Germany illegally. Indications that would confirm this to be the case have been provided by estimates for the number of illegal entries. Whereas the number of asylum seekers in 1997 was 107,000, the number of illegal entries for the same year is estimated to be an additional 175,000.
>
> Refugees in Germany without any right of residence form a "hidden" population - not just statistically but in real terms, being closely woven into the fabric of society. The extent of the illegality is hard to quantify."[2]

3.2. The route to Soest during the course of the asylum procedure

"In accordance with the Asylum Procedure Act which has been in force since 1st July 1993, the course of the asylum process is essentially as follows:
Provided that the asylum seeker is not immediately expelled by the border authorities, he is then referred to the closest reception centre which every federal state is legally obliged to establish and maintain.

Distribution

*With the help of the national distribution system EASY ("***E***rstverteilung von* ***Asy****lbewerbern" - meaning: First distribution of asylum seekers), the asylum seekers are distributed throughout the individual federal states in accordance with a quota system laid down in the Asylum Procedure Act (take-up quotas in %).*

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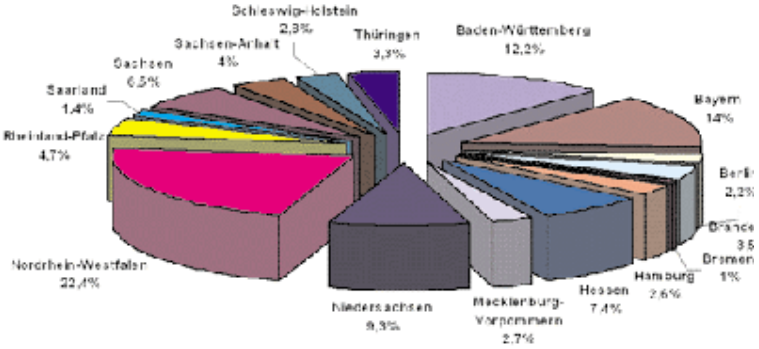
[1] See http://www.bremen.com/migration/auslg/verfahren.html
[2] Ohne Recht auf Aufenthalt, published by: Ev. Kirche von Westfalen, Bielefeld, 2000

Moreover, through EASY the respective reception centre is determined that will be responsible for providing the accommodation. These are assigned to a local office of the Federal Office



The alien can normally stay in the reception centre for up to six weeks, at the longest, however, for up to three months. The responsible local office of the Federal Office is issued with the relevant documents of the asylum seeker required for conducting the asylum pro-cedure. There, the employees in the Asylum Procedure Secretariat (AVS) open an asylum file for the asylum seeker as soon as he has applied for asylum and has been fingerprinted and photographed for identification purposes.

On receiving the asylum application the data of the respective alien is entered into the ASYLON computer system, whereby it is checked to see whether it concerns an initial application, a follow-up application, or even possibly a double application. The data of the asylum seeker is then transferred to the Central Register of Aliens (ARZ) at the Federal Administrative Office (BVA) in Cologne.

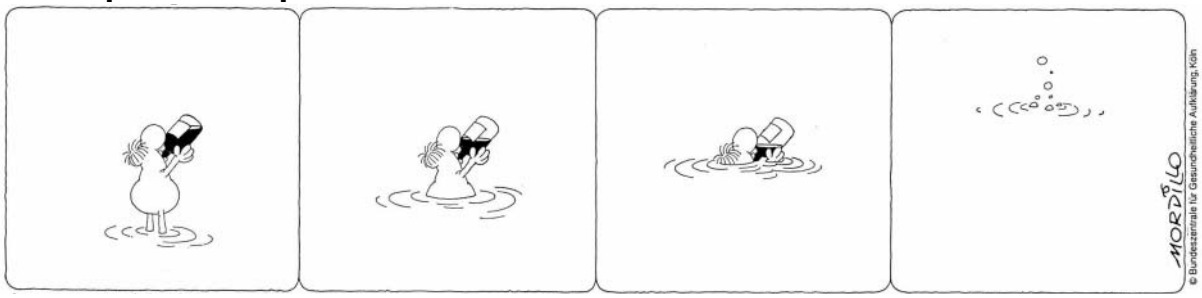
The asylum seeker is then issued with a resident permit which provides him with a temporary right of residence for the purposes of carrying out the asylum procedure in the Federal Republic of Germany.

Interview and decision

Following this, the asylum seeker is then interviewed by an individual assessor in the presence of an interpreter. The asylum seeker is obliged to explain the grounds for his persecution, to provide facts and any existing documents. A transcript is produced of the essential assertions made during the hearing which is then translated for the asylum seeker and normally given to him as a copy immediately after the interview.

The individual assessor then reaches a decision on the asylum application based on the hearing and, should it be necessary, on the basis of further investigations ordered by him to clarify the facts of the case and any knowledge gained from the information and documentation office of the Federal Office[3]*". All this means that the asylum seeker has to wait . . .*

It all depends on our point of view



Whenever I drink... I have the pleasant feeling... that the big bad world... sinks into oblivion.

[3] http://www.bremen.com/migration/auslg/verfahren.html

3.3. Further information on the living conditions of asylum seekers in Soest/Germany

The living situation for refugees and asylum seekers after their assignment to Soest has already been briefly described.

Providing accommodation to asylum seeking families has proved to be particularly problematic. Frequently, they are temporarily accommodated as single persons in short-term hostels where there is often little space and, from our point of view, a very problematic mix of various nationalities.

An obligation to remain present, and in extreme cases, a daily registration requirement, causes an enormous amount of strain and even discrimination. Because there are no or only limited employment opportunities, this means that they are dependent on state care that, depending on the status of their residence, is provided through the Federal Welfare Act, the Asylum Seekers Benefits Act (§ 3, § 1a and § 2) or child care and housing benefit. Here, payments are made which are frequently smaller than those made to needy Germans/foreigners living in Germany (for example, besides other allowances, up to the age of 14: 20.00 €, from 15 years of age: 40.00 € per month as a sum of money to cover daily personal needs).

The support provided by charitable institutions, non-organised voluntary carers as well as those involved in the field of asylum work has proven to be both helpful and indispensable.

Otherwise, the problems mentioned by the colleagues from the research teams in the other countries are repeated here.

4. The RAR team of the German project partner

For the German team the greatest problems already became evident during the preparations before the project start: the addiction and psychiatric co-ordinator from the Soest District suffered a complicated, drawn-out illness.

She was in charge of the team that, supplemented with employees from the Diakonie Hochsauerland-Soest, was supposed to begin the work.

After a phase of uncertainty when transitional arrangements had to be made, responsibility for the project was transferred to **Dieter E. Hauck**, a qualified social worker, social therapist and department head of the four addiction counselling centres of the Diakonie in the Soest District. This included the initial survey and reports, instructing employees, conducting semi-structured and structured interviews, moderating focus groups and co-authorship of reports. **Cornelia Witt**, a qualified educationalist and preventive specialist for the Soest District Authority was asked to carry out the evaluation of the data and statistical material, as well as being involved in preparing and documenting the focus groups, the moderation of these groups, and the production of prevention material. **Beate Wolf**, who is currently studying to become a qualified educationalist and is a student assistant with experience of empirical social research, was responsible for conducting and transcribing the (predominately structured) interviews, as well as preparing and participating in focus groups and producing prevention materials.

5. The course of the RAR process in Germany

5.1. Rapid Assessment and Response (RAR)

After the initial problems with compiling the RAR teams, luck returned with the selection of interview partners.

During the preparation of the project we were advised to use certain "key persons", who in the end were all available for the phases of semi-structured interviews. The results of the interviewing as well as the arrangement of contacts for the structured interview phase was deemed by us to be very successful.

The following provides an overview of the "background" of these interview partners:

- Key informants from the group of people closest to the refugees and asylum seekers
- Employees from various hostels (social workers, caretakers)
- Employees from the "Britische Siedlung" resident centre
- Employees from the drug counselling centre who provide special services in the resident centre
- Town Social Services- Aliens Authority
- Refugee Counselling Centre
- Asylum Work Group
- Advisory Council for Aliens
- Treatment facilities
- District authorities (Addiction Co-ordination, prevention experts, Commissariat for Prevention)
- "Stadtteilkonferenz Süd" - (council for the town's southern district which includes the working group on addiction prevention)
- People working voluntarily as individuals or in groups

Most of the interview partners were able to name people who made desirable candidates for questioning within the framework of the structured interviews. Moreover, many proved to be very helpful in making successful contacts - an important phenomenon that is linked to the traditions of refugees and asylum seekers which develop out of the conditions/ experiences in the homeland, the places travelled through and finally the host country.

During this phase, we met the majority of the interview partners from the target groups of Kurds and Tamils in hostels, addiction care inpatient facilities and in a penal institution (JVA).

Besides the extensive problem of nicotine misuse amongst most refugees and asylum seekers, all the information up to this point suggested that with both Kurds and Tamils the vast majority of young men living alone or independently (aged between 14 and 35) use substances in a problematic way.

Regretfully, it proved impossible for our team to find interview partners outside the JVA or therapy facilities. Here those concerned were either unwilling or the respective "key persons" lacked the possibilities to provide contacts.

5.2. The focus groups in the RAR process

As a result of the "crisis situation" regarding personnel during the initial phase of the project, and as a result of missing or deviating answers from interview partners which, in those individual cases where interviews were conducted by phone, were not able to be clarified, we decided to dispense with focus groups during the interview phase - a decision which we later regretted! When considering the course of the process from today's standpoint, this led to a delay in reaching any success:

From today's standpoint we feel that when the respective persons from the target groups and other "key persons" participate in focus groups, these groups provide a phase of personal sensibilisation to the theme and its content, which increases the ability to make contact, build up relationships and become more approachable, and breaks down reservations, reveals hidden approaches, clarifies hindrances, reveals existing protective factors - i.e., to put it briefly: reveals perspectives, possibilities, limits and conditions for interventions.

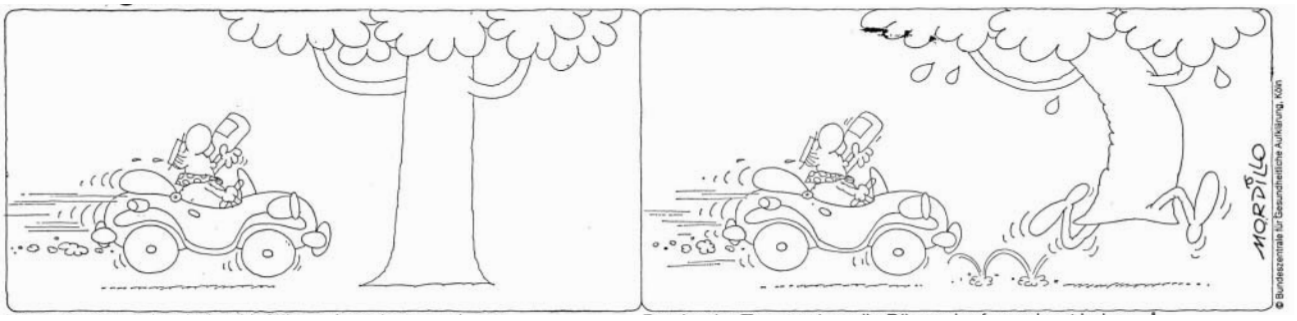
Example: During the entire phase of the semi-structured and structured interviews there were no indications at all of problematic substance use amongst Tamil women.

With regard to the specified intention of developing culturally suitable prevention measures, it became clear during the course of the focus groups, which were held in an atmosphere of competence, trust, openness and helpfulness, that there is a much greater problematic medicine use amongst women from Sri Lanka than expected, that had previously been overlooked or not mentioned. The causes are considered to be traumatic stress and post-traumatic stress reactions as a result of the asylum seeker procedures on arrival.

The reasons for this:
- Cultural circumstances and, in particular, the lack of willingness to address these and other problems outside the family in the public realm,
- Position of the women in the community of the homeland,
- Lack of education on the risks and dangers of medicine use in the host country,
- Inappropriate use of prescriptions instead of necessary therapy.

This knowledge led to short-term interventions and changes/expansion of the intended preventive measures.

One Day...



One day there will be no more accidents due to alcohol... That is the day when the trees learn to walk

6. Results of the RAR in Germany

The studies in the target communities of the Kurds and Tamil asylum seekers in Soest were unanimous in showing that amongst the persons most at risk in terms of problematic substance use were *young men living alone*.

During our researches we furthermore discovered that, with some of the Kurds, organised crime apparently lay behind some of the asylum applications. We received indications that in particular *young* Kurds are literally "recruited" to emigrate to Germany in return for money. The price for doing this: they are supposed to sell drugs at their destinations at schools and elsewhere.

The results reveal the wide-spread consumption of nicotine; for organisational reasons, however, we dispensed with conducting a more thorough survey about the use of this substance.

Particularly noticeable is that in both of the named communities there is a lack of social contact and lasting relationships, segregation bordering on open disapproval, financial dependence, isolation in the host country, legally unsure residence, consumption patterns which are brought with them and a wide-spread "openness" to substance use.

Tamils: Summarised factors which encourage/promote problematic substance use:

a) The consideration of alcohol as a "luxury good" and the tolerance of alcohol consumption in the host country (in stark contrast to the homeland), as well as the problem of availability.

b) Effects of the asylum policy; the course and duration of the asylum procedure,the manner in which they are dealt with by the authorities and the type of accommodation.

c) Traumata; Whilst initially caused by the persecution and violence experienced in the homeland, these traumatic experiences are often first communicated in the host country, which in itself can trigger of the use of substances.

d) The effect of alcohol;This helps to repress isolation and to forget or dispel problems, thus increasing the apparent sense of well-being. A particular problem is the wide-spread, genetically-determined low toleration of alcohol by people within this cultural group, which again increases the risk of becoming addicted. In individual cases there have been reports of liver damage caused by the toxic effects of alcohol.

e) Through the incorrect estimation of ages by the authorities, as well as through false statements given about their ages, young Tamils (>16 years of age) are often assigned to group accommodation with men living alone. Here, the adolescent youths are very much at risk of being exposed to violence, addiction and sexual assault.

f) The activities of the "Tamil Tigers" in Germany. This group, which fights for the independence of Northern Sri Lanka with the aim of defending the culture and language of the Tamils, is financed through "donations": "Nobody can avoid their obligation to provide support" (quoted from an interview partner).

Kurds: Summarised factors which encourage/promote problematic substance use:

Alcohol

a) In contrast to widely held assumptions, there appears to be a more wide-spread consumption of alcohol in the homeland (e.g., Raki as a "medicine"). Nevertheless, the liberal approach to alcohol in the host country eases/promotes its consumption and misuse.

b) The trauma resulting from political persecution and experiencing violence, as does

c) The duration of the asylum procedures, the type of accommodation, the attitude of the authorities and their restrictive way of dealing with applicants.

d) The effect of alcohol - forgetting, suppression and denial of problems and consumption as a way of trying to compensate.

e) Moreover, the easy availability of alcohol at any time and place must be emphasised as a significant factor.

Kurds: Illegal drugs

Kurds who are refugees in Germany frequently come from areas in their homeland where drugs are cultivated. The original trade in drugs leads to consumption. Also influential here are:

a) Traumatic experiences in the homeland

b) When compared to the homeland, the more liberal drug policy of the host country breaks down inhibitions

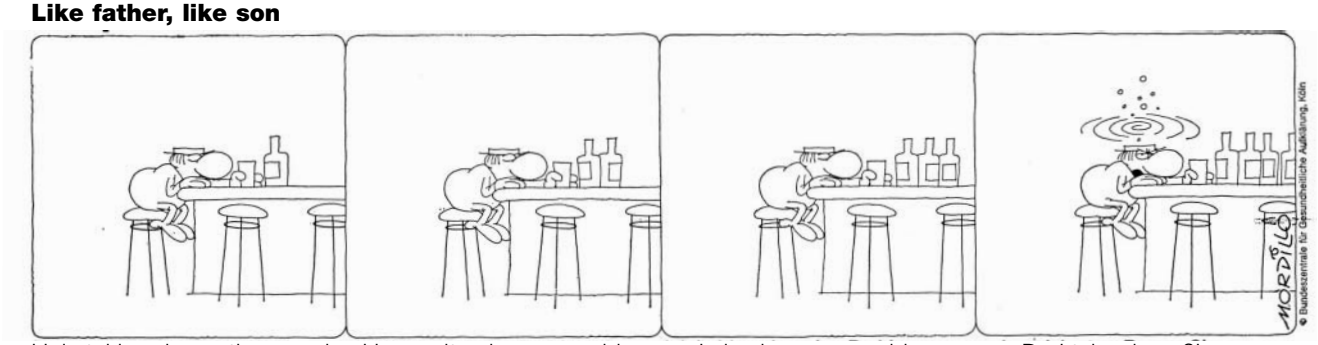
c) The ability of drugs to suppress problems, changes in the consumption pattern (injection instead of smoking).

d) The opportunity to earn an income both as a consumer and as a dealer.

e) The pressure to "donate" to the PKK, which is active in Germany, is described as a great psychological strain. In particular there is increased pressure when family members remain in Turkey and live in houses financed with mortgages. The total money required for donations to the PKK, interest payments for Turkey and the cost of living can normally only be achieved through illegal means by dealing in drugs.

In the field of alcohol misuse, the RAR team found that those Kurds who were examined showed slight withdrawal symptoms and significant mental problems (e.g., psychoses and schizophrenia). In the field of illegal drug misuse, there was a wide-spread consumption of heroin and cocaine, and in individual cases dependence requiring treatment.

Like father, like son



He's taking drugs, the rascal... He won't solve any problems with that!... I also have my problems... Do I take drugs?!

7. Conclusions for culturally appropriate addiction prevention

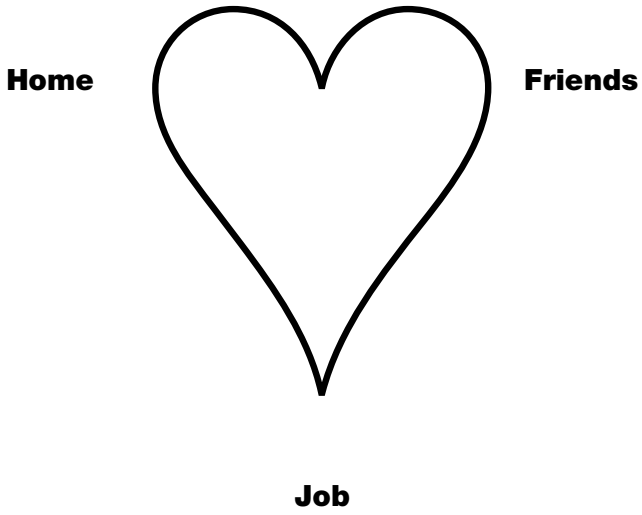
As has already been mentioned, the RAR team did not come across any previously prepared prevention activities for our target groups in Soest. Looking back on the RAR-supported process we have been able to establish the following points which will be important in terms of providing *culturally appropriate addiction prevention* for the target groups mentioned.

Existing *protective factors* which we consider to have a preventative effect are:
- Family ties;
- Positive social contacts;
- Lasting relationships both with their own people but also with people from the Soest population;
- Prohibition of alcohol amongst devout Muslims.

For all the target groups, the following preventative measures were mentioned as having priority:
– Measures for cultural integration and intercultural contact
– Measures for occupational integration
– Measures for social integration
– Health education
– Improving language skills.

Moreover, the following appear appropriate for addiction prevention:
– Organised, structured leisure activities
– Creating possibilities to avoid problematic peer groups
– Repressive measures
– Improvement of the living conditions.

The oppressive social situation (forbidden to work, low income, etc.), the living conditions (poor, cramped and partly inhospitable accommodation in the asylum homes) and the social isolation (hardly any contact outside of the homes, discrimination by the local population, etc) are all considerable factors which lead to a higher risk of addiction and would therefore be aims for structural addiction prevention. Accordingly, the highest aim of all prevention efforts should be to create balanced, suitable conditions in the various areas of life.



Job means here an economically sufficient livelihood,
Home means suitable living conditions, a new home and
Friends means lasting relationships with fellow human beings, family and partners.

8. Background information on addiction prevention

At this point we would like to incorporate some fundamental ideas and definitions that appear in "meet the need", published by the LWL Münster/Germany in 1999[4] within the framework of the EU project "euro-net", and which are highly appropriate for describing the inital position of addiction prevention in Germany, including for refugees and asylum seekers with different age structures:

"Addiction prevention should be [...] a way of approaching the world of refugees and asylum seekers that treats them like partners.

Coming into contact with one another means achieving a form of communcation that succeeds in respecting the national, cultural, ethnic, religious and moral traditions and creates an awareness of society as a whole that represents the basis and aim of a fruitful coexistence".

Definitions:

HEALTH

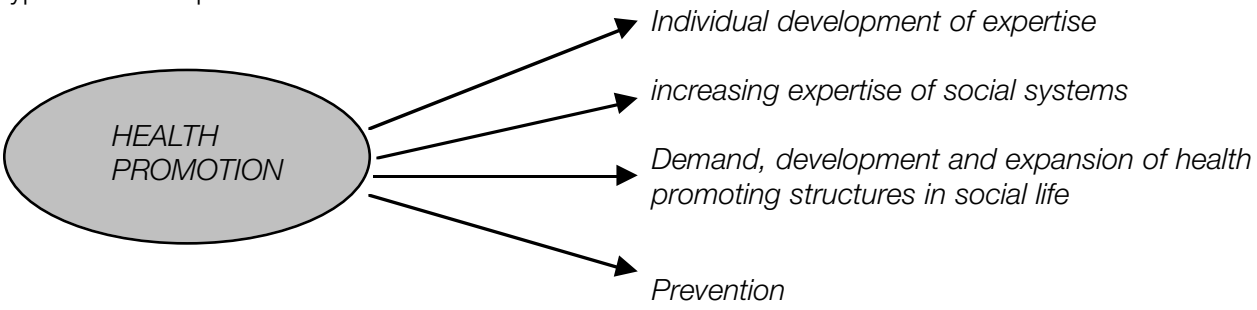
is the striving for physical, mental and social welfare and the development of a style of living which is characterised by increasing independence, solidarity and satisfaction."

HEALTH PROMOTION

describes a supplementary set of structural and individual strategies for promoting resources which, on the basis of social structures, enables

- economic, educational, social, ecological, cultural and political preconditions to be developed so that
- individuals
  - can organise their lives independently
  - can deal with the internal and external conditions for physical, mental and social health, and
  - make their own personal experiences and so promote social development.

Types of health promotion:



[4] "Meet the Need", Curriculum for addiction prevention peer group education in out-of-school youth work, produced by G. Koller, Austria, published by LWL, Münster/D. 1999

ADDICTION PREVENTION

Prevention in general refers to very differently developed strategies in the health, social and legislative sectors which can be implemented for the purpose of reducing and eliminating imminent risks.

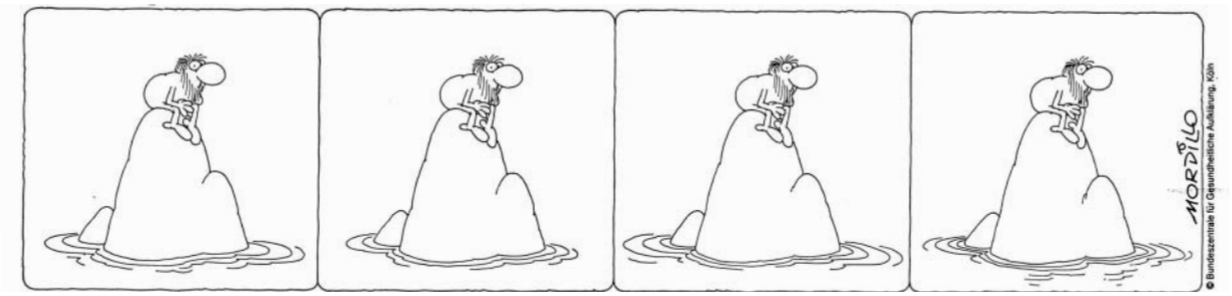
Addiction means permanent, compulsive misuse of a substance, or a behaviour which has a physical, mental and/or social effect on the individual.

Preventive Aims

Approach	Person oriented	Structure-oriented
General health promotion	Increasing self confidence, general ability to act and communicate (e.g., solidarity independence helpfulness)	Improvement of the general living conditions (improved quality of life e.g., in terms of air, noise and the social climate)
Prevention of addictive behaviour	Development of special competences (e.g. resisting group pressure, ability to deal with conflicts and pleasure)	Reduction of structures which encourage addiction (e.g. in firms, schools, etc.)
Prevention of substance abuse	Information on drugs	Legislation in the field of drugs

In our opinion, the preventive measures named in the RAR study can be classified within this system.

The Promise



Get me out of here. I will never smoke again | I will keep off tablets | and I won't drink any more alcohol | But I do want to have a shave!

9. Prevention activities for refugees and asylum seekers in the Soest District / Germany

After critical examination of the research findings, taking into consideration the inter- and intra-cultural conditions/traditions and the accessibility of the refugees and asylum seekers for selected prevention concepts and measures, our RAR team decided to conceive exemplary projects for the Tamil target group. During the entire course of the work it was important for us that the planned interventions were so designed that the structure and method of working can be transferred to other "nationalities" without any great expenditure or loss of time.

An undeveloped transfer of the existing prevention measures to the population group of the Tamils was ruled out because in its present form it would not have been culturally appropriate. It became clear that the development of promising concepts/measures that were culturally appropriate could only be possible if key persons from the target community were included. These contacts enabled interview partners to be included in the focus group.

In an initial step the existing focus group was enlarged with the addition of selected members. This thus created a network from which steering groups were then trained to carry out special tasks for the further development of addiction prevention work for asylum seekers and refugees.

Meanwhile, involved in the network 'SEARCH' Soest are:
– The RAR team
– Full-time refugee counsellors
– Head of a refugee hostel
– Head of the Volunteer's Centre for the Diakonie Hochsauerland-Soest e. V.
– Head of a residential centre - meeting place
– 5 heads/members of the Tamil cultural group.

Following the establishment of the network, the introduction of the RAR team to the Tamil community was arranged. According to the original agreement this was intended to occur on the occasion of a cultural festival in autumn 2002 in Soest.

However, we rejected this plan after being (somewhat tentatively) informed that, although we would meet more than 1000 Tamils at the festival, these would include very few of those living in Soest since these would be present only very briefly - if at all.

As an alternative a summer festival in the "Waldstraße" hostel was planned for the summer of 2002. Until then, the team members shall be informed about the activities of the steering groups that involve individual persons and/or families. This new way seems to be more suitable for breaking down reservations and for receiving positive recommendations.

Further projects were agreed upon; their implementation is being carried out at the moment in small stages:

A. With the support of new voluntary helpers who will need to be recruited, "sponsors" shall be established who, for example, accompany the asylum seekers to language courses and if necessary ensure that there is child supervision.

   The languages courses themselves shall be so changed or expanded that:
   1. Besides the language, they convey social aspects about Germany in a practical way (for example, we explain the names of fruit and vegetables not only by using pictures but by going together to the weekly market).

2. They provide space for explaining in a suitable way more about life in the homeland of the German population.

B. Projects concerned with health education:

1. With the involvement of employees from the local health authority, courses shall be organised in which dental hygiene and prophylaxis shall be taught - particularly for children from asylum families.
2. Accompanying visits to the doctors - particularly for women. Aims: Interpretation help, explanation of treatment, ensuring that there is a regular course of treatment, explanation of the risks and dangers of medicine misuse and problematic self-medication.

C. Contrary to our original assumption, flyers and information material in the mother tongue are read.

For this reason, it was agreed to rework the existing information material and to produce new flyers. These should be brought into a culturally appropriate form, translated, and already distributed as soon as people arrive in the reception centres. The latter should be done by contact persons who will need to be newly recruited and corresponding trained.

The flyers should include the addresses of regular services which can provide help in dealing with specific questions.

This method of proceeding was described by the Tamils in our working group as a way that looked promising[5].

D. A further sub-project to establish the measures needed for improving living conditions shall begin in February 2002.

E. Peer multiplicator training shall be conceived and conducted.

F. Linking with the activities of the Stadtteilkonferenz "Soester Süden" (council for the district of South Soest).

[5] At the point of drafting this report the flyers are still in a working version. In the meantime we have been able to find not only translators to translate them into the mother tongue of the Tamils (while at the same time checking and adapting the text , which has been initially written in German, in terms of its cultural appropriateness), but have been able to translate them into Sanskrit. Examples can be found on the enclosed CD-rom.

10. Addiction prevention amongst refugees and asylum seekers in the Soest District following the completion of the EU 'SEARCH' project

Following the prevention activities described above there shall be in a second phase, in the area of

– structural prevention:	a continuation of the projects started. Moreover, planning of necessary and sensible changes to the projects.
– communicative prevention:	an evaluation of the measures in phase 1.The measures started shall be continued.
– preventive measures that increase social and cultural awareness:	a cultural festival. Information campaign aimed at the German population about the culture of the refugees and asylum seekers. Further measures conceived that provide general education.

With this planning, an essential task becomes clear which will be decisive if there is to be success:

The procurement of necessary funding!

We listen - and we forget
We look - and we remind ourselves
We do - and we comprehend

(adaptation of a Chinese proverb)

Literature:

Ev. Kirche von Westfalen (Editor.) Ohne Recht auf Aufenthalt, Publisher:, Bielefeld, 2000

The Mordillo cartoons have been used with the kind permission of the Federal Centre for Health Education (BzgA).

'SEARCH' in ITALY

"From the Grids to the Music" Drug Prevention for Maghrebian Immigrants in Turin

Gruppo Abele, Turin, Italy:

Giorgio Morbello ***Project coordinator 'SEARCH' Italy***

0. "GRUPPO ABELE"

Gruppo Abele is a non-profit organisation that has worked for more than thirty years in the field of social services with people highly at risk. From the beginning the organisation has divided its activities into three distinct areas, but while maintaining continual contact between them:

- **reception/community care**
- **culture** and
- **work.**

A fundamental concept of the organisation is that implementing generic projects in solidarity is not enough: work needs to be done that is oriented to social justice. For this reason, alongside the rehabilitation communities for drug addicts, drop-in centres and special projects to assist prostitutes, there are also "cultural" initiatives which enable the consolidation of the extensive experience gained by means of the comparison, collection and development of concepts, ideas, themes and initiatives concerned with everything to do with life in society.
An integral part of Gruppo Abele is its

- Documentation and Research Centre, which is directly involved with 'SEARCH',
- the journals *Narcomafie* and *Animazione Sociale,*
- the training services,
- the school workshop project,
- the publishing house, etc.

In this context work has a particular significance, not only between educators, psychologists, researchers, journalists, and those working in administration and finance at Gruppo Abele where more than100 people are employed, but also because the association has directly contributed to the establishment of numerous social co-operatives (carpentry and leather goods, plant nursery, recycling business, etc.) which favour the reinstatement of less advantaged people into the world of work, and for whom work represents an educational and emancipating tool.

It is clear that a research and intervention tool such as RAR, which closely combines research with the necessity to adapt elements, is perfectly suited to the "style" of Gruppo Abele. Furthermore, over the past few years Gruppo Abele has found itself dealing with problems associated with drug use amongst the immigrant population. Initially this was with the Street Unit, the first outreach project in Turin, which met drug addicts, including both Italians and foreigners, on the streets and piazzas: when they came into contact with the outreach team they were provided with information, sterile materials and counselling. This project is now under the direct management of the national health services.

The phenomenon of drug use amongst immigrants from outside of the European Union is, however, also dealt with in two other specific Gruppo Abele projects. The **Udna** project (meaning 'respite' in Arabic) assists foreigners with drug problems in rehabilitation centres, and in cases where they are illegal immigrants it provides for their "assisted" re-entry to their country of origin. The **Drop-in** is a day centre open to those who need a place to go during the day. This is a "low-threshold" service where it is often possible to encounter illegal immigrants with drug problems. The 'SEARCH' project has therefore combined the diverse activities of Gruppo Abele, not only in terms of the method but also in regard to the effective operational capability. It has also enabled knowledge to be improved and the resources of the association to be networked with others.

1. Structural aspects

1.1. Provisions and services

The provisions that regulate immigration in Italy and the presence of foreigners on national territory are relatively recent (1998). This is a law that opens up the possibilities and the rights of people to be legally present in Italy. It allows access to all national health services, facilitates the procurement of residency permits for family members, regulates access to the workplace (providing entry quotas each year) and legalises all foreigners present on national territory before 27th March1998 who can demonstrate that there is an actual possibility for them to have a job and a house. With regards to foreigners who are illegally in the country, the law tends to make their presence in Italy even more difficult. It provides for a bureaucratic procedure for expulsion, bilateral accords with the countries of origin for their immediate return to the borders, and the use of detention centres where illegal residents can be held for thirty days whilst waiting for identification procedures to be carried out. There are many gaps in the legislation regarding refugees, and in fact for those asking for asylum for whatever reason, no assistance at all is foreseen.

On the health front the law allows for services and treatment in *emergency* situations even for illegal immigrants. A circular from the Ministry of Health explicitly extends this right for drug addiction as well. To implement these provisions, I.S.I. centres (health information for immigrants) have been established in the local public health districts. Here, with privacy guaranteed, illegal foreigners can see medical staff and in urgent cases be prescribed treatments or admitted to hospital if necessary. However, a contradictory situation has been created: an illegal immigrant has the right to be treated but does not have the right to receive the minimum requirement in terms of preventative medicine, i.e. to spend the night in a warm place, such as a communal night shelter where people with legal resident's permits can go.

It also needs to be underlined that in the past few months, the attitude of the new centre-right government has changed with respect to the immigration phenomenon. In fact a new law is currently being discussed that would be much more restrictive regarding the presence of immigrants in Italy, and which follows the logic of residency permit = work permit, an equation that will bring an increase in the number of illegal immigrants. Furthermore, it is expected to introduce other obstacles in terms of re-uniting families, and a more restrictive provision regarding minors.

In the area of personal services, many of which are managed directly or in agreement with the municipalities, the room for discretion is wide and often the possibilities for treatment, support and help are the result of the willingness and efforts of individual officials, doctors, lawyers and volunteer groups. They know how to work within the law and find options for providing services and hospital admissions, even in difficult situations such as that presented by illegal immigrants. In Turin, for example, there exists a large network that provides the basic needs (bed for the night, food, clothes) where public, private, social and volunteers work together. In this way, even illegal immigrants are guaranteed certain basic support thanks to a co-ordinated intervention by volunteer agencies in situations where for legal reasons (for example the person does not have identity documents), the municipal institutions are unable to provide assistance.

1.2. Definition of the target group

The 'SEARCH' project has highlighted the profound difference that exists in the immigration situation between countries in northern and southern Europe. It was immediately clear, for example, that the situation of those requesting asylum or political refuge in Italy is insecure, and that they lack any real social identity. You only have to consider here the fact that the first Italian detention centre specifically

designed for asylum seekers was only opened in Rome on 5th December 2001. Previously, and certainly for many more who will be unable to find a place within this structure, those who entered Italy requesting political asylum could not benefit from specific services.

It needs to be remembered that approximately a year passes from the time of lodging the application for refugee status until a reply is given by the responsible commission. It is clear that, given these requirements, relatively few foreigners request asylum in Italy. When the 'SEARCH' project began, the data for 1999 referred to 40,000 refugees or asylum seekers, a number that, while demonstrating a large increase (in 1997 there were less than 3000), is still greatly less than countries such as Germany (more than a million), the Netherlands (more than 250,000) and Belgium and Austria (both with more than 100,000 refugees and asylum seekers).

Furthermore, the absence of structures and specific services makes it very difficult to find and define a target group using their refugee status or asylum application as a basis. This Italian feature has meant that the reference target group for 'SEARCH' has other characteristics. The experience of Gruppo Abele and the gathering of preliminary information has highlighted another hidden reality which few in the city know about. Here, the RAR method has produced good results, both in terms of the analysis and the planning of prevention projects.

The use of drugs amongst the illegal migrant population is actually a very difficult phenomenon to analyse. It emerges only in specific circumstances (hospital admissions, imprisoned persons, individual requests for help from low-threshold projects in the city), but for which there has been no study or concepts regarding specific prevention projects. Very few know the actual number of illegal foreigners in Italy. The last serious estimate was in 1998 which stated that there were approximately 250,000 people, but when in that same year the possibility was given to demonstrate that they had a job and a place to live so that they could become legal, around 300,000 applications were made. It is therefore clear that the total number of illegal immigrants must be even higher. Since then, the most serious research made on the phenomenon has not yet come up with any further estimates as to the quantity. Even with respect to the city of Turin, it is not possible to provide a reliable estimate regarding foreigners without a residency permit.

In the overwhelming majority of cases the illegal immigrants live and frequent two specific districts in the city: the area around Porta Nuova and the central railway station, and the area around Porto Palazzo, where the largest fruit and vegetable market in the city can be found. Another situation which is specific for Turin is the fact that the number of people coming from the Maghreb region (Morocco, Algeria and Tunisia) is much greater than those from other foreign communities, and represents 25% of the total number of foreigners legally resident in the city.

It is for this reason that the Italian part of the 'SEARCH' research has defined its target group as:

"*Illegal North Africans living in Turin that use drugs in a problematic way*".

1.3. Characteristics of the target group

The illegal situation of the people studied by the 'SEARCH' research project conditions every aspect of their existence. The rights and services which they have access to are very few and, whilst up until a few years ago many resided illegally in Italy awaiting an amnesty that legalised their position on the basis of certain criteria (income, guarantee of an employer, possibility to have a house, documented presence in Italy prior to a certain date), the current political situation today seems to make such a possibility remote. The situation of an illegal immigrant is that of a "person who does not exist". It is impossible to work, gain access to public services (apart from perhaps health services in emergency situa-

tions), or sign a rent contract, which means that as a consequence they are exploited by unscrupulous apartment owners. Even with regard to illegal minors, a year ago it was possible to construct a way of becoming "legal" via school or work that meant that a resident's permit could be obtained once the minor reached the age of 18. Today, that possibility no longer exists, and even if minors are not expelled in accordance with international conventions they are nevertheless not permitted to work or study. An important indication of the consequences of this situation comes from the data for crimes committed by foreign immigrants. Amongst the foreigners imprisoned, 38.52% are in jail for crimes connected with drugs. Furthermore, 24,420 crimes were registered in 2000 in Piemonte (Turin is the capital of this region) by non-European foreigners, 85% of these cases are people without a resident's permit. With regard to the younger age group, it should be added that for quite some time now the majority of the juvenile prison population in the city has been made up of young foreigners who have entered Italy illegally, and in most cases the crimes they have committed concern drug dealing.

Even without conducting in-depth investigations and studies, it is clear that the condition of being illegal without any possibility of integration, and without adequate services and resources, favours the drifting towards greater marginalisation. The situation is also characterised by the problematic use of drugs. This is a reality that appears to be unexplored and again only emerges in data regarding prison populations: of 1,059 foreigners who were imprisoned in Piemonte in 2000, 313 were declared to be drug addicts. If the phenomenon therefore exists, but nevertheless remains hidden because of the un-likelihood that illegal immigrants will approach a public service for drug addiction (and when they do they do not always receive an adequate response), it is clear that the situation of being illegal multiplies and increases the psychological, physical and social problems caused by drug use.

In summarising it can be said that the target group which 'SEARCH' has researched is characterised by the following aspects:

- North African origin
- Lack of resident's permit
- Problems relating to dependency
- Involvement in drug dealing
- Lack of work, and often a home

In many cases the 'SEARCH' investigation led to the conclusion that it is often difficult to distinguish between the harm caused by just the use of drugs and that caused by poor diet, lack of accommodation, as well as the occurrence of psychological problems associated with the lack of a future, loneliness and the impossibility of returning home with dignity.

1.4. Strong points

In undertaking the Italian part of 'SEARCH' it was therefore necessary to be conscious of a complex situation that, with respect to the illegal Maghreb immigrants, had, and continues to have blurred contours and many grey areas. Nevertheless, the issue of drug use within this target group showed signs and indications of problems at many levels.

Analysing the "strong points", we realised that we could count on:

a) A non-homogeneous framework consisting of reports and official data that, while describing the phenomenon in an absolutely inadequate manner, provided certain indications (composition of the foreign population in the city, incidence of the number of drug addicts within the foreign population in jail, indicators with respect to the number of illegal immigrants).

b) A good network amongst the institutions, private social organisations and volunteers that provid social and medical assistance as well as support and basic services. Few of these persons had dealt with the issue of drug use in a direct and specific manner, but many had seen something of this problem in the night shelters, the municipal offices, in prisons, etc.

c) The thirty years of experience of Gruppo Abele in the area of drug addiction and the involvement of the association in certain specific projects.

d) The presence in the city of some cultural mediators or exponents of the North African community who had in-depth knowledge of the situation of their co-nationals.

1.5. Weak points

We were also aware that work of this type would encounter many difficulties. We were worried about two aspects in particular:

a) The "open setting".
The immigrant illegal population lives and moves continuously, and not just within the city limits. They move according to the seasonal work where they are used as illegal workers, when they feel in danger because they were perhaps stopped by the police, or simply to find better living conditions else where. Furthermore, although the districts frequented by the target group are in actual fact limited in size (the railway station at Porta Nuova and the district of Porta palazzo), it is difficult to make contact with people who live on the street outside of protected structures.

b) Trust.
In an "open" setting it seemed to us that it would be difficult - and indeed it was difficult - to be able to make direct contact with a target that naturally tends to keep itself hidden. It was even more difficult to suggest an interview on drug use when in many cases the same people took and dealt in drugs. Notwithstanding the efforts of the people who had earned the trust of the target group, only in very few cases was it possible to make direct contact.

c) The vicious circle of information.
While in fact the support networks in Turin for assisting foreigners in difficulty represent an excellent resource, from the point of view of gathering information there was a risk that the same source would always be used or that a new version would be heard of something that had already been told, but which had been reinterpreted during the natural exchange of information between people, i.e., the interviewers ran the risk of recounting not what they saw from their viewpoint but what they reinterpreted during discussions with other workers, doctors and public officials. For this reason, we tried as much as possible to find witnesses who perhaps stood more "on the margin", but could offer interesting information on individual aspects.

2. The process

2.1. Snowballing

The departure point for contacting the key informants, even with all of the reservations previously expressed, was by necessity the existing service networks. In particular the initial witnesses were contacted in the following organisations:

- ”I.S.I.”: An ambulant public health and information service reserved for illegal or legal immigrants.
- ”Ser.t” (drug services): A public service distributed regionally. Only the office in Via Ghedini (ASL 4)

deals continuously and specifically with drug use amongst migrants.

- ”Can Go”: An outreach project of the ASL 4. It is a bus that each day positions itself in "hot" points in the city to offer active drug addicts sterile materials, counselling and information.
- ”Udna”: A project of Gruppo Abele. Accepts a restricted number of immigrants in the first phase of taking "sliding scale" methadone.
- The Franz Fanon Ethno-psychiatric Institute: Offers psychological support for migrants.
- Foreigners' Office, Turin Municipality: An office that directs immigrants to the different services, offering counselling and information. Manages certain projects themselves. Does not specifically deal with drugs but is a fundamental reference point for all immigrants.
- ”Caritas Migrantes”: An organisation linked to the Catholic church which undertakes activities similar to those of the Foreigners' Office, but with greater freedom owing to it not being a public institution.
- ”Cooperative Sanabil”: Run by Moroccan social workers who provide cultural mediation and manage certain educational projects for foreign minors.

In the first phase of 'SEARCH' the members of the organisations provided an outline of the situation, giving some of their thoughts and above all directing us to other workers who know the situation at first hand. We then tried, using the snowballing system, to find out about names and persons who are less on the periphery regarding the public service or volunteer sectors, such as religious dignitaries, bar/cafè/restaurant managers and people living in the community. In this sense the method worked well, enabling us to make contact with a good number of people that knew about the problem, or at least some of its aspects, without being part of the restricted circle of professionals. With regards to the target group, only in a few cases was it possible to use the knowledge or indications of a professional as a starting point for a meeting or interview.

2.2. The team

The group that worked together for 'SEARCH' consisted of three people: **Giorgio Morbello** (co-ordinator), **Marina Marchisio** (researcher) and **Aldo D'Agostini** (social/health professional). **Susanna Ronconi**, the director of the research centre, monitored and supported the entire team work. The group was diverse and there was a good mix of practical expertise: Aldo D'Agostini also has a master's degree in political science and thus a theoretical background, and the others have experience of more "official" research methods.

A "horizontal" and participatory work method was adopted, whereby the role of the co-ordinator was limited to gathering and organising the materials and the information obtained, organising meetings and supervising the entire process. The remaining aspects were undertaken together. Firstly the RAR method and its instruments had to be learnt: from interviews to grids and reports. Two afternoons were dedicated to specific training on interviews, using simulations and observations that enabled familiarisation with the questions and possible reactions of the people being interviewed. The team then decided what key informants to approach, and they began by dividing up the interviews.

Having been adequately instructed, each team member then carried out the interviews and recorded the results onto the grids. Every two weeks a meeting was held to summarise the situation and to exchange information, impressions and suggestions. At the conclusion of each section (SI, SSI, FG) the information obtained was evaluated. Together it was then decided how to proceed with the RAR in the best possible manner (what issues to explore, how to formulate the questions better, etc.).

The co-ordinator had the task of collecting all the grids and compiling summaries, as well as producing written intermediate reports.

With respect to the RAR method, the team felt that it was more than functional, it was necessary. If in fact 'SEARCH' was to be a succession of information, scenarios and frameworks which gradually became clear and developed as the process advanced, then *continuous comparison* was the necessary means to enable all viewpoints and problems to emergence.

2.3. From the idea to action

The team work was the engine for all of the decision processes and the turning into action. The first choices were made in terms of the specific features of at least three different vulnerable groups within the same overall target group (adult users, alcohol users, young users). This meant that it was necessary, following the semi-structured interviews, to thoroughly analyse certain aspects:

- We realised that the structured interviews were too "narrow" an instrument and, following the advice of the scientific co-ordinators of 'SEARCH', it was agreed by all to conduct the second round of interviews in a more open manner, taking into consideration the information that did not strictly come into the grid categories and that was used in the verification meetings to better orientate the work of the focus groups.

- Another important decision taken by the team was not to consider the two focus groups in combination with each other, but as separate opportunities to provide in-depth analyses of two vulnerable groups for whom there remained some open questions, and for whom it seemed prevention projects were more urgently required. The situation of adult users appeared to be somewhat clearer, and rather than prevention it seemed there was an urgent need for treatment and care. Furthermore, although there were numerous gaps, this vulnerable group seemed to be able to get access to health services and there was a small possibility of recovery. On the other hand, those who abused alcohol and the younger drug users appeared to be without any support or assistance. It was therefore deci ded to orient the first focus group towards the problematic use of drugs *amongst youths*, while the second group dealt with the open issues regarding alcohol *assumption amongst the illegal North African population*. It should be said that, before the two meetings were realised, the team did not have any clear idea about the area in which a prevention project could be directed. Given the time and budget restrictions, it was clear that a choice would have to be made. It would not be possible to plan prevention projects both for alcohol consumption and drug use amongst youths. The focus groups represented a very important moment for the transfer from the part of 'SEARCH' that was connected to research to that of prevention planning. It was the place that enabled a choice to be made as to which vulnerable group to concentrate on (youths) and, particularly with regard to alcohol use, offered the possibility to clarify certain fundamental aspects such as the influence (or not) of religion and the use amongst people "integrated" into the social life of the city. It also represented the departure point for the creation of a network that could elaborate prevention ideas. It was not by chance that almost all of the organisations contacted for the youth focus group were willing to work in co-operation so as to enable the realisation of specific prevention projects.

If an attempt is made to evaluate the entire search process, as far as Italy is concerned it could be said that the part that worked best of all was the transfer from theory into practice.

Particularly In the focus groups there was a smooth passage from the statements and points of view made on the phenomenon and concerning operational proposals, to determining the availability of places, money, people, and structures for the realisation of the proposals that emerged. It was clear that for the final shift to establishing an efficient network and participation in a concrete project, other

meetings and discussions would be necessary, but the embryo could already be seen in the focus group. From our point of view this represented one of the more relevant features of our RAR because it was an experiment that provided first-hand experience: information gathering, the selection of those to be interviewed, snowballing, compiling the grids, verification meetings - all found their natural outlet in concrete proposals, ideas and co-operation.

2.4. What worked, what did not work

In the analysis of the RAR process and method and of all its parts, it is possible to identify the useful results and the aspects that are less positive.

Amongst the positive aspects:

- *Team work*

As described previously this represented the place for the elaboration and direction of the entire process.

- *Focus groups*

They contributed to defining the outline of the problem (particularly concerning the problem of alcohol consumption. Although for various reasons this did not lead to the planning of prevention projects, they provided indispensable clarification). The focus group oriented to drug use amongst youths was also a departure point for the development of a comprehensive prevention project.

- *Snowballing*

The indications were useful and the people indicated for interviews were valuable. However, some of the people indicated were not interviewed due to lack of time.

- *Willingness of organisations*

The indications regarding the prevention projects were quite clear: a working partnership needs to be formed and a network constructed. When this proposal was put to diverse organisations and the municipal administration, a general willingness to work according to this methodology was found.

The less positive points:

- *SSI and SI*

The questions for the semi-structured and structured interviews were found to be too schematic, with the risk of losing important information. It should also be remembered that the target group considered in Turin was particularly complex and heterogeneous, and in itself provided a large number of open and unexplored questions. The main difficulties were encountered in the structured part of the interview owing to the difficulty of many of those being interviewed to provide answers in quantitative terms. For this reason the team decided to also collect the information obtained in this phase by means of the grid used for the semi-structured interviews, a grid that permits more information and details to be collected. Indeed, a series of facts that the team found to be important emerged outside of the questions foreseen by the interviews.

- *Access to the target group*

The efforts made to obtain more direct information from the target group members were hampered by the illegal situation, the drug use and drug dealing, the difficulty in organising meetings with people who do not have any points of reference in the area and the lack of time to develop a trusting relationship.

- *The time*

The strict time period allowed by 'SEARCH', which on the one hand provided a guideline and a planning tool, but on the other hand created some problems. The lack of time did not allow for the

possibility of further interviews to substitute others that turned out to be useless because the person being interviewed was found to be less informed than had been assumed.

• *Economic resources*
A rapid and concrete method to collect information, such as that proposed by RAR, is efficient if a secure and adequate budget is foreseen for undertaking the prevention activities, otherwise the whole process risks slowing up and losing time in finding resources. Furthermore, the risk is run that expectations are raised and that concepts for interventions are formulated which are then found to be beyond economic means. Essentially, it seems that the economic aspect is a variable that needs to be taken into consideration immediately, beginning with the planning phase of RAR.

3. The results

The North African population in Turin has been found to be the group which is at most risk regarding general drug use, even if in terms of alcohol abuse other groups, such as South Americans and Romanians, are cited. Three vulnerable groups were identified: adult drug users, youths and minors, and people who misuse alcohol.

3.1. The adults

These are drug addicts who have used drugs for some time and in some cases are known to public services and professionals in this area. Heroin and cocaine are the most commonly used drugs and it appears that many of these users are in prison for crimes associated with dealing. Furthermore, there are also adults in this group who, having worked in Italy for a certain period of time, became familiar with drugs and drug dealing. Regarding the problems that stem from drug use, it should be remembered that this behaviour occurs within a context of great physical, psychological and social suffering, characterised in the majority of cases by loneliness and a lack of work, future prospects and a house. Added to a situation of this kind is the harm caused by prolonged use of drugs, often taken in very poor hygienic conditions. A situation is therefore created of *extreme marginalisation*, accentuated by rejection by the same North African community present in the city, who strongly criticise this kind of behaviour. The failure of the immigration project, the absence of affection and "social control" present in the country of origin, and contact with the drug dealing scene as a result of financial problems, are the factors that most favour and induce problematic use of this kind.

Furthermore, for those who have been here in Italy for many years, and who for a long time were integrated into the social life, traumatic events such as losing a job and the resident's permit were confirmed as representing one of the access doors to drug use. In general it can be said that the search for *self-healing and "getting out of it"* prevailed in this group. This group appeared to be relatively well informed about the risks associated with drug use, whilst the information regarding services available was judged as insufficient. With regard to the prevention route, it seems necessary therefore to increase the level of accessibility to services, while the need is also seen for specific projects for *prisons*, for possible admission into *therapeutic rehabilitation centres*, and for programmes that assist *the return home to the countries* of origin.

3.2. Youths and Minors (12-25 years)

The use of heroin intravenously is not widespread amongst youths. The more commonly used psychotropic drugs are cocaine, hashish, alcohol and in some sporadic cases, glue. Often a combination of these drugs is taken (alcohol + hashish, alcohol + ecstasy). In this group two types of users can be identified:

• the marginalised sector (youths without family, house or work),

• the integrated group where a youth with a job or a family, or who is still going to school, begins to use drugs in a manner similar to his/her Italian peers. In the first case the door to use is often dealing, an activity for which the illegal North African minors are enlisted. Furthermore, their life on the streets presents a distorted reality, so much so that behaviours that are in reality not normal are perceived in Italy to be non-problematic or "normal". For the group who are integrated, however, factors such as emulation or the need for self-confirmation come into play. The situation of being illegal and the certainty for the "illegals" that, once they reach the age of 18, they will have no possibility of remaining legally in Italy, are factors that amplify the psycho-physical and social problems caused by drug use.

With regard to the prevention project, 'SEARCH' has enabled many aspects and opportunities to emerge:

• On the information front, the fact emerged that many young people present in Turin who take drugs have very different levels of knowledge about them. A person who lived in Casablanca, and saw and perhaps even tried drugs, recognises the effects and some of the risks, but for someone from a rural area these aspects are unknown. Any specific information campaign would need to take into account these differences.

• Moreover, some city districts were found to have the highest numbers of young immigrants, with or without families, and it became evident that it would be necessary to learn more about this situation, using street outreach workers and involving natural leaders.

• The more practical proposals regarding prevention foresee the use of creative forms of communication (video and audio cassettes, music), to transmit messages and information. This is one way of involving the youths themselves and to develop relationships of trust and friendship that, above all for the young, are necessary to impart information and proposals.

• It was decided to work specifically with this group to establish a prevention project. In order to maintain a wide scope, work has begun with the minimum conditions necessary so that the projects shall not be sporadic, taken out of context and not be ineffective. The creation of a *network of public-private partners*, project planning and the obtaining of funds have all been necessary steps to enable work to start on the prevention projects.

3.3. Consumers of alcohol

The problematic drinking appears to occur amongst three distinct groups of North African users: adults that work (drink in their free time, during holidays); adults who are marginalised (chronic drinkers, homeless); youths and minors (emulation, sense of freedom, etc.). It emerged from the focus groups that amongst the adults the progression from one group to another was easy, and that amongst the youths there is a gradual series of steps that even reaches chronic use. Furthermore, it was underlined that the effects of drunkenness appear to be much more "devastating". Often the abuse of alcohol provokes serious problems within the family, while in some cases it is taken to sustain an activity deemed "undignified", such as that of a windscreen washer or beggar.

The question of religion was central to alcohol abuse. For some, less emphasis was placed on the differences between the countries of origin since alcohol was always consumed in secrecy and taken with the precise aim of procuring an altered psychological state. Others, however, emphasise the illegality for a Muslim to consume wine or spirits and on the subsequent feeling of guilt. In either case it appears to confirm that the lack of social control exercised in the country of origin by parents, friends or neighbours is a decisive factor in the increase of abuse in the host country.

With regard to prevention, the need to operate at three levels emerged:

1) Analysis and improvement of the social and psychological background situation: work, house, resident's permit, relationship between leisure and work time, self-esteem.

2) Sensibilisation and involvement of the North African community (mosque, family, cultural associations, shop owners, informal groups)

3) Street work to encourage "encounters" and not only work with services that wait for clients to present themselves.

The complexities of this phenomenon, the profound interactions between the diverse areas (religious, cultural, family, relations), and the necessity to better understand the implications of a problem so well hidden and unmentioned, would have made a prevention project in the context of 'SEARCH' very ineffective. For this reason the work regarding alcohol was limited to recognising the extent of the phenomenon.

3.4. Activities

The basis and guidelines for a prevention project aimed at young North Africans present in the city have been derived from the entire 'SEARCH' process, but in particular from the focus group on drug use amongst youths. The Turin situation is also characterised at a national level by the ability to offer responses and assistance to foreign minors, and in particular to those in Turin without a family. However, such services, while being efficient, limit themselves in many cases to dealing with the problems of survival, food and shelter, and occasionally intervening to deal with the school placement. The arrival in the city of a new awareness of the issues that specifically concern young migrants, such as drug use, is definitely one of the more important and concrete results of 'SEARCH'. In the phase that has just been concluded, work was done on the operational side to establish the necessary conditions for this awareness to have an influence on the co-ordinated activities and projects that will have a wide remit and long duration. The situation of young North African drug users in Turin appears to require neither new flyers, posters or festivals, nor a series of meetings that inform young people of the risks and dangers of drug use. What has actually emerged is the need to develop structures and frameworks within which this content can easily be delivered in a comprehensible, participative and educational manner. If the use of drugs is found to be strictly tied to all the other problematic aspects associated with the situation of being an illegal young immigrant, a serious prevention project cannot only limit itself to aspects concerned with providing "drug information". It was therefore decided to begin a process that permitted the youths involved to express themselves, make proposals, be creative and *to act themselves as protagonists*. In this regard the work of the other organisations and people who deal with young foreigners residing in Turin became fundamental. Since the meeting with the focus group, a willingness has been displayed by the major Turin organisations to form a network and work in co-operation. The organisations who have become involved in this work are:

a) **Foreign minors office** of the Municipality of Turin
Co-ordinates and partly finances the activities concerned with initial contact/assistance

b) **ASAI - intercultural association**
For many years has provided foreign minors with educational courses, language courses for learning Italian and leisure activities. Also manages a hostel for foreign minors.

c) **Ben DIR**
A project of the social co-operative Stranaidea, that aims to get young, foreign drug dealers together using music as a tool for meeting and educating.

d) **Progetto Cisti**
A project of Gruppo Abele and the Valdocco social co-operative that deals with prevention and information regarding the use of new drugs. It is not a project aimed specifically at foreign youths.

e) **Coop. Sanabil**
A social co-operative consisting mostly of educators and Moroccan cultural mediators who have been involved for some time with the problems of young Arab-speaking immigrants.

These organisations were invited to participate in a network whose first objective was the development of a prevention project aimed specifically at young North African drug users. The project guidelines have already been drawn up and we are currently working on the final draft. This, in summary, is the basic proposal from which the work began:

3.5. My music: New ways of communication and integration. Talking about everything, even drugs.

OBJECTIVES

- *To bring together groups of young North Africans through initiatives of a musical nature*
- *To learn to value peer relationships and self-esteem, and to develop the ability to take the initiative*
- *To activate communication mechanisms between educators and groups regarding drug use (collect the stories of the youths and provide information and proposals)*
- *To organise with the youths "something" that has been decided together (it could be a concert or a party, the cutting of a disc, the forming of a band, the participation in a course run by a DJ.)*

WHO WAS IT AIMED AT ?

Minors or very young foreigners. Further evaluation needs to be done to determine if the target refers only to "unaccompanied" minors or to those already integrated.

ACTIVITIES

- *Creation of a network and agreement on the guidelines of the project (with particular reference to the themes to be proposed to the youths regarding drug use)*
- *Creation of an initial group (need to think about the method for getting them together and the content of the initial proposal). The idea is that, through the initiatives organised with the youths, other people can be involved and brought together, so enlarging the initial group.*
- *Involvement of the youths in decisions about further activities, gathering and referring the ideas that emerge*
- *Realisation of the activities decided upon*

RESOURCES

If some of the city organisations willing to work on these issues are also involved, it is believed that the entire process could then be guided and directed by one of the co-ordinating groups. It can be assumed that those who initially participate are those already involved in 'SEARCH' (the foreign minors office- Turin municipality; Ass. ASAI; ASS. Stranaidea, Gruppo Abele, Info-Zone, Coop. Sanabil). If further financial resources are obtained from the municipal authorities, it is possible to envisage an educator employed for 15 hours a week on this project. Otherwise the use of the individual organisations could be evaluated.

The realisation and maintenance of the network, the draft of the project and the initiatives for obtaining funds represent the preliminary and necessary activities that have been undertaken by 'SEARCH' to develop a prevention project. The participants involved in the co-operation are willing to proceed in any case with this work, even beyond the time and resources foreseen by 'SEARCH'

3.6. Limits and perspectives

The decisive result of 'SEARCH' was to choose the young North African drug users as the reference group for prevention measures. The network and the meetings also influenced the decision to work within the form of preventative intervention chosen. It seemed essential to work with something that could "last" over time, establishing relationships, meetings, exchanges and trust with the youths that we managed to contact. The project briefly outlined above represents a type of "flexible container" to involve youths that could last for a long time. Furthermore, it could permit the possibility of working in a more intense manner when there are perhaps more youths present or when more economic resources be-come available, but at the same time would allow there to be a minimum of prevention activity, meetings and dialogue when the larger activities finish for whatever reasons. There are considerable restrictions and possible obstacles, however, that are less understood with respect to this type of work:

- Firstly, the legislation regarding minors illegally present in Italy. This is a growing phenomena at a national level, but has not yet been dealt with in all its aspects. The requirement of expulsion once legal age has been reached brings with it difficulties in establishing educational relationships and steps for integration. It is even more difficult to convince a youth who is dealing, and as a result is earning a significant sum of money which he can send home, to abandon this activity and take time to become involved in meetings, training or perhaps even work experience in a company. With the laws that came into force this year there is in fact no opportunity left for this type of educational pact proposed for foreign, unaccompanied minors: "if you stay in a community, go to school or receive practical training, when you reach the age of 18 a resident's permit will allow you to stay in Italy for study or work reasons". It is clear that without this possibility it will be very difficult to persuade young illegal people to come out into the open, even more so if they are involved in drug dealing or drug use. On the other hand, it cannot be expected that there will be a drop in the number of young people entering Italy, something that for the coming years will bring with it a net worsening of their physical, psychological and social circumstances and for which the possible use of drugs will have a "multiplying" effect. This appears to be perhaps the biggest "structural" limit that needs to be dealt with in undertaking a prevention project of this type.

- Nevertheless, it is worthwhile trying to contact these youths all the same. If the situation does not permit the establishment of a stable group, the relationships formed between workers and clients will still enable measures to be undertaken that are more oriented to providing "personalised" information on the risks of using and abusing drugs, and to the possibility of providing help in one of the public structures.

In regard to possible obstacles, there are two that can be named in particular (other then of course the problem of finding funds, which is a continual problem):

(1) The first is the ability of the different organisations to co-operate. It is one thing to construct a network, agree on a project, develop it and then propose it to the institutions, another to share the daily workload, resources, availability of persons and time. Tools need to be developed periodically for verification and control (monitoring) that permit the mediation and lessening of any eventual tensions that arise.

(2) The second obstacle that could represent some problems is the relationship with other organisations and institutions not directly involved in the project such as, for example, the police or the young offenders' institution on one hand, and schools, the workplace and social services on the other. It will therefore be necessary, once the limits, length and framework of the project are clearer, to begin commencing introductory meetings that will lessen tensions and misunderstandings, or that will even perhaps encourage other synergies and co-operation.

'SEARCH' in The Netherlands

Drug Prevention for Juveniles Inside and Outside of Asylum Centres

TACTUS, Enschede, The Netherlands

Cor Struik ***Project coordinator 'SEARCH' in The Netherlands***

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 marihuana.*

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 to 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. 81Euros. 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 then 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 'coffeeshops' 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. Th 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.

'SEARCH' in Austria

Drug Prevention for Iranian Asylum Seekers in Vienna

Institute for Social and Health Psychology (ISG), Vienna, Austria:

Dr. Karl Bohrn ***Coordinator 'SEARCH' Austria***
Mag. Marc Bittner ***RAR-team Austria***

1. The Austrian partner of Search: Institute for Social and Health Psychology (ISG)

The Institute for Social and Health Psychology (ISG) was founded in 1994 as an independent institution working in different psycho-social fields, mainly focused on issues of addiction. It aims to implement different activities in the fields of psychosocial research, counselling and prevention, clinical diagnostics and treatment, as well as psychotherapy.

The multidisciplinary team consists of clinical psychologists, educationalists, physicians, sociologists, social workers and psychotherapists.

The main areas of work are:
- Psychosocial research on behalf of ministries, provinces and municipalities
- scientific reports and publications

Recent Research Projects:
- Research Project "Substance use and misuse in childhood and adolescence" (1996-1999)
- Research Project "Drug Affinity amongst Youths in the 'Techno Party Scene' in European Metropolises" (Rave Research), together with SPI-Research, Berlin (1999)
- "SONAR": Study about nightlife and substance use in 8 European cities (IREFREA, 1999)
- "European Healthy Schools and Drugs (EHSD)": Drug abuse prevention in secondary schools, co-operation with Trimbos, NL
- "Research and Intervention Project for Risk Reduction among Socially Excluded Individuals, "IDUs and people with HIV/AIDS (EURO-EXCLUDE)", co-operation with EASP (Granada)
- "Drug abuse prevention for refugees and asylum seekers", co-operation with the Landschaftsverband Westfalen-Lippe

- Concepts in the field of psychosocial prevention and rehabilitation
- Training of target groups (mediators, peers) in the area of education, health and youth welfare (in close co-operation with "RISIKO - Association for Prevention and Intervention")
- Prevention and rehabilitation of substance abuse and addiction as well as other forms of psychological deviation (in the last years the ISG carried out several prevention projects in schools and companies in co-operation with the association "Risiko")
- Clinic-psychological diagnoses and treatment
- Health psychological and psychotherapeutic work
- Counselling, information and care of people with psychosocial problems

The Institute for Social and Health Psychology is a member of the International Council on Alcohol and Addictions (ICAA), Geneva.

2. Target group(s) of Search Austria and their presumed drug consumption

In the beginning of the RAR process it was unclear how to define the target groups for the Austrian part of ‘SEARCH’, because there were no information available about the drug consumption of refugees/ asylum seekers in general. It was also necessary to use the semi-structured interview phase to explore the field and to gain hints from key informants. During this process we learnt that the problem of

addiction exists among asylum seekers as in other parts of society but is concealed by what can be called a "*collusion of silence*". This occurs for several reasons:

- staff members in refugee care centres are overburdened by their work, and by the huge amount of problems in the field of refugee care (providing a place to sleep, fulfilling the basic needs). They therefore have no desire to encounter drug problems among their clients since an awareness of the problem would create additional work for them which is beyond their given resources and time.
- The issue of drug problems among refugees is also considered taboo because of the fear of negative consequences for the clients if authorities, such as the police, get to know about the problem. In addition, until Search the staff did not even know how to deal with the addiction problems because they had not been specially trained in this field and were not aware of existing professional resources which could provide external help (such as drug care/treatment centres).
- The asylum seekers themselves also suppress this theme, either due to their fear of being sent back to their home country in case their drug problems become known, or because they feel ashamed. The political system also seems to be suppressing the problem: so long as a problem is not perceived then officially it is unnecessary to devise (expensive) measures to counter it.

The most precise information we obtained concerned refugees from Iran (with over 3,000 persons, this was one of the largest refugee groups in Austria at the beginning of the Search project), who particularly had drug problems involving opium and marijuana (substances which are culturally very common in Iran and are often not considered to be drugs in our sense but to be medicine), and to a smaller extent alcohol and medicines. Among the Iranian refugees it was necessary to differentiate between Moslems, amongst whom the consumption of opiates has a high cultural and social importance, and the Christian Armenian minority (which was actually a very large refugee group), for whom the consumption of alcohol is much more important and wide-spread. This is because in Iran it is not forbidden for this group to produce or consume alcohol.
All key informants told us that only Iranian men have drug addiction problems; most of them can be found in the age group between 18 to 45 and are in Austria without a family.

Another potential target group named by our informants were the black African refugees, but only in the sense of their presumed role as drug dealers (which has also been pointed out by a far right-wing political party and used as an argument for a more restrictive asylum policy in Austria). Although in our semi-structured interviews it was confirmed that drug trafficking as a way of making a living is indeed a problem amongst this group, hardly any of the interviewees knew of drug consumption among black Africans. Because of these results - and reliable hints that it would be very hard to conduct interviews among members of this group which is socially very close-nit - we decided not to define this group as a target group of Search-Austria in the further steps of the RAR.

3. Development of asylum applications in Austria during the last decade

The number of asylum seekers in Austria was very high between 1989 and 1992 as a result of, for example, the fall of the Iron Curtain in Eastern Europe and the high number of Kurdish refugees during that period. After the crisis in Yugoslavia in 1993 the number of asylum seekers decreased very considerably. Because of the crisis in Kosovo in 1998 the numbers increased again and have remained at a very high level since then.

In the year 2001, the biggest group of asylum seekers have been people from Afghanistan, followed by refugees from India and Iraq.

Although the overall number of asylum seekers in Austria is still increasing, the number of asylum seekers from Iran (our target group) decreased rapidly in the year 2001 owing to the migration of Christian Armenian refugees to the USA. Previously, however, (at the beginning of Search) the Iranian group had been among the 4 largest ones.

According to projections by the Ministry of Internal Affairs, about 30,000 asylum applications were made in Austria in the year 2001[1] (over 5,000 from abroad in Austrian embassies); about 1,000 of those are children/juveniles who came to Austria without parents or relatives.

4. The social situation of asylum seekers in Austria

A new and stricter asylum policy of the new middle-right government in Austria (since February 2000) has intensified the poor situation for asylum seekers in Austria.
The UNHCR has referred in recent publications to a situation for asylum seekers in Austria which is life-threatening[2]. Asylum seekers in Austria have no legal right to receive care and are treated as needy or beggars.

Those asylum seekers who are lucky enough to be cared for by the federal government receive a place to live, food, basic medical care and monthly pocket money amounting to about ≠ 38.00. Unlike other Member States of the EU, however, in Austria only about one third of all asylum seekers are in federal care, the rest have to look for other possibilities. The criteria for gaining acceptance to federal care are rather restricted: possession of a mobile phone, for example, can be a reason for not being accepted, with refugees being given the number of a private help organisation instead. Thus, two thirds of asylum seekers in Austria are dispatched to private organisations such as the Caritas, Volkshilfe or the Evangelische Diakonie, whose capacities and resources, however, are very limited. Even the emergency hostels/homes in cellars or churches are overcrowded. In Eastern Austria alone, each week about 100 asylum seekers cannot be cared for, who in the worst cases are forced to live on the streets.

NGOs try to ease the situation for asylum seekers, and without their help the situation would escalate. Only very few European countries show as little interest in asylum seekers as the federal government in Austria. In Great Britain and France, all asylum seekers are taken care of through financial support of the government; only in Greece and Portugal are the circumstances for asylum seekers comparable to Austria.

Thus the living conditions for refugees in Austria are unsatisfactory since most of the asylum seekers are not in federal care (70%) and have to be supported by private/church organisations (as pointed out above) if they are to have a place to sleep. Not being in federal care also means not being insured in case of illness and having no money at all. However, even the situation for refugees in federal care is not ideal: like all asylum seekers they have to live either in large camps without privacy or intimacy, and with poor hygienic conditions, or they are dispersed throughout Austria in small inns, with hardly any contact to Austrians or to friends or family. Their monthly pocket money of only about € 38.00 is insufficient to buy anything meaningful. We know that even "normal" migration can lead to psychological and physical problems. The migrant can develop traumata, which can lead to symptoms such as sleep disturbances, pain and physical or mental diseases. In the case of flight or expulsion, the migration

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1 comp. http://www.unhcr.de/news/pr/pm020311.htm
2 comp. http://www.unhcr.de/news/pr/wien/ap011121.htm or: http://www.unhcr.de/news/pr/wien/ap020123.htm
http://www.unhcr.de/news/pr/wien/ap020123.htm

takes place involuntarily, thus increasing the physical or psychological problems in exile[3]. Given the living circumstances described above, these problems can be made even worse.

The biggest problem for the asylum seekers in Austria, however, seems to be the fact that they are not allowed to work until their asylum applications are decided (which very often lasts for years). Having the opportunity to work would structure their daily lives[4], give them the chance to be responsible for their own lives and enable them to develop a feeling of security. On the contrary, asylum seekers are either completely dependent on the care organisations or make their living on the black labour market under difficult circumstances, with the danger of being detected and deported back to their home countries. This situation is very unsatisfying and leads to a feeling of senselessness, agony and despair among many refugees.

Another problem is that asylum seekers take the lowest place in Austrian society, and therefore are socially segregated, discriminated and are very often victims of racism or xenophobia. Because of all these negative factors, many refugees are very disappointed after having had high expectations of the "golden west" before their flight.

Our target group of Iranian refugees could be found both in federal and in private care; the minority group of Christian Armenians was concentrated in special camps and homes while waiting for their permit (visa) to move to the USA or Canada, which is the destination most of these people are heading for.

5. The RAR team for the ISG

Out RAR team consisted of 4 persons:

- A *male clinical psychologist/ psychotherapist*, who as national project director co-ordinated the RAR phases, was involved in the secondary analysis, conducted semi-structured and structured interviews, and was the moderator of the focus group and co-author of the country report.
- A *male sociologist* who was responsible for research activities, the conducting and transcription of semi-structured and structured interviews; the preparation, documentation and analysis of the focus group, and who co-authored the country report.
- A *female clinical psychologist and psychotherapist*, who co-moderated the focus group and had a consulting role in the RAR process.
- A *female psychologist*, responsible for conducting and transcription of a couple of semi-structured and structured interviews (especially with female interviewees); participant of the focus group.

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[3] comp. e. g. BOHRN, A. & BOHRN, K. (1992): "Mit meinem Verstand bin ich Österreicher, aber im Herzen bleibe ich Lateinamerikaner." Jugend zwischen Getto, Integration und Rückkehr. Eine psychosoziale Langzeitstudie über Lebenswelten, Identität und Perspektiven von lateinamerikanischen Flüchtlingen in Österreich. (Vienna: unpublished research report on behalf of the BMWF) ("In my mind I am an Austrian, but in my heart I am a Latin American". Youth between ghetto, integration and return. A socio-psychological long-term study about social environments, identity and perspectives of Latin American refugees in Austria)

[4] Not having a daily structured routine often means that refugees lie in bed the whole day and that they become lethargic

6. Getting started with the RAR in Austria: mapping the community and snowballing

At the start of the RAR process in Austria there was no information available about drug-related problems among refugees other than a few hints which had been given on the role of black African refugees as drug dealers (see Chapter 2). So we had to deal with an unexplored field, which in the beginning required all members of the RAR team to make a considerable number of phone calls with all kinds of people who we thought could provide us with information about drug addiction among asylum seekers. Therefore in a brainstorming process the RAR team made a list of potential informants (officials/authorities, doctors, NGOs concerned with asylum issues, social workers, etc.). Although our first discussions with officials/authorities had led us to think that there was no drug problem at all among refugees in Austria, we were then able to make contact with key informants (named by doctors and social workers from drug care centres and refugee organisations with which the ISG has permanent contact), who were able to give us a brief outline of the drug situation amongst asylum seekers. These key informants included staff members from the refugee camps/homes, an Egyptian psychotherapist who gives psychosocial treatment to refugees, as well as members of staff from the drug care centres.

During interviews with these persons it was suggested that the Iranian and the black African groups might make potential target groups (see Chapter 2), so we asked our initial key persons to name persons they knew who might have a good insight into these groups and who might be interested in taking part in further semi-structured interviews.

During the *semi-structured* interview phase we carried out a couple of interviews with experts concerning the black African group: since the results of the first semi-structured interviews persuaded us not to choose this group as a target group, the snowballing in this group ended at this point (see also Chapter 2).

With regard to the Iranian group, we were fortunate to find a director of a camp for Christian Armenian Iranians who provided us with essential information and with good contacts to other informants in the field of refugee care. The Egyptian psychotherapist named a member of the "Asyl in Not" association (supports refugees with any kinds of problems), who himself was of Iranian origin and had good knowledge of this group, including drug-related problems, and had a central role in the further snowballing process. We were also able to find another social worker in the field of drug care who already had contact to Iranians with addiction problems as part of her work, and who supported our snowballing in that area.

For the Iranian group, our interview partners in the semi-structured interview phase provided a good basis for further snowballing during the structured phase. It seems that once you are able to start a snowballing process (which in our case was initially difficult since we had no basic information before researching the field), you will be able to proceed with the networking process. The only problem in our case was to find interviewees directly from the target group because of the fear refugees had of talking about the subject of drug addiction. That is why in the case of Austria the majority of interviews had to be made with people working closely together with asylum seekers. In the cases where interviewees came from the target group, these people also played an important role as arrangers of interviews, convincing other refugees that they could trust the RAR team.

7. Advice for interested colleagues concerning aspects of the RAR process

It is essential to co-operate with persons whom the refugees trust- but even then access is not so easy, as is illustrated by our example. During the *interview phases* more time was required than expected or

anticipated. This was as a result of cultural differences in answering questions. For example, our interviews with a different cultural background did not keep to the interview format as much as the Austrians did. They sometimes told stories around the concrete answers and they invited us to drink a cup of tea first (cultural politeness). Language problems also sometimes led to delays: it is important to attempt to find out before the interview phase how cultural differences can influence the interviews themselves in order to be able to adapt the interviews (in expert talks!); and more time should be anticipated for each interview.

With regard to the *focus group*, not all the potential participants were either willing to participate or could afford the time (it was hard to find a date that could accommodate everyone even though in principle they wanted to participate). Because of these problems, the actual number of participants in the focus group was lower than we expected. Nevertheless, those who came made the discussion very interesting and valuable.

It is therefore important to ensure that:

- all participants turn up nearly every day, because their reliability is sometimes not so good, and not all people who are invited turn up even if they confirm that they are coming.
- For the preparation of the focus group it is very useful to note deviant answers from the interview phase in a separate file so that you do not have to separate them from the rest of the individual inter views just before the focus group.
- Because of the language problems of some of the participants, it was sometimes difficult to have a fluent discussion (translations were needed). People from Iran have a different discussion behaviour (very polite, but talking very much before coming to the point of interest, in a manner opposite to that of the Austrian participants): that is why more time should be taken into account, because a discussion between people of different cultures seems to last longer than "normal" ones.

8. Austrian results

8.1. Results of the RAR concerning the drug consumption of Iranian refugees

Our most important findings concerning the drug consumption of Iranian asylum seekers were that the use of opium and marijuana among the Moslem people is mainly based on a strong cultural background and tradition. The use of (smoked) opium is something accepted in the society of origin. The use of opium regularly takes place when men meet to talk, discuss, drink tea and so on. This form of opium use in most cases does not lead to physical or psychological problems, or addictive behaviour, because the use is socially controlled. As in all societies, however, some people intensify the use and become addicted. Among these are people who also decide to go to Austria as asylum seekers. Our results show that *the majority of Iranian refugees with drug problems (opium or heroin) started their behaviour in the country of origin*. The poor situation of refugees in Austria, however, sometimes leads to a more dangerous form of opiate consumption (injecting), or to a more intensive use of the respective drug concerned, or even to a change, such as from taking opium to taking heroin.

Besides opiates, some Iranian refugees also tend to consume alcohol in a problematic way; but again they do not start from nothing in Austria or as a result of their traumatic flight experiences. Basically these people have already had their first experiences in Iran, even though the use of alcohol is strictly forbidden there and punished even more severely than the use of opiates (opium). The fact that, in contrast to Iran, alcohol is available in every Austrian supermarket at relatively low prices encourages them to drink alcohol more often and in a problematic way.

In Iran the use of alcohol is not forbidden in the Christian Armenian group and is far more common than in the Moslem group. In Austria, many members of this group consume considerable amounts of alcohol - the reasons for this are somewhat different than for the Moslem group:

For the majority of the Christian Armenian refugees, the declared aim is to migrate to the USA. Because they are Christians, they have had very good chances until this year of getting visas for the USA, and they regard their stay in Austria as just an intermediate stop on their way overseas. Because they do not expect to have to stay in Austria very long, they feel no need to integrate into Austrian society, to care for anything, or to respect the rules of the Austrian authorities and refugee camp directors. They feel they could do whatever they want, being sure to leave Austria in a couple of weeks. For this reason the alcohol consumption in homes where Christian Armenian refugees were concentrated was very high, and the staff of refugee centres had hardly any chance to do anything about it.

Some informants from the RAR phase also referred to the misuse of medicine by Iranian refugees, in particular in terms of self-medication, using tranquillisers, sleeping pills or pain-relieving medicines without a doctor's prescription.

8.2. Existing prevention models

During the RAR in Austria we were unable to identify any existing prevention measures for our target group in Austria. The only things concerning drugs and refugees which we could find were:

- psychotherapeutic care for refugees (in individual cases, but not on a large scale), which also sometimes is concerned with addiction, but not in a preventive way (only therapy)
- psychosocial care for refugees (voluntarily organised by the NGO "Asyl in Not"), which only deals with addiction when the issue is mentioned during counselling (again only individual cases) and refers them to psychotherapeutic treatment (see above)
- One NGO which visits asylum seekers in prison, and which offers counselling and treatment in cases of drug-related problems among refugees waiting to be sent back to their home country because, for example, they broke the law.

8.3. Prevention ideas based on the RAR

By the start of our prevention part of Search, the number of Christian Armenian refugees had decreased rapidly and no such new refugees arrived, so we had to concentrate on the Moslem Iranian asylum seekers with regard to drug prevention.

Since we had discovered that Iranian people with drug problems regularly bring their problems with them and continue, intensify or change their substance consumption patterns in Austria, we recognised that the approach of implementing primary prevention measures for our target group did not seem so meaningful.

We defined our prevention approach instead as *secondary prevention / early detection & intervention / harm reduction to minimise the negative consequences of drug abuse and to provide possibilities for changing / stopping the addictive behaviour.*

General ideas
With regard to preventive factors for drug abuse among asylum seekers in Austria, one of the main findings of the RAR was,

- that nearly every respondent pointed to the poor social situation of asylum seekers (see Chapter 4) as being the cause of many of the problems experienced by refugees, including drug-related problems. If refugees could live under better circumstances, have a chance to work and be accepted by the population/authorities, criminality or drug abuse, for instance, would be reduced/prevented.
- Another issue mentioned by respondents was the need to intensify the forms of psychosocial work among refugees in order to help them deal better with their asylum situation during their stay in Austria. Only a few associations offer this help and they can only care for a very small number of refugees owing to a lack of funding.
- The important role of the family as a social protective factor for drug abuse was also mentioned. Since most persons in our target group are alone in Austria without their families, however, this approach is merely theoretical. Since 'SEARCH' does not have the means to change the general problems of the Austrian asylum policy and the living conditions of refugees, and also cannot provide financial support for existing care organisations, the ISG had to think about other forms of preventive activities.

Concrete idea
On the basis of the interviews, *an information folder on drugs, dangers of substances, detection of addictive behaviour and the possibilities for receiving professional help and treatment* was considered as a concrete prevention measure (tailor-made to the cultural needs of the Iranian group). However, many respondents believed that only a few refugees would actually read such a brochure, and for this reason we consider that such a folder should be directed not only to the target group itself but also, for example, to the care staff in refugee centres in order to increase their awareness of the problem and to give them advice on how to (re) act.

Additional, very general ideas for secondary prevention projects included:
- Establishment of training programmes for persons who have frequent contact with refugees (social workers, doctors, etc.) or for refugees themselves (as a kind of peer education) to enable them to react properly to any problems that occur relating to drug abuse among asylum seekers
- "harm reduction": measures to minimise the negative consequences of drug abuse

Both ideally should take place in co-operation with existing partnerships in Vienna (drug care centres, "Aids-Hilfe", etc.)

8.4. Adapting prevention ideas

Following the 'SEARCH' workshop in Turin, in a further brainstorming process on how to actually start our prevention activities we developed concrete prevention ideas based on our own suggestions and on the results of the discussions in Turin. We decided to concentrate on:

Developing an information transfer and creating networks between drug services and refugee services:

This should ensure that the asylum seekers are able to profit. A very important result of the RAR process was the discovery that there was a lack (non-existence) of networking between refugee care organisations on the one hand and drug care centres / treatment centres on the other. Until 'SEARCH' this had hindered the measures taken by separate refugee care staff to help their clients simply because of the lack of information on drugs, possibilities of drug therapy or drug counselling. With this in mind we decided that it was essential to start a networking process between those two "parties" in order to guarantee the success of any secondary prevention activities.

Within this context, our first concrete steps were aimed at integrating the ideas and expectations of the persons relevant for making the prevention measures. Discussions on the issue took place in personal talks, telephone calls and small working groups, with the added difficulty that the summer period meant that many relevant persons were absent. Nevertheless, positive developments, such as involving the "Asylum Co-ordination Austria" and strengthening the good relationship to refugee care organisations, took place during that period.

The forming of a permanent, inter-disciplinary "steering committee" which had been originally planned appeared to be impossible because of difficulties co-ordinating the different parties in terms of time. Thus the development of prevention measures went on at a rather non-institutionalised level.

8.5. Three concrete preventive measures

As a result of this process of discussion, gathering concrete prevention ideas and expectations of relevant persons, and then adapting these ideas, the ISG agreed upon three concrete prevention measures within Search-Austria:

A Organisation and conducting of a one/two-day symposium, which seemed more realistic than establishing another new network (networking these days is very common, and nearly every organisation takes part in several networks which makes it hard to join a new one because of a lack of time).

This symposium should include talks, discussions and working groups and is aimed at the staff of drug and refugee services. It should ideally give the necessary impetus for co-operation and should provide an information exchange between different organisations.

In organising this symposium, existing resources and sources of co-operation should be used, and national and international institutions should also give their support.

The major problem with this project is the very time consuming preparation which cannot be completed in the intended period of 'SEARCH'. This approach is therefore foreseen as a possible continuation of 'SEARCH' starting in summer 2002 - logistic preparations for that can be started now so as to ensure that it will be well organised.

B Integration within existing networks, which means that the subject of "asylum seekers and addiction prevention" should be integrated within existing networks, circles, etc., such as the network of drug services "Migrants and drugs" (in which at least some participants are very interested), the working group "Notquartiere", or the network of "Asylum Co-ordination Austria". The intention is to spread information about the need for drug prevention among refugees and to work on establishing institutionalised forms of co-operation.

However, as our experience in this field has showed, networking is a very long-term process and, because of the relatively short period of time for our prevention work, we thought it would be best to focus primarily on a short-term pilot project. This would provide an example for following equivalent approaches, which ideally could then continue without the supervision of 'SEARCH'/the ISG.

C The pilot project: "secondary prevention within a group of asylum seekers in an emergency refugee hostel" with the intention of developing co-operation between two specific organisations: an emergency refugee hostel and a drug counselling centre to improve the situation in the refugee hostel concerning the drug/addiction problems of refugees. The ISG had good contact with both organisations during the RAR process.

The pilot project was aimed at developing a new policy in asylum care centres for dealing with drug abuse-related problems (until now drug dealers and consumers have been handled in the same way - the only possible consequence of detection is expulsion from the refugee home). This new policy shall also include training measures for the staff where information is provided on substances, early detection, and on resources that can give help and so enable early intervention (before 'SEARCH', the staff had no idea that there are drug care/counselling centres which work anonymously and for free). The external resources (drug care/treatment centres) which are needed for this pilot project shall be arranged with the help of the ISG, which can also use its experience in policy-making and have a guiding and supervisory role in the project. In addition, the intended information brochure shall be produced for trial use in the emergency hostel concerned - in co-operation with an Iranian refugee worker.

The need for such a project became very clear during the frequent discussions about prevention; it was planned to be conducted during the remaining period of 'SEARCH'; evaluations shall provide know-how for later, similar projects.

8.6. Target groups receiving the Austrian prevention measures

All the prevention measures planned by the ISG are not only directed at Iranian asylum seekers. This is because on the one hand, with the exception of the pilot project, our activities are more general in nature, and on the other hand because the number of Iranian refugees is steadily decreasing. Furthermore, we did not want to exclude refugees of other origins from the pilot project. In terms of the Iranian group, however, the knowledge about the cultural background gained through 'SEARCH' can and should be used.

8.7. The pilot project - turning it into practice

After the 'SEARCH' workshop in Vienna where the specific prevention projects of all partner countries were discussed, the following steps were taken which concentrated on the pilot project:

- We intensified our contacts with the drug care centre (where people are counselled anonymously and for free[5]), which during the RAR phase was very interested in co-operating with our project. Although the talks seemed very positive, problems came to light which included the impossibility of providing counselling in languages other than German or English, the lack of treatment facilities following the counselling process, and the need for an official decision by the board of directors of the care centre as to whether there could be any form of co-operation.
- At the same time the ISG had intensive meetings and discussions with the staff of the emergency home. This was initially with the director, who was still very interested in co-operating with the pilot project and who wanted to change the way drug-related problems are dealt with in his home.
- Following this, a meeting was convened with the entire staff which lasted for several hours. This was used to exchange information while at the same time providing a first training step in dealing with the addiction problems of their clients. Subjects covered by this training included the need for a clear differentiation between drug dealers and drug consumers, advice on different reactions and conse-

[5] As pointed out previously, only one third of the asylum seekers are in federal care and insured and have the theoretical chance of receiving treatment. The problem is that asylum seekers lose their right to receive federal care when drug problems become evident.
Those refugees outside federal care have no chance at all to receive treatment because no one would pay for it. It is therefore important that there is anonymous and free access to drug services.

quences, and alternatives for helping consumers instead of throwing them out and leaving them alone with their problems (for instance, refugees with addiction problems could remain in the home if they seek drug counselling from a drug care centre). Also covered were ways to differentiate between different substances and their dangers, and means of detecting drug-related problems among their clients at an early stage. Primary prevention issues were also included such as the need for refugees to be able to take responsibility for their own lives or to have a meaningful occupation to structure their days (since refugees are not allowed to work, some care centres such as our emergency home have already started activities such as renovating/redecorating the homes). This training session, which was very well received by the staff, was continued a couple of weeks later after finding out about additional subjects which the staff were interested in.

- In our first staff meeting we also pointed out that it was essential to establish co-operation or a network with external resources when it comes to secondary prevention, and that we were trying to convince a drug care centre to take part in the pilot project. The reaction of the staff to that approach was very positive because they stressed that they would never be able to do the prevention work all on their own, parallel to their rather exhausting regular work. However, the staff questioned the usefulness of providing drug counselling without the chance of follow-up treatment for those refugees who are not insured (the refugee organisations cannot provide the money for the costs of inpatient or outpatient treatment). We agreed that, together with members from the drug care centre concerned, this issue and the various possibilities should be discussed at a following meeting to see what opportunities there were in concrete terms.
- Another activity which concerned both the pilot project and our networking idea was the ISG's participation in the working group that has been established for all Viennese emergency hostels ("Arbeitskreis Notquartiere"). There we introduced the 'SEARCH' project and our prevention ideas and measures within the pilot project. The intention was to disseminate the information amongst potential partners for following prevention programmes who would then be able to profit from the experience gained from the pilot project. The working group was invited to the annual NGO forum of UNHCR to present the results of their work in November 2001. There the subject of "drug prevention among asylum seekers" was focussed upon in a brief presentation in order to raise interest in this subject at a higher institutional level.

Parallel to this we continued to collect material for the information folder in co-operation with the Iranian refugee worker.

8.8. Problems faced

The drug care centre that was intended to assume the role of an external expert resource for drug counselling surprisingly decided at board level that it would be impossible to co-operate with the emergency hostel without additional funding for that work (even though in principle this institution is open to everybody).

As an alternative we immediately contacted the psychosocial service of the municipality (the only place which gives treatment to non-insured persons). The result was very similar: additional funding would be needed. Contrary to the other drug care centre, the responsible medical doctor was willing to think about ways of obtaining funding from the officials together with the organisation which runs the emergency hostel.

8.8.1 Reducing the aims and developing new strategies

Thus in the final phase of the prevention stage of 'SEARCH' we were forced to limit our aims. This was because it would not be possible within the remaining period of time to concentrate our efforts on getting funding for our prevention idea of establishing co-operation between existing drug care centres and the emergency hostel (our experiences with trying to get national co-funding for 'SEARCH' had been rather disappointing in general). For the rest of the period we therefore adapted the pilot project by concentrating more on the "staff training approach", while at the same time trying to develop a strategy for dealing in future with the funding problem and the organisation of the emergency hostel.

- With regard to *training*, we were able to increase our co-operation with the emergency hostel, although the expectations of the members of the staff were not able to be fully satisfied in that the provision of external resources and possibilities for treatment cannot be guaranteed at the moment. We were able to leave the staff with better knowledge of drug-related problems, the early detection of drug problems, how to deal with drug addicts and aspects of primary prevention (risk factors/protective factors), but we have not (yet) been able to provide co-operation partners from the field of drug care/treatment with whom the staff would be able to implement early intervention measures.
- With regard to the *problem of funding*, we had discussions with the director of the emergency hostel about making the problem of drug addiction among refugees an official issue. Refugee organisations are very careful about how they deal with information on problematic situations in their homes/ hostels because they are financially dependent on funding by authorities, such as the municipality, or by private sponsors. Letting those people know that drug addiction is (at least a minor) problem in the refugee centres has the inherent danger that they could lose funding, lose their good image (in the neighbourhood, in the municipality) and could complicate the work for these refugee organisations. This is one of the main reasons why the problem is still treated as a taboo subject that nobody really wants to be aware of[6].
- On the other hand: if refugee organisations want to start to handle the problem properly it is essential to integrate officials in the prevention process as sponsors as our example shows. Without a certain amount of financial backing the extent of our prevention measures was very much limited.

By the end of the project period of 'SEARCH' the refugee home had still not made a decision whether to apply or not for funding for specific prevention measures in our sense. The next step to be taken by the director of the emergency hostel, however, will be to meet the director of the psychosocial service of the municipality who has already showed willingness to co-operate and to consider funding ideas. This should enable these two institutions to make a concerted effort, which would raise the chances for funding. The ISG is ready to play a counselling role in these discussions even after the end of the project period of 'SEARCH'.

The director will also discuss the subject with the board of directors of the "Evangelischer Flüchtlingsdienst" (the organisation behind the emergency hostel and other refugee homes), particularly in regard to finding ways of funding. The board of directors also includes people with a certain amount of influence within the municipality, so it seems to make sense to integrate those persons in the funding efforts. Although it was unfortunately not possible to arrange a meeting of this board within the project time, the ISG still is ready to participate in discussions with that body.

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[6] see page 3 "collusion of silence"

8.8.2 Consequences for the information folder

The negative developments also influenced the production of the folder, which, besides information about drugs, dangers and addiction, ideally should also name a definite place or person which/who could be contacted by the refugee, the staff of a refugee home, or a relative in order to get help. As we do not have this possibility at the moment, we consider our concept for the folder to be a draft to which the missing information on possibilities for getting help will have to be added after the necessary networking and financial funding has been established. We do not intend to produce a high number of copies of our draft folder because we do not consider it to be complete: it is rather useless to distribute a folder in which people can learn about drug abuse but in which the most important information (namely a definite resource for counselling/treatment) cannot be found.

You will find enclosed a draft version of the information folder in English (the translation into Farsi will take place when the folder is ready for publishing and will be done by Iranian ex-refugees).

9. Plans of the ISG

Our plans for the immediate future primarily include efforts to integrate local authorities/officials, such as the Fonds Soziales Wien (Social Vienna Funds) which previously provided the drug co-ordination for Vienna, into the prevention plans.

Just recently there has been a positive development: a former colleague and friend of the director of the ISG became director of the "Informationsstelle für Suchtprävention" (Information Office for Addiction Prevention), the office which co-ordinates all preventive measures of the municipality, which may lead to a good basis for talks about possible national funding of Search II, funding of training activities, or co-operation in producing the folder and organising the symposium planned in the year 2002.

We also wish to maintain good contacts with the different networks in the field of drugs & refugees in order to keep interest in that topic alive so that we can get things moving quickly when funding is guaranteed.

10. Long-term implementation of addiction prevention for asylum seekers in Austria

If there is going to be a long-term implementation of addiction prevention for asylum seekers then it is essential that there is a guarantee of funding for carrying out the pilot project in the planned form (see Chapter 9). This would then provide a useful and evaluated example which other refugee centres/organisations could adapt for themselves and for which long-term funding is realistic.

With regard to the national funding, a continuation of ‘SEARCH’ in the summer of 2002 could guarantee at least further activities in the field of addiction prevention among asylum seekers, which would maintain awareness of the problem among refugee and drug care organisations and could also improve the chances of receiving necessary additional sponsoring.

The symposium (planned for Search II, see Chapter 8.4) would provide a useful basis for spreading and exchanging information between refugee and drug care organisations (which the ISG also wants to continue in 2002 through regular information talks on the current situation with the relevant institutions). Since this symposium would provide a certain amount of publicity, it could also serve to increase awareness of the problem by authorities with the hope that they might start their own efforts or support our prevention measures with financial or infrastructure measures.

'SEARCH' in Spain:

Drug Prevention for Maghrebian Minor Immigrants in Barcelona

Fundación Salud y Comunidad (FSC), Barcelona, Spain:

Helga Gabarró Núñez ***Project coordinator 'SEARCH' Spain***

1. Initial situation: From the analysis to action

1.1. Introduction

The document presents the results of the work of "Fundación Salud y Comunidad" following the execution of a RAR-supported analysis in Barcelona on the use of drugs by immigrants in risk situations. In concrete terms the project concentrated on the use of solvents and other drugs by juvenile immigrants from Morocco who live or stay in the Raval district in Barcelona without documents or family.

The Fundación Salud y Comunidad (FSC) is a non-profit, non-government organisation (NGO)[1] which works both *nationally* and within an *international* context. The FSC has recognised an extensive experience in establishing and providing services for the prevention and treatment of problems in the social and health sectors. The foundation offers professional services such as, for example, counselling, scientific studies, documentation as well as providing training for experts, social players and leading figures in the community. The concentration on therapeutic and preventative measures reflects the desire of the foundation to improve the quality of life of people affected by problems associated with drug use, alcohol, AIDS, violence, mental or physical illnesses. Accordingly, the work in the foundation concentrates on themes such as social exclusion, racism, discrimination, poverty, abused women, youth violence, drugs and leisure, public safety, health and welfare for senior citizens as well as sexually transmitted illnesses. In these fields of work the FSC has more than 20 years of experience and currently employs more than 90 full-time staff and around150 voluntary workers.

The study on which the following work is based was conducted using the "Rapid Assessment and Response" (RAR) method. The aim was to collect concrete information on substance use amongst certain target groups in Barcelona in as short a time as possible in order to obtain useful data for planning concrete addiction prevention interventions. As will be illustrated in the following section, the method was of great practical benefit in terms of the needs analysis and the planning and implementation of future interventions. At the same time it enabled the surveying and optimisation of regional resources for the corresponding interventions.

Both the study as well as the corresponding activities were conducted by the psychologist **Helga Gabarró Núñez**, a specialist in addiction prevention and immigration, in collaboration with the social worker **Carolina Pascual Romero**, who is an immigration specialist. In the development phases for the prevention methods they were assisted by **Sandra Astudillo Moreno,** a social psychologist who specialises in "social community intervention". The entire work was supervised by **Roland Hallmaier**, the Director of the Department for Prevention and International Co-operation of the Fundación Salud y Comunidad.

1.2. The immigration situation in Spain

Traditionally Spain has never been an immigration country but instead has "exported" people over the centuries. Although we only know the number of "legal" immigrants (the "illegal" ones are of course not recorded!), it is clear that in the last 20 years the number of foreigners who have arrived in the country has increased considerably, (a growth of 16.6 %, a figure which lies considerably above the European average of 9.83 %). The government immigration authorities assume that although the current immigration situation in Spain does not display the same characteristics as in other countries such as Germany, France or the United Kingdom, the experience which has already been gained in these coun-

[1] It has the legal form of a foundation

tries places us in the privileged situation of being able to learn from them and so develop a co-ordinated policy that will provide impetus to dealing with the phenomenon of immigration in the European Union in a homogenous and appropriate way.

Currently the entry of immigrants of North African and sub-Saharan origin without documents by means of illegal and unsafe entry routes is a controversial theme which is reflected in the press with a certain consternation. At the same time numerous Mafia organisations have been created for the illegal "trade" in immigrants. They organise illegal passage in dangerous, primitive and unsafe forms of transport, such as the so-called "pateras" (small boats with out-board motors), which numerous immigrants use for crossing the sea from Gibraltar and thus gain illegal entry into the country. Some of them manage to reach Spanish territory while others are captured by the Guardia Civil, and are arrested and sent back to their own country - and some of them even lose their lives while making the attempt.

As has already been mentioned, although Spain has increasingly become a target country for migrants, in terms of their absolute numbers and relative to the overall population there are still a lot fewer migrants entering than in most other EU countries. Although the migration is still relatively small in Spain, (and at the moment is just a new tendency), it should not be treated as an 'insignificant factor'. Since its accession to the European Union Spain has, relative to its overall population, played a vital role in the regulation of migration movements; thanks to its geographical position it is the next gateway south of Africa[2].

From the number of applications for legalisation of their immigration status we can presume that the Moroccan immigrants form one of the largest groups in Spain. The other large immigration groups who come to Spain come from Morocco and Algeria, Latin America (Columbia, Ecuador and the Dominican Republic), Eastern Europe (Rumania, Ukraine and Poland) and from the sub-Saharan areas of Africa (Senegal, Gambia and Nigeria). They are mainly concentrated in Madrid (particularly the South American migrants) followed by Catalonia (particularly Barcelona), the Mediterranean coast, the Canary Islands and the Balearic Islands.

1.3. Drug use by immigrants before the RAR

During the data collection phase of our study we established that there was no specific data concerning drug use among immigrants in Spain: correspondingly, and probably because this is a relatively new phenomenon in Spain, **there are no addiction prevention programmes in Spain specifically developed for immigrants and their children** where their language is used or which are specifically oriented to their cultures and their most important needs.

Those immigrants who, because they do not have a resident permit, are in Spain illegally, are very much discriminated against for reason of their marginalisation and are highly vulnerable in social terms. It also means that they are a group which is particularly vulnerable to drugs. Therefore it is important to create a corresponding care service which is appropriate to this group of persons and which can offer it needs-oriented treatment. Special preventive programmes also need to be designed and implemented, not just for the new arrivals but also for the very important generation of children growing up between two cultures. Finally, necessary (evaluation) systems must be developed so that data can be collected periodically which will enable a picture to be created of the existing problems and the results of the implemented preventative measures and care services.

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[2] The distance from the port of Tangiers to Spain is only 14 kilometres!

1.4. Consumption tendencies within the target group

During the preliminary phase of the project we found ourselves confronted with the difficulty of having little knowledge of the actual situation in terms of drugs and the presumed problems of immigrants since there was no corresponding information nor had any interventions been conducted in this field. The little information that was available was either very specific, or concerned a different approach, so that it was impossible to draw any conclusions from it. A further factor which hindered the gathering of information was the fact that, when in contact with people from our target group(s), the immigrants concealed things which they feared would damage their reputation, such as admitting, for example, that members of their ethnic community use or deal in drugs.

At this point we would like to emphasize once more that our statements concerning drug use by immigrants in risk situations are based on only a *small amount of hard data*. The data determined in the RAR process are *indicators* for the existence of certain problems, they are not validated data[3]. Nevertheless, for reference purposes we would like at this point to briefly examine the background situation.

It can be observed that, although considerable legal and social barriers exist, there is nevertheless a considerable demand from immigrants in the various drug care establishments, and in particular in the low-threshold facilities. The majority come from North Africa (Morocco and Algeria) and from the sub-Saharan region (Ghana, Nigeria and Senegal). The reason for this is that it is mainly immigrants from these regions who live in Barcelona. The data reveals that the most important drugs for which the care facilities are required to help are alcohol, cannabis and heroin, drugs which are also taken by the Spanish.

Following the explorative survey at the start of the project we decided to concentrate on the Moroccan community (which is currently on of the largest groups of immigrants in Catalonia), and using questionnaires began to collect information on the possible problem areas regarding drug use in this community. Right from the start respondents from different areas expressed in particular concerns regarding *single male youths from Morocco* without documents and without existing social contacts in the target region. On arrival they typically make their way to areas which are frequented by people from their homeland in order to make contact and look for work. If they do not have legal documents it is impossible for them to find legal work and to earn themselves a living. In this situation they are soon contacted by Mafia organisations who are active in theft, prostitution and drug dealing. They are frequently very well organised and are looking for "workers" for their types of business. There is a very high risk factor in terms of vulnerability to drugs and other addictive substances when, owing to the lack of "legal" alternatives for earning a living, they become involved in the criminal world of drug use and dealing.

In terms of alcohol consumption it needs to be said that whilst in Morocco the Islamic religion forbids the consumption of alcohol, outside of family relations it is tolerated in urban areas and amongst men. In rural areas and within the context of the family, however, there is no traditional use of alcohol, neither in the gastronomic area nor in social relations. In Spain, however, consumption is very normal and traditional. Once in Spain these people are exposed to this substance on a daily basis and are easily tempted to try out the psychoactive effect of alcohol.

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[3] Also compare with the problem of gathering data: R. BRAAM/H. VERBRAECK/F. TRAUTMANN, Rapid Assessment and Response (RAR) on Problematic Substance Use among Refugees, Asylum Seekers and Illegal Immigrants, Münster/ Germany 2002

While conducting a comprehensive review of material in search of information on groups within the Moroccan community particularly at risk in terms of drugs, we identified press reports on so-called "glue-sniffing" children who come to Spain without the help of their families, friends or other adult acquaintances, and live on the streets of Barcelona. We received from various sources information what was initially very unspecific information on the problematic use of solvents and other drugs by these juveniles. We decided to concentrate our RAR-supported analysis on

the group of juvenile Immigrants unaccompanied by family members

1.5. Background: The living situation in Morocco

In order to be able to understand and comprehend this problem area it was necessary to familiarise ourselves with the situation of the population in Morocco:

- At the moment two thirds of the Moroccan population are younger than 20 years of age.
- The growth rate of the population is 3.47 children per woman (whereas in Spain this figure is 1.2 and in Catalonia even lower!)
- In addition the unemployment in Morocco is very high. 73% of the unemployed are under the age of 30 and *men are more affected by unemployment than women*.
- At the same time, as a result of increased foreign investment in the Moroccan textile industry in recent years, women have become increasingly important in working life and have meanwhile become the most important source of income for families, whereas
- on the other hand male unemployment is very high.
- In the course of this process the family structure has changed, the authority and social role of the father has begun to be slowly challenged (whereby the influence of sons within the family circle has also been lessened).
- In Morocco a third of the population live beneath the poverty line, whereby the poverty in the rural areas is so serious that it causes migration towards the cities.

It is against this background that increasing numbers of people are immigrating from Morocco to Spain, and it also provides the main reasons for the migration of juveniles: in Tangiers dozens of youths (some of them only 10 to 12 years old) can be increasingly seen waiting by luxury hotels looking for buses, or waiting near the dockside loading areas looking for lorries in which they can conceal themselves at night and be taken to Spain, the land of their dreams. Some of them die under lorries after many attempts and others think that they have nothing much to lose. Several studies indicate that the majority of cases concern children from broken homes who already know life on the streets of their own country. On the other hand many families do not know the precise reasons for the motives of their children, but in the end they often accept this anyway: they sees this as a solution to their financial problems since they know that their sons will send money as soon as they reach Barcelona. Thus it is less difficult for them to let them go…

1.6. The situation of juvenile immigrants without parents or legal guardians in Barcelona

The group of migrants who were identified as a risk group comprises young male migrants of Moroccan origin without documents, who are mostly juveniles (usually aged between 14 and 17) and who live on

the streets in the "Ravel district" in Barcelona without family members. They have either not yet made use of the care services of the City of Barcelona, which comprises various centres (Circuito de Atención al Menor de la Generalitat de Catalunya, which herewith shall be referred to as the "Circuito"), or have already done this but for some reason or other have returned to the streets. The problematic use of liquid solvents (inhalation or "sniffing"), but also of other (illegal and legal) drugs could be particularly found within this group. Although this group mainly consists of juveniles, it also includes young men who have just reached adulthood.

1.7. The most important consumption tendencies identified

There is *general multiple drug use* amongst the youths. In particular, the sniffing of solvents was identified and in some cases the use of adhesives. When first consumed they tend to try them out for *fun* and to *experiment*, but then increasingly as a reaction against the stress of the difficult living conditions. The use changes to misuse and thus becomes dangerous. With many, this consumption regularly alternates with the use of sedatives. The youths prefer these substances because they are very cheap and they themselves have either very little or no money.

At the same time, a habitual and normalised use of hashish was also identified, particularly when they had money available. Alcohol is consumed less, but not necessarily because of religious or financial reasons. There is selective use of synthetic drugs and cocaine, particularly from older youths who have already been on the streets for a long time.

1.8. Aspects which increase the vulnerability of the juveniles

The youths adopt more or less the role of adults who seek work in order to send money to their families. However, they are treated as children who are legally forbidden to work. The reason why many of them do not wish to attend the centres which have been created for such groups is partly because this would then prevent them from pursuing their main goal: namely earning money. While a very small number attain this aim through the legalisation of their status, the vast majority of youths live in very poor conditions on the street until they reach adulthood, without having sorted out their legal situation; their situation thus further worsens and becomes chronic. Those who live on the street spend the most part of their time in contact with other socially marginalised groups, with drugs, the previously mentioned Mafia organisations, and of course with peers who live in a similar way and use drugs as they do.

Accordingly, as far as the legal situation in our country is concerned these youths find themselves in a hermetically sealed society that does not offer them any opportunity to fulfil their hopes and wishes, nor even to attain a single goal (and which therefore forces them to live in a state of illegality).

1.9. Problems associated with solvent use

Broadly speaking, and listed in order of importance, the problems which are associated with solvent use are mainly ones of a psychiatric, physical and social nature:

- rejection by neighbours in the district and through other members of the same ethnic community,
- group pressure - some of the group habitually inhale solvents-,
- pressure by the Mafia organisations,
- use in order not to feel cold, hungry or lonely,
- problems with the law due to consumption and stealing (which they normally do after the consumption so that they can pluck up 'courage'),

- money problems and
- sometimes the lack of stability in the reception centres (Circuito, etc.).

1.10. Main reasons for using solvents

One of the aspects which most of all encourages the use of solvents and other substances is the **easy access** to them in the district. The use of solvents has three clear **functions**, and these are closely associated with the living conditions of the youths:

- On the one had there is **playful use** amongst the newly arrived juveniles for the purposes of primary socialisation with their peers.
- In addition there is use aimed at **suppressing fear** and as a
- **means to find courage** so that they are less scared when stealing and dealing with the police.

These last two aims are the main motives for problematic use, both for those youths who for various reasons have turned their backs on the Circuito and have returned to the streets and the immigrants who have reached adulthood and continue to live on the street in the same situation and with the same dynamic.

The *cultural differences* between Morocco and Barcelona do not seem to have too great an influence on the use of solvents. What does have a considerable impact, however, is the fact that the youths in Barcelona live in a largely isolated situation, both in terms of social and family ties.

Another factor that exercises influence is the fear and considerable pressure (and corresponding frustration) that arise through the impossibility of them ever being able to fulfil even a *single one* of their expectations and hopes. Moreover, they live in a situation of permanent insecurity as far as their immediate future is concerned. They react to these increasingly unrealistic hopes and illusions with increased use of solvents (and other drugs).

This therefore is a brief summary of the situation of these youths in terms of their problem use of solvents. If you are interested in further details of the research report, then do not hesitate to request this under the following e-mail address at the FSC: fsyc@fsyc.org

2. Activity phase

After the compilation of the investigation results was completed, we decided to obtain direct feedback on the conclusions and possible needs and preventative measures to be conducted following the analysis. For this reason we invited the employees working in the overnight shelter of the Red Cross to a meeting there. This centre provides lunch, evening meals, showers and overnight accommodation for 17 juvenile immigrants within the district. The group consists of 6 teachers from the centre, the director of the addiction care department of the Red Cross in Barcelona, as well as the director of the overnight shelter for juvenile immigrants. The results were presented and discussed during the meeting, as well as the difficulties which the professionals face in dealing with such situations.

We have until now broadly outlined the current risks in terms of drug use that are associated with immigration to Spain and Catalonia, the main aspects of the development of the first phase corresponding to the RAR analysis, and the most important conclusions reached on consumption that were derived from the study. In the next section we will describe the phase concerned with "possibilities for action and measures" that have been derived from the previous activities. It is important to point out that one

of the main advantages of the "Rapid Assessment and Response" method is the fact that it is a process of research and action, and in doing so brings together the key players in the community concerned. In this strategy information is first of all collected and evaluated, and then building on this the most important measures required are determined and evaluated together in order to efficiently tackle the immediate problems. During the process of searching for information, mapping and investigating the district and developing contacts, the various social players are incorporated into the project, and naturally this includes those who are themselves affected.

Thus, during this process a working platform is developed based on a network comprising individuals, experts, inhabitants, social workers and those affected, as well as organisations, establishments, associations and centres whose contributions are indispensable for the conceiving and implementation of prevention measures[4].

2.1. Necessary measures for preventing solvent use and associated problems

The contacts made during the analysis phase also yielded a series of measures necessary for tackling the problem of solvent use and other drugs within the target group. Everyday in Barcelona, considerable time and efforts are invested to stem both the use of solvents and other drugs and the consequences which accrue from this use. However, there is no *specific, co-ordinated* programme for professionals for preventing and reducing drug use within the target group of juvenile Maghreb immigrants. Suggestions from these professionals, the youths themselves and other "social players" led to the following urgent measures which need to be tackled.

One more preliminary remark: Although in some cases these concern measures which require financial means that either do not exist or are difficult to procure, we are nevertheless presenting them here so that those working in this area can decide for themselves as to the demands that need to be made and the focus of their activities in order to tackle the problems investigated by us. Some of the proposals are aimed at solving basic everyday problems that while admittedly not *directly* associated with solvent use, nevertheless provide deep-rooted causes for encouraging this use. The main needs that have been established in order of importance are:

- **Covering basic needs**, such as a permanent place to sleep, adequate food, attention, protection and care, background information on the city district, information and counselling on their rights and possibilities for support, establishing daily routines concerning food and hygiene so as to reduce the constant stress to which they are exposed. Owing to the fact that solvent use is very much determined by the living conditions, it is of the utmost importance that these needs are covered (structurally-related prevention). Here, we are not just referring to the most necessary basic needs to

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[4] The following is a list of all the different establishments, organisations and centres contacted in the RAR:
- Asociación Ibn Batuta., Centro Abierto (open centre) del Raval "J.S Gavina",
- Centro de noche Cruz Roja (overnight shelter for the Red Cross),
- Ayuntamiento de Barcelona "Circuito de atención al inmigrante"(immigration drop-in centre run by the Barcelona city authorities),
- Piso asistido a menores (supervised youth accommodation) de Cáritas Alcántara,
- Amical de los Inmigrantes Marroquíes en Cataluña (friends of the Moroccan immigrants in Catalonia),
- Centro de atención a las drogodependencias (drug care centre) SPOT,
- "Café-Calor",
- Other linked points of contact in the community:
  Mosques and imams, various inhabitants of the Barrio (Spanish and Moroccan), various traders in the Barrio such as the chemists, various drug stores and cut-price shops (todo a 100), Arab shops, barkeeper in a bar in the Barrio, telephone shops, police patrols in the Barrio and of course various juvenile Moroccan solvent users, drug-addicted youths and young immigrants who consume other substances.

survive; it is also necessary to tackle aspects such as vocational training, and to offer them practical experience, training time, etc, since these are directly related to the reason why they left their homeland: to earn money.

- It is important that cases where inhalant use has intensified to dangerous levels are referred to the district addiction care establishments in order that personal treatment can be instigated. *El Òrgan Tècnic de Drogodependències de la Generalitat de Catalunya* is familiar with the problem and is currently developing solutions.

- Personal treatment is not only necessary in cases where it concerns psychiatric and/or physical dependence, but also in cases where it has been established that there is serious, habitual use that is chronic, whereby *solvent dependence* is a subject where there is no clear consensus. On the one hand it is clear that psychiatric dependence can occur, on the other hand the possibility of physical dependence is very much disputed. There is no consensus of opinion on the possible course and severity, although it is at least accepted that there is a possibility of psychiatric dependence and increased tolerance to the substance. As with other substances with addictive potential, this is shown by the difficulty of controlling the substance and/or stopping (of course seen against the background of the described living conditions of the solvent users). As a consequence, the required measures should not only foresee the option of treatment *in cases where there is clear dependence to solvents* but also in those cases where the health of the youths and that of those associated with them is already seriously at risk *before* addiction starts.

- At the same time our key informants confirm how important it is to rapidly identify the juveniles who have freshly arrived on the streets in order to transfer these to the Circuito and thus prevent them - without family and left to themselves - from coming into contact in the street situation with peers who are consuming drugs i.e., to prevent them coming into "easy reach" of inhalation substances and other drugs. With the same argument, the professionals consider it necessary to be able to provide a permanent emergency hostel. The proposals reveal differences of opinion concerning the degree to which such centres should be open or closed. They are all in agreement, however, in pointing out that the centre should be in the city, since this would be so-to-speak "closer to the reasons" that attracted the youths to Barcelona (they did not come to enjoy the rural splendour...).

- Barcelona City Authorities (the "Serveis Personals" department), together with the Circuito (***Circuit d'Atención al Menor de la Generalitat de Catalunya***) have been conducting work since the beginning of 1998 that attempts to reach the stated aims. Nevertheless, the professionals and key figures in our survey emphasise that an expansion of the means and services is still necessary.

- Parallel to this, the centres and other establishments frequented by the youths[5] have signalised the necessity of providing **workshops and/or activities for health promotion** for these youths, in particular in terms of establishing daily routines and activities concerned with nutrition and hygiene, and special events concerned with the **prevention of solvent use and other drugs** that provide information on the substances used and the risks and consequences of their use. The majority of the professionals and social players interviewed say that such activities are essential in addition to the other measures already mentioned.

These are all provisions that can be taken as an initial step in meeting the basic needs, but others also need to be considered in terms of their possible influence on the problem:

- **Encouraging the "idea of returning home" and improving self-confidence**. It is particularly difficult for the juveniles to consider returning home; they prefer the situation which for them

[5] We are referring to the various establishments that are attended by the youths on a daily basis: day and night centres, canteens, migrant associations, sport and district youth training facilities.

seems like freedom and gives them the possibility of earning money. They believe in the better possibilities of a life in Spain - compared to a life on the street, without any perspectives and/or in a broken family in their homeland. In the end their short and medium term plans are not influenced by thoughts of returning home: **a return would mean failure**. Street workers have attempted without success to speak about this subject with the youths on several occasions: in general the youths cannot imagine returning to their families as "losers". For this reason they construct lies and fairytales about their situation in Barcelona and tell them that they are doing fine in order to justify the sending of money. One approach would be to deconstruct the lies and to transform them into something real and acceptable:

- **Example:** A youth tells his family that the money which he sends home has been earned by working. In reality he earns this by stealing. In such a case it should be attempted to persuade the youth to stop stealing - which, however, would stop the sending of money. This can be justified to the family by saying that he has stopped working for a period in order to undergo training which will bring him a concrete job in the immediate future.

- The **sensibilisation of the population** has also proven to be indispensable - in the Raval district in general, but in particular those who belong to the same ethnic community. The aim is to crush the myth that solvent use represents something irreversible - and that these youths are beyond all hope - in order to prevent them from being stigmatised and rejected. The causes that lead to this situation should be demonstrated without reducing the youths to the role of "victims". This is an important aspect in so far as rejection by their own compatriots could create a situation of fear which further worsens the use of solvents and other drugs.

- **The provision of specific information and training for the educators and other specialists who work with the youths on the subject of "solvents"** is a further proposal. The specialists (in particular the educators) should have knowledge about everything concerning solvents (substances, reasons for use, effects, etc.), in order to be able to deal better with the intoxication situations with which they are frequently confronted. At the same time it is necessary to provide them with expertise for dealing appropriately with youths in this situation.

- **Prevention of solvent use through daily activities.** The aim of this proposal is to convey to the youths that solvent use and activities which for them are most interesting (such as playing soccer) are rather incompatible. This would provide an indirect and practical form for promoting health and preventing drug use within an non-institutionalised everyday context[6]!

2.2. Preventive activities which were implemented within the framework of the 'SEARCH' project

The last three proposals listed in the previous paragraph led to the idea to start an activity during the period of the 'SEARCH' project based on the proposals mentioned in the previous chapter, which at the same time would mark the start of future prevention activities. The working group within the foundation evaluated the proposals that had been provided and, in accordance with the financial possibilities of the project and the time available, we chose:

"Guidelines for professionals for preventing the use of inhalation substances ".

[6] This proposal has been developed and can be seen at the end of the third part of the manual

2.2.1. Guidelines for professionals for preventing the use of inhalation substances

The idea for the guidelines arose from the specific need for action to prevent or reduce the use of solvents by these youths, and likewise from the need for information on solvents, consumption situations, and possibilities for intervention from the view point of the various care facilities in the community. These guidelines are specifically intended for those professionals from a variety of different facilities who work for and with the group of single juvenile immigrants in risk situations. Apart from the youths who are already habitual consumers of solvents or adhesives, the rest - although not yet users - are extremely vulnerable. Although the guidelines are specifically intended for professionals working with the youths mentioned, it can also provide suggestions for other professionals working with youths in risk situations (whose definition can be extended both in practical as well as analytical terms).

The guidelines have the following aims:

- **Sensibilisation** of professionals in this area to the necessity of tackling the problem in a coherent and co-ordinated way.
- **Information and training** on solvents and the prevention of their use.
- **Introduction of preventative activities** concerned with the use of solvents and other drugs within the framework of programmes by the centres that are aimed at providing daily activities.

The guidelines are divided into three main sections:

1. In the first section the **research results** are presented on the basis of which the present document was developed. The use of solvents and other drugs within the group of Moroccan youths without papers and families in the Raval district of Barcelona is described in detail. This first section focuses on the reasons, consequences and secondary aspects of the use.
2. The second section describes the most important measures for preventing solvent use among the youths that were deemed to be necessary by the professionals and other social players involved in the study and analysis.
3. The third section, the most important and detailed part of the guidelines, includes theoretical and practical information on preventing and dealing with the problem of solvent use among these youths. This addresses such aspects as the definition of the substance (s), the effect(s), motives for use, consequences and what should be done when there are doubts or problems. It also includes a series of educative and preventative activities which the educators can build into their everyday programme. Below is a summary of the contents of this capital:

3.1. **Solvents and liquid substances (inhalants)**
Definition
Examples of substances frequently used
Ways of using them

3.2. **Solvent use**
Recognising use
When is there intoxication by solvents?
What side effects are caused by the use?
When can we refer to a ***misuse*** *of inhalants?*
When is there ***dependence*** *on inhalants?*

3.3. **Which risks and harmful effects are associated with the use?**
Aspects which must be considered in emergency situations
In concrete situations: what needs to be considered?
Practical suggestions

3.4. **Can we speak of "harm reduction" for inhalants?**
Risk minimisation in every life

3.5. **What does the future look like for glue sniffers in health terms**

3.6. **Prevention activities with juvenile glue sniffers and drug users from the centres and the streets**
Aspects which must be considered when planning and conducting these prevention activities (practical examples)

3.7. **Use and knowledge of neighbouring resources**

Professionals from the fields of drug use prevention and migration were involved in the elaboration of the guidelines. During the preparation, research was conducted into documents on solvent use and existing prevention and treatment programmes in other countries. Contacts were made and information received from various Ibero-American organisations who have years of experience in the field of solvent use amongst street kids. Some of the information originates from the Master de Drogodependencias course of the University of Barcelona, which is taught by lecturers who also actively work in the FSC, as well as from other sources which are listed in the bibliography. Some of them originate from countries where the use is more established (Guatemala, Honduras, Costa Rica, Mexico, Peru, Nicaragua and Argentina).

The elaboration of these guidelines within the framework of the project provided a realistic opportunity to conduct an activity within the project whilst simultaneously providing a starting point for future activities, which every organisation can initiate on the basis of its national and financial possibilities. As was

shown before the start of the project, **neither Spain nor any other participating country knew of any specific prevention programme for immigrants and drug users.** Thus the care, prevention and reintegration provisions for immigrants have a very fragmented character. From the viewpoint of the FSC, we are convinced that the Project 'SEARCH' was fundamentally important in establishing an approach for the prevention and support of immigrants at risk from the use of drugs.

In the previous points we have named various proposals which, even if we are unable to implement all of them immediately, are worth passing on to other organisations as a means of providing political pressure and as a way of unifying the lines and approaches taken in the different areas involved in the problem. All this information is included in the guidelines and made available to professionals.

In this respect the guidelines developed within the time and financial restraints of the project directly answer one of the demands of professionals working with youths.

2.2.2 Evaluation of the guidelines

The guidelines were distributed amongst the professionals who work in the educational area together with the youths in the target group; i.e., it is offered to them as a tool to manage and unify their activities for preventing solvent use as well as to enable them to deal better with situations in which they work. For the evaluation a series of questions were formulated on the practicability, benefits and interest seen from the point of view of the professionals working with youths. At the end of the guidelines a page was included with the evaluation questions which record the information qualitatively and quantitatively and which should be answered after 5 months working with the guidelines.

2.2.3. Perspectives for the guide following the 'SEARCH' project

In December 2001, 20 self-published versions of the guidelines were printed, each comprising 50 pages (16x23cm). The guidelines will be initially available in a limited edition and only distributed amongst the professionals working in the Raval district who are in contact with juvenile immigrants for the study.

Parallel to this, interest has been shown in the project and the development of guidelines for prevention professionals in order to begin measures for preventing solvent use with these youths. For this reason, within the framework of a possible second phase of 'SEARCH' ('SEARCH II') we are considering the possibility of extending and improving the guidelines as the next intervention step and also as a necessary prerequisite before the beginning of the direct prevention work with the youths in the target group.

With the end of the 'SEARCH' project the first stage of the work has come to an end. The project has laid the foundation for the development of addiction and health prevention among immigrants in risk situations in Spain, and at the same time work is already carried out on the further development and consolidation.

3. Material and useful internet adresses for the work with "sniffers"

1. On the substances:

http://www.fad.es/sustancias/index.htm (Spanish)

http://www.inhalants.org (English)

http://www.fortunecity.com/meltingpot/botswana/268/inhalabl.htm

http://www.arconet.es/familia/111Lavidahumana/Droga/Inhalantes.htm

2. Various intervention and prevention projects:

http://www.une.edu.ve/pnhp/info.html

Medicus Mundi: street children
http://med.unex.es/medmund/infomundi/ncalle.html

Latinsalud: inhalation substances
http://www.latinsalud.com/Temas/inhalantes.htm

Casa Alianza: street children and inhalation substances: a world-wide survey.
http://www.casa-alianza.org/ES/street-children/glue/overview.shtml

Drug use (and the use of inhalation substances) in Mexico: diagnosis, trends and actions. Mexico's answer to drug use:
http://www.ssa.gob.mx/unidades/conadic/CDM%202-3.htm

NIDA. National Institute on Drug Abuse. National Institutes of Health. inhalation substances:
http://www.nida.nih.gov/Infofax/Inhalants-Sp.html

3. Used article:

Reyes del OLMO, P y García ROSETE, J. Los menores inhaladores (aspectos psicosociales).
http://omega.ilce.edu.mx:3000/biblioteca/sites/maestro/adicion/htm/sec_43.htm

Some terms used in the texts:

FG	focus group, research tool in the ▶ RAR
grids	questionnaires in the ▶ RAR
harm reduction	term from addiction care, meaning measures whose target it is not primarily to overcome addiction but to preserve health as far as possible, even if drugs are perhaps still used
NGO	internationally used abbr. for "Non Governal Organisation"
RAR	Rapid Assessment and Response: research method used in the 'SEARCH' project
RSA	Rapid Situation Assessment: former term for ▶ RAR. This term was omitted because the process dynamic, accompanying aspect ("Response") does not find expression in it
snowballing	term from the ▶ RAR: the identifying of informants by "throwing" snowballs; "somebody names the next person"
SSI	semi-structured interviews,research tool in the ▶ RAR
SI	structured interviews,research tool in the ▶ RAR
UNHCR	United Nations High Commissioner for Refugees

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