Delivering Drug Treatment to New Minority Communities: fresh perspectives

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Appendices

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Appendix 1 Published Works

Appendix 1.1 Paper 1

Mills, K., Brooks, S., Sender, H. & Green, R. (2006). ***Accessing Drug Services in Peterborough: a study of black and minority communities*****. Hatfield: Centre for Community Research University of Hertfordshire.**

Accessing Drug Services in Peterborough:

A Study of Black and Minority Ethnic Communities

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1. KEY FINDINGS

- The majority of respondents were not users of Criminal Justice Services.
- The findings offer considerable insight into the needs of members of BME communities.
- The findings support the engagement and retention of individuals from BME communities within the Peterborough DIP.
- Drug misuse among minority communities in Peterborough, seems to be shaped in part by the context in which the community is living and in part by the drugs available in the country of origin, in common with the findings of Sangster (2002) eg. the use of dance drugs by the young eastern European community, the use of opium by those from the Middle East and the smoking of heroin by the Pakistani community.
- BME communities are characterised by high levels of shame and denial in relation to drug use and tend to ostracise drug users.
- There are particular difficulties for some BME communities in broaching drugs problems across the generational divide.
- Drugs, knowledge and awareness in hard to reach BME communities is low.
- Loss of immigration status, and indefinite leave to remain in Britain, are of overriding concern to asylum seekers who fear that leave to remain will be refused if their drug taking is discovered.
- Issues around maintaining confidentiality are paramount.
- Drug agency clients do not think that workers needed to be ' matched ' for ethnicity or race but that drug workers need to have knowledge and understanding of the cultural issues for clients.
- Clients wanted daily contact in the early stages of treatment.
- Clients wanted help in establishing a new non-drug using lifestyle and developing skills for employment.
- The life history respondents valued the Nene Project (DIP) and Bridgegate.
- Where new communities in Peterborough are not integrated into social networks there seems to be an increased risk of substance misuse.
- Data regarding to BME communities, particularly the ‘new’ and emerging communities is limited.

2. INTRODUCTION

The University of Hertfordshire's Centre for Community Research was commissioned by Peterborough Drug Action Team (DAT) to undertake a study of Peterborough's 'new' and emerging BME communities into their needs, their experiences of using drugs, and their knowledge and experiences of accessing drug services in Peterborough. The research was also intended to inform Peterborough's Drug Intervention Programme (DIP) work with individuals from these communities.

The research was undertaken over a four-month period between October 2005 and January 2006.

The project used a collaborative approach, between the three partners involved in the project, Peterborough Drug Action Team, Bridgegate Drug Services, and the Centre for Community Research.

Information was gathered using semi-structured interviews and life histories. An analysis of statistical information relating to ethnicity and the DIP was also undertaken.

Two days research training was provided to members of BME groups who undertook the interviews.

A Steering Group was established to monitor and progress the project. Membership of this group included representatives of the 'new' and emerging BME communities who were sessional outreach workers at Bridgegate.

The research has produced a number of local and national recommendations, which will inform the planning, and delivery of drug treatment services, including the DIP, to BME communities in Peterborough.

The need for further research in related areas is also recommended.

3. BACKGROUND TO THE STUDY

Peterborough is becoming a more ethnically diverse city with over 10% of the population classifying themselves as belonging to a non-white ethnic minority group in the 2001 Census compared to 7.5% for the 1991 Census.

The largest non-white ethnic group in Peterborough is the Pakistani community (4.5%) but the city is also home to people from other minority ethnic groups such as Italian and Caribbean, and newer groups from Eastern Europe, Africa, and the Middle East.

Peterborough also had over 14% of its population as being non 'White British' at the time of the 2001 census compared to 12.5% for England and Wales and 8.5% for the East of England (Peterborough, 2005).

However these figures exclude 'new' and minority populations, which the broad Census categories do not reveal and which are an important part of Peterborough's changing demography.

In recent years Peterborough has experienced new arrivals including asylum seekers and refugees, in its location as a National Asylum Support Service (NASS) dispersal area for asylum seekers, and economic migrants from a number of EU countries such as Portugal.

In addition, Peterborough's economy is supported by a substantial number of migrant workers from EU accession countries. This group of individuals would appear to be relatively transient within Peterborough and consequently harder to reach by local drugs services.

The impression of the DAT is that the inclusion in the community of refugees from Afghanistan, Iraq and Iran as well the troubled areas of Africa, is crucial to the development of appropriate services. These individuals present different challenges to service providers, with experiences of abuse in the country of origin compounded by isolation, vulnerability and sometimes exploitation within the host community.

It was to explore the perceptions, attitudes, and experiences of the individuals from these emerging communities that this report was commissioned.

To facilitate the project a key local drugs agency, Bridgegate Drug Services, was identified by the DAT as having a successful track record in accessing and contacts with minority BME communities.

4. BME COMMUNITIES AND DRUG SERVICES: REVIEW OF THE LITERATURE

This literature review aims to examine the existing research on Black Minority Ethnic (BME) communities and their uptake or non-uptake of drug services.

The majority of black and minority ethnic groups live within deprived inner city areas (SEU, 1998). Black and minority ethnic people figure disproportionately in statistics of those:

- Unemployed (CRE, 1995)
- Living in poverty (Jones, 1996)
- In the criminal justice system (Home Office, 1998)
- Detained under the mental health Act 1983 (Department of Health, 1999)
- In ill health (Erens et al, 2001)
- Excluded from school and in care (SEU, 2000)
- Vulnerable to homelessness (Chahal, 2000).

4.1 Take up of Health Services

Research has found that people's access to health services was dependent on the area that they lived in. The research found that that the poorest parts of Scotland's towns and cities had 11% fewer GPs and less access to health promotion programmes. Professor Graham Watt argues that:

> *"Too many NHS agencies have policies that fizzle out in the most deprived third of the population" (BBC, 2005).*

The Social Exclusion Report (2005) states that ethnic minorities are more likely to be in poor health. For example, Pakistanis and Bangladeshis are up to four times more likely to be in poor health then their white counterparts (SEU, 2005).

Parveen, in Harding (1995) argues that the low take up of services may be due, in part because:

> *"Services are inappropriate or harmful to people with different cultural axioms….In such circumstances it is essential that the real needs of the communities are identified. Reliance should not be placed solely on self-appointed community leaders. New initiatives also need to avoid colluding with the simplistic concerns of anti-racist and equal opportunity rhetoric".*

Within the mental health service, there exist racial discrepancies:

"Black people are three times more likely than the rest of the population to be admitted to mental health hospitals in England and Wales. They are twice as likely to be sent there by the police or the courts" (The Guardian, 2005).

The Muslim youth helpline (2006) argue that Muslim youth experience a high level of mental illness, particularly those that enter Britain as refugees. Almost one-half of the Muslim Youth Helpline's clients complain of mental anxiety, depression or suicidal feelings. The also state that Muslims make up 7% of the country's prison population, this is a very high figure as it is five times that of the total Muslim population in Britain today. They cite the example that many of their own clients who use the Muslim youth helpline have been in prison.

The Muslim youth helpline recommend that services should be able to respond sensitively to the needs of Muslim youth, who appear to be marginalised by existing mainstream services.

4.2 Research on Drug Service Usage

There is significant evidence to suggest that the most serious drug related problems are concentrated within areas of high unemployment and social deprivation (Haw, 1985; Peck and Plant, 1986).

The economic and social circumstances of many young people from BME communities mean that they are at risk of problematic drug use (Patel and Wibberley, 2002). Despite the clear correlation between harmful drug use and the range of predisposing factors that BME communities experience, both school based surveys (Parker et al, 1995) and general population surveys (Ramsey and Spiller, 1997) suggest that BME respondents are less likely than white respondents to use illicit substances. Interpretations of these figures need to take into account that drug use may not be revealed to researchers due to the 'fear of stigma':

"Although the knowledge base on the prevalence of drug use within BME communities remains sparse relative to that on the white population (Johnson and Carroll, 1995), over the last 13 years a growing body of evidence indicates that it exists and/or is increasing".(National Treatment Agency for Substance Misuse, 2003).

The Muslim Youth Helpline (2006) state that:

"drug abuse and smoking are shown to have a significantly higher prevalence amongst Muslim youth between the ages of 16-25 years, despite the fact that an estimated 45% of Muslim youth have never used illicit drugs, smoked tobacco or drunk alcohol".

A study conducted by Chantler et al. (1998) on drugs services in Greater Manchester found that there exists a need for improved drug service provision to BME communities and that race issues were very rarely given priority within service planning or in the delivery. The main areas that the research highlighted were that:

- Levels of uptake were low for the majority of the drugs services across Greater Manchester by Black and minority ethnic people.
- There were low numbers of drug service employees from BME communities.
- Equal opportunity policies within the drug services were not actively implemented.
- There were few examples of good practice identified and managers of agencies in the area highlighted gaps in service provision to BME communities.

Chantler et al. main recommendation was that there was a need for constructive action to be taken to redress the balance. The outcome of this report was a Greater Manchester wide 'Drugs and Race' initiative was established (Tyrer et al.,2004).

A recent study carried out by Tyrer et al. (2004) was designed to update and build upon the work carried out by Chantler et al. (1998). Tyrer et al. argue that there exist gaps in the knowledge base of BME communities and drug use. There is particularly a lack of knowledge of drug use among refugees and asylum seekers and other recently established populations. The majority of the information is on Bangladeshi, Indian and Pakistani populations. Tyrer et al. analysed data on patterns of clients using the drugs services in Greater Manchester.

They found that in 2001/2002 a total of 3.92% of on going clients accessing the services were from BME communities. However 6.02% of new clients accessing the services were from BME communities. They state that within this increase in numbers, there are particular increases in numbers of Indian, Pakistani and Bangladeshi clients accessing treatment. From the interviews conducted with service providers, Tyrer et al. found that they would find having access to certain sources of quantitative and qualitative data on drug service users and BME communities useful. This includes: a profile of service users by ethnicity, gender and age; drug use among certain offenders; experiences, views and needs of users and community groups and organisations; needs assessments relating to the drugs misuse needs of BME communities. Tyrer et al. argue that the reality for many commissioners is that they feel that they have very limited knowledge about the needs of BME communities.

A study conducted by Cottew and Oyefeso (2005) looked into the drug use of Bangladeshi women living in East London. They found that there exist many reasons for the under-utilization of drug services by minority ethnic substance misusers. Some of the main reasons are seen as being: cultural value systems; cultural dissonance; education; literacy; previous experience of persecution; communication difficulties; religio-cultural prescriptions and discrimination; and a lack of knowledge of service provision. Some members of the Asian population would not wish to attend drug services nearby because they may be scared that it may become known by the larger community. Minority ethnic groups do not perceive substance misuse services as meeting their needs and that attending may be regarded as a threat to themselves or their self-image (Oeyfoso and Ghose, 1998).

Cottew and Oyefeso argue that within many cultures there exist barriers to help-seeking behaviour. For women this is compounded by the fact that female drug use is taboo in many cultures. Research suggests that people from BME groups experience disproportionate levels of physical health compared with those from the ethnic minority. A survey carried out by the Department of Health (2002) found that Bangladeshi's were the most socially disadvantaged of all the groups investigated. Bangladeshi's were the least likely to make use of health services other than a GP.

Evidence exists which supports the view that woman are less likely to receive support from their social environment than men, for using services aimed at treating their substance misuse. A main reason for this is the social stigmatisation of women who misuse substances; as it goes against the perception that they should in some ways be more responsible then men and they are also perceived as having the role of carers. The impact of how social stigma is perceived is an important influencing factor in women's decision making process when deciding to seek help for drug problems (Ruben, 1995).

Becker and Duffy (2002) conducted a study on women drug users and drug service provision. From an analysis of the literature they found that a main argument emerging from it was that:

> *"Women problem drug users have specific experiences and complex needs which are not always recognised or met by some existing drug services. Women attending treatment services have a higher level of mortality than male attendees. As well as those needs associated with pregnancy, childcare responsibilities, and sex working women seeking help often also had sexual health and mental health needs, which may have resulted from past sexual and physical abuse" (p11, Becker and Duffy, 2002).*

Becker and Duffy state that from their literature review the main barriers that restricted women accessing drug services, included: stigmatisation and child protection issues; weak social support networks; problems in maternity services; negative attitude of health professionals; and ineffective

interagency working. The women who do access drug services often find weakness in the services that they receive. Some of the main shortcomings highlighted by the literature are a lack of: childcare and transport facilities; women-only services; provision for black and ethnic minority women, and services within the Criminal Justice System.

Research conducted by Cottew and Oyefeso (2005) found that there exist multiple barriers to the utilization of drug services. The main barriers that they identified are: people's perception of their use of drugs as being non-problematic; a loss of motivation due to the lengthy waiting lists in accessing services; a belief in self-efficacy, the view that they do not require or need outside help; the seeking of advice, help and support from peers who take drugs; and the fear that their drug using status will be exposed, this is in particular an issue for members of a minority ethnic group who are part of a small community. They also identified a number of additional barriers, these being: a lack of knowledge of how to contact drug agencies; the environment of the drug treatment agencies, such as having contact with other drug users; a fear of being identified by people they know; a lack of knowledge of drug service provision, the impact that it will have on their future or current employment; and a fear that there will be a loss of confidentiality.

Cottew and Oyefeso (2005) argue that the main reasons that were identified for not wanting to attend drug services were that they were afraid of social services intervening and the resulting loss of custody of their children.

The National Treatment Agency for Substance Misuse (2003) states that very few mainstream or specialist drug services, in particular needle exchanges have been able to attract or work with many BME drug users. They argue that some of the main reasons for this are: the lack of acknowledgement of drug use by BME communities; the ethnicity of drug service staff; a general lack of understanding of BME cultures; language barriers; a lack of awareness of drug services and their role and function; and a perceived lack of confidentiality.

The National Treatment Agency for Substance Misuse (2003) states that there exists a complex relationship between ethnicity and substance misuse. They identified three main key themes, these being: a lack of knowledge on the extent and nature of drug use amongst the UK's BME groups; that BME are not homogenous and therefore should not be researched as such; the impact that social, economic and psychological factors have on drug use.

The National Treatment Agency for Substance Misuse argues that there exists an environment whereby the issue of ethnicity, drug use and related service provision has been neglected, due to the above mentioned key themes and the multi-dimensional nature of drug use, fears of accusations of

racism and a general lack of BME workers in drug services. The review found that there exists a lack of research on refugees and asylum seekers and certain BME communities are far more researched than others, in terms of drug related research.

The Centre for Ethnicity and Health during 2000-2002 carried out a series of drug service reviews, which included the conducting of interviews with service providers and community members in Calderdale, Bury, Bedfordshire, Bolton, Shropshire, Waltham Forest and Redbridge. The findings from the reviews indicate that there is an increasing perception of a rise in drug use, of a range of drugs including heroin, in South Asian communities, particularly amongst young men. The research also found that there were community concerns about young South Asian women using drugs, an example being South Asian young women using cannabis in Bradford (Bashford et al, 2003).

Sangster et al. (2002) argue that they found important ethnic differences in patterns of 'problematic drug use'. They use the term 'problematic' to refer to drug use that is likely to result in serious social, health and legal problems for the user. They state that there exists data to suggest that problematic drug use among African Caribbean users is particularly focused on crack use and is also more likely than any other group to focus on cannabis use. Studies have been conducted which have found people raising concerns on the usage of crack cocaine by members of the Black Caribbean community, within Newham, Bradford, Manchester and Oldham (Maynard, 1994; Gilman, 1993; Chaudry et al, 1997; and Chantler et al, 1998).

Sangster et al. (2002) argue that Black and minority ethnic opiate users are less likely than whites to inject. They state that there is limited data on new communities that have been formed as a result of refugees moving to the UK. The data that they examined did indicate that there is problematic drug use within the Vietnamese and Somali communities, which is mainly limited to men. The effects of post-traumatic stress disorder, the role of khat within Somali communities, and the availability of drugs that were not known in Somalia and Vietnam, are regarded as being some main areas of particular concern:

> *"Patterns of problematic drug use vary between ethnic groups and the continued focus of services on opiate-injecting in an important source of institutionalised racism. The failure of services to engage adequately with crack, opiate smoking, cannabis and khat has particularly marginalised the needs of African Caribbean, south Asian and Somali users. At the same time there is evidence of opiate injecting by Black and minority ethnic drug users and it is crucial that services actively engage with injectors from these communities" (p62, Sangster et al., 2002).*

An area of importance, within the literature is that of gaining access to women from BME communities who are misusing drugs. Mistry (1996) argues that for their research gaining the views of South Asian women who were not drug users, on their views on local drug services was also difficult. Abdulrahim et al. (1994) state that one of the main barriers for women that prevent them accessing services are the sense of shame that they feel. There is research that supports the existence of rising concern that certain BME females, are misusing drugs. Sheik et al. (2001) use the example of the concern about young Pakistani female heroin and crack cocaine users being recruited into prostitution.

Results from studies that have been designed to find out the actual drug use of members of BME groups, provide statistics to support the view that it both occurs and is increasing. A study by ADP (1995) found that out of a sample of young people in Tower Hamlets (77% of whom were South Asian), 60% had used an illicit drug at least once. Bentley and Hanton (1977) carried out interviews with 150 young South Asians in Nottingham; they discovered that there existed relatively high levels of drug use. They also found that more of their female than male respondents had never used drugs. Sheikh et al. (2001) states that from an analysis of the regional drug misuse database for Anglia and Oxford in 1997/1998, they found that 30% of new cases presenting for treatment were from BME communities, mostly South Asian.

There is therefore strong evidence from both quantitative and qualitative sources that demonstrate that drug use with BME groups exists and is increasing. The National Treatment Agency for Substance Misuse (2003) argues that it is still significant even in cases where drug misuse is shown to be less than the white population.

Research has tried to examine the level of drug awareness amongst BME communities. Younger members of BME communities are more knowledgeable about drugs than older generations. Sangster et al. (2002) argue that the BME users, who do present themselves to drug services, are the people who have reached a late stage in their drug using problems. It is therefore difficult to estimate the number of people who are using drugs but do not access drug services. There have been several studies, which have identified the low level of drug awareness that exists amongst older members of BME communities (Arora and Khatun, 1998; Bola and Walpole, 1997, 1999; Carrington, 1993).

Other research which has involved interviews with young South Asians highlight the ease that the young people are able to hide their use of drugs from their parents. The main reason for this is due to the parents 'lack of awareness of drugs and how to help' and also because 'parents are reluctant to acknowledge drug use due to the associated shame' (Bola and Walpol, 1997). Support for parents is

therefore necessary to allow for them to be empowered so that they can cope with drug use in their family (Perera, 1998).

Bashford et al. (2003) argue that generic and drug specialist services currently have only a very limited capacity for meeting the needs of refugee and asylum seekers. Bashford et al. (2003) state that:

> *"It is important that service planners and providers understand the histories of the different refugee communities who live within their area. These histories are diverse…..many refugees and asylum seekers have feelings of hopelessness and despair, which may place them at increased risk of substance abuse" (p15, Bashford et al., 2003).*

4.3 Improving Take-Up of Drug Services

Within the research literature a number of suggestions can be identified, in order to develop appropriate drug services for BME communities. These include the need for drug services to be publicised better to their targeted audience. Communication tools that are appropriate need to be used, this includes using the media effectively.

To target BME groups, radio and television stations that are aimed at specific cultural groups should be made use of, examples being South Asian radio and TV stations. Audio tapes, dramas, road show events and music events should all be made use of (ADP, 1995; Bola and Walpole, 1997, 1999; Hothi and Belton, 1999). The publicity that is used should promote anti-discriminatory images of service staff and facilities (Awiah et al, 1992). Images of the target groups should be used (Dhillon et al, 2002). The message that drug services exists for all ethnicities and not just for white people needs to be reinforced (Sangster et al, 2002). Another recommendation is that black and ethnic minority workers need to be appointed and appropriate publications need to be developed (Penfold, 1991).

The main recommendations given by Tyrer et al. (2004) in regard to planning and commissioning of drug services so that they become more responsive to the needs of the BME population are: gaps in the knowledge base need to be identified; further work to fill these gaps may need to be commissioned; BME communities should send regular updates to commissioners; DAT's need to thoroughly integrate race and equality throughout their plans; all tenders and Service Level Agreements need to demonstrate that commissioners think about the needs of BME communities; a template needs to be developed for the purpose of monitoring effectiveness of services around race equality needs.

A multi-agency approach needs to be taken. This will allow organisations to respond effectively to drug-related problems in the context of broader health service provision. Multi-agency working

includes the involvement of community organisations and the use of local health promotion initiatives. By using a multi-agency approach this will help with the development of services, as they are able to share resources and duplication will be minimised (Awiah et al, 1990). ADP (1995) state that aftercare services are an important part of drug service development plans.

There is a debate within the literature regarding whether specialist or generic services are the most appropriate and effective. Hothi and Belton (1999) argue that for some BME drug users, there is a view held by some that specialised drug services are not the most appropriate way to treat them. Young people in particular may require a different approach. Sangster et al. (2002) state that from their research they found that their respondents regarded specialist services as including cultural ownership and an understanding of cultural needs. They also found that the respondents viewed specialist services as being expensive, impractical and as providing limited occasions for expertise to be shared. Generic services were viewed as being 'mainstream' services, and this had the seen benefit of statutory commissioners funding these services as part of their core service provision and were also seen as having lengthier life spans then specialist services. Sangster et al. (2002) argue that there was an overall view from their respondents that specialist services could have an important complementary role to play.

The main disadvantages of successful specialist services are that mainstream providers, may use them as an excuse or as a justification for not addressing their own service responses (Bashford et al, 2001; Prinjha et al, 2001b). There could also be an unfortunate consequence of increased attendance at existing drug services by BME drug users after awareness-raising activities, this being that the increased numbers may be used by decision makers to argue that the problem of service access has been resolved and this could act as a barrier to more culturally-specific services (ADP, 1995).

Outreach work is regarded as being a requirement by some authors, for example, (Mirza, 1991). It is viewed as being necessary to access BME drug users and those who are at risk of drug use (ADP, 1995; Bentley and Hanton, 1997; Prinjha et al, 2001a). Outreach work also has the added benefit of enabling a comprehensive needs assessment to be conducted (Patel, 2000b). Patel (2000a) and Ram (2000) also stress that people conducting action work and action research need to be careful that their work does not simply consist of drug workers and researchers 'parachuting' into a community, to conduct their projects and then disappearing leaving behind raised expectations.

For improving drug services for women, a set of main recommendations is given by Becker and Duffy (2002). They argue that a key way to improve access for women drug users is through outreach work. They state that outreach work can be achieved in five main ways: home visiting which is targeted at

women looking after children and pregnant women; pre-care and after-care schemes, this is mainly aimed at women and children in residential services; services that are aimed at sex-workers include well women's clinics, a well-equipped mobile clinic, and detached work from saunas and flats; use of community health and non-health services; a court division worker or other services working from the courts could be used to target women involved in the criminal justice system.

Becker and Duffy (2002) state that some other ways that services can improve accessibility to women are by creating women only space, this is particularly important for women are the most vulnerable. Transport could be provided to take women directly to services and appointments, childcare and/or child places could also be provided by services. In order to make access to the service more flexible opening times could be varied and late time sessions could be introduced. Becker and Duffy also recommend that a fast response could be provided such as immediate telephone contact prior to face to face meetings. They also argue that a major gap in service provision is that which is aimed specifically at ethnic minority women and that this gap needs to be filled. There is also a need for specialist provision aimed at women with mental health problems, vulnerable young women and crack users.

5. METHODOLOGY

5.1 Aims and Objectives:

- To offer insights which will support the DIP in delivering the Drugs Directorate's Diversity Agenda and potentially increase engagement and reduce attrition.
- To investigate the knowledge of and barriers to take up of drugs services for BME communities within Peterborough.
- Work with Bridgegate Drug Services BME outreach project sessional workers to carry out semi-structured interviews with minority and 'new' BME groups to gain an awareness of their needs for drug services support.
- Support Bridgegate Drug Services in undertaking life history interviews of BME drug users focusing on their knowledge and experiences of drug taking and accessing drug services.
- Analyse DIP statistics relating to individuals from BME communities provided by Peterborough DAT.
- To produce a report by the end of January 2006 detailing the findings from the study and setting out the lessons learnt.

5.2 Background

In order to reach members of Peterborough's BME communities the research team sought to employ the contacts of sessional outreach workers already employed by Bridgegate. Staff at Bridgegate identified sessional workers who had rich community contacts and an interest in learning research skills. It was agreed to train these individuals in interviewing skills in order that they could undertake a series of semi-structured interviews to gather data for the research team.

Key to the success of the project was a collaborative approach and at all times during the project the research team maintained a close working alliance with Bridgegate staff.

5.3 Development of the Questionnaire

The first stage in developing the questionnaire for use by the interviewers was a steering group meeting. At this meeting the parameters of the project were finalised, and an open discussion was facilitated to gather from the DAT the expectations they had as to the direction of the study. Some initial areas for investigation were identified.

The research team used these ideas as the basis for the development of a semi-structured interview questionnaire. This document passed between the Bridgegate and research teams for redrafting prior to its inclusion as part of the two training days for outreach workers. This process was crucial in developing a jointly owned project. The questionnaire when completed was to be translated into a number of different community languages. It was important that the language of the document lent itself to this process to minimise misunderstanding.

The final stages of developing the questionnaire occurred within the training days. At the first of these days the near final draft was shared with the sessional outreach workers. Their comments at this early stage in the training were limited, but they took away questionnaires of which they felt some ownership. At the second day of training comments about the value of certain questions were revisited and at this stage the workers felt themselves to be more powerful in requesting changes. The questionnaire was finalised in the light of these comments.

5.4 Training the Interviewers

Bridgegate staff identified the group of sessional outreach workers. The group selected were chosen in order to reach the widest variety of minority groups. This meant that the length of their involvement with Bridgegate varied considerably.

In total 12 sessional outreach workers undertook the training programme. Ten individuals attended on Day One of the training and a further two joined the project for the second day of training having undertaken 'catch up' sessions with Bridgegate staff in the interim.

The composition of the group included the following ethnic groups: Lithuanian; Polish; Pakistani; Iranian; Iraqi Kurdish; Afghani; African; Portuguese & Italian, thus enabling contact with the gamut of target groups within Peterborough.

Two days of training were designed to develop interview skills of the sessional outreach workers and to empower them in undertaking what was an unfamiliar task. Overall the style of the training was experiential as this best suited the learning styles of the workers as identified by Bridgegate staff.

Training Session: Day One

The first of the training days focused on developing the sense of group cohesion and safety; considering the nature of interviewing and the styles of interviewing best suited to our task and beginning to explore the skills required to draw out interviewees.

- The group undertook a forming game, to introduce one to another and to enable each person to hear their voice in the room, facilitating later participation.
- A first exercise encouraged participants to consider the range of situations in which interviews occur, the extent to which interviewing can be a comfortable or a threatening process and the techniques, which distinguish the two.
- Consideration was given to the practicalities of the interview process – when and where interviews should be conducted – the impact, which circumstances have upon the gathering of high quality information.
- As part of this participants were given guidance about confidentiality and introducing the interview process
- A large part of the training on day one was given over to the development of interview skills. Connections were made between the interpersonal skills, which facilitate good communication, and the skills required of the interviewer. Participants undertook skill development exercises to enhance their capacity in this area. Attention was given to verbal encouragement and non-verbal clues.
- The trainees were encouraged to explore the extent to which communication is culturally defined and the group spent a considerable time considering the adaptations they might bring to the process.
- Attention was given to the techniques needed to probe for further information should an interviewee prove hesitant.
- The training was able to offer some guidance as to what to do in case of problems.
- Attention was given to closing the interview, and reassuring the interviewee as to confidentiality.

At the conclusion of the first day of training the draft questionnaire was introduced to the workers for comment and adaptation. These were amended in the light of the workers' comments and packs of questionnaires were handed to workers to prepare for the next training day.

Training Session: Day Two

The aim of the second day was to manage any difficulties, which workers found in administering the questionnaires, and to empower interviewers to own and to a limited extent adapt the questionnaire should circumstances demand this. The style of the training continued its experiential tone. Participants were encouraged to describe their initial experiences of interviewing. The tone of this feedback was one of frustration – the workers had found the process of interviewing more complex

and multi-faceted than they had anticipated. During this second day of training the workers were able to revisit key sections of the first day's learning, these included:

- Probing for more information.
- Adapting the tone of the questionnaire to suit the cultural setting of their own interviews.

The participants were able to observe these techniques in action via role play. At the conclusion of the second day of training levels of enthusiasm and the sense of potential were high. Each day of training was concluded with a group meal.

5.5 Undertaking the Interviews

It had been made clear to interviewers prior to the beginning of the research project that there would be no expectation that they should cultivate drug using acquaintances in order to gather information. Instead interviews were undertaken using both opportunistic and snow-balling non-random sampling approaches. The information gained therefore, are indicative of the levels of knowledge and the attitudes of the minority BME communities within the city rather than a drug-aware sub-group.

During the process of administering the questionnaires staff from Bridgegate supported the workers. It is to their credit that these individuals were able to undertake a large number of interviews in a very short period. The gathering of this information so swiftly speaks of real application and interest on the part of the interviewers. At the conclusion of this process the gathered questionnaires were dispatched to the research team for analysis. In total 96 questionnaires were returned.

5.6 Life History Interviews

Bridgegate staff undertook six life history interviews with interviewees non-randomly selected for this process from Bridgegate's existing client group using a purposive sample.

As with the semi-structured interviews these interviews was discussed at steering group meetings and via email communication. Bridgegate staff took the lead in developing and administrating the interview schedule with the research team providing advice.

Preliminary editing of the questionnaires was undertaken by Bridgegate staff prior to forwarding them to the research team for additional editing and commentary

5.7 Steering Group

An important aspect of this collaborative research project was the establishment of a project steering group to monitor and progress the research. This group comprised of the Peterborough DAT Co-ordinator, Bridgegate Drug Services Community Development Manager, and Senior Project Worker, researchers from the University of Hertfordshire's Centre for Community Research, and BME sessional workers from Bridgegate Drug Services. The group met on a regular basis.

Sessional workers who attended the research training will receive certificates from the University of Hertfordshire.

5.8 Local Statistics

Statistical information provided by Peterborough DAT relating to individuals from BME communities involvement with the DIP was analysed, and along with 2001 Census information provided a contextual framework for the study.

6. FINDINGS

6.1 Questionnaires

6.1.1 Introduction

In relation to ethnicity the analysis of the 96 questionnaires returned followed, as far as possible the categories within the 2001 census. From the point of view of this report, those categories are inadequate, offering no platform to explore the responses and attitudes of several large groups within our sample, for example, the relatively large group of Iraqi Kurds amongst the respondents are not marked out as a specific group within the census criteria.

Furthermore, as has been pointed out above, previous research indicated that exploration of the needs of minority ethnic service users cannot occur where there is an assumption that these communities form an homogenous group (NTA 2003).

For these reasons the categories of Asian and Black were used since those were pertinent, but additional categories were added reflecting the views of populations from Eastern Europe; the long established Portuguese and Italian communities within Peterborough and the responses of migrants from the Middle Eastern countries of Iran, Iraq, Afghanistan and Palestine.

It is recognised that such demarcation is artificial and that, for example the responses of the Afghani community could also usefully be analysed in conjunction with those from the Pakistani community. However in the case of this sample those people from the Pakistani community were in fact British Asians of long standing, while the majority of the 'Middle Eastern' individuals travelled to this country in the last 4-5 years. The communities presented within this report have, then, both geographical and temporal connections.

According to the census groupings the data regarding ethnicity is as follows:

White	Other white background	41
Asian	Indian	2
	Pakistani	9
Black	African	13
	Caribbean	1
Other ethnic groups		30
TOTAL		**96**

A more refined picture emerges when the figures are broken down to reflect the changing reality of Peterborough's diverse community:

- Western European n.21 (Italy n.11; Portugal n.10).
- Eastern European n.21 (Lithuanian n.10; Slovakian n.2; Czech Republic n.1; Poland n.8).
- Asian or Asian British n.11 (Pakistan n.9; India n.2).
- Black African n.13 (Rwanda n.2; Egypt n.1; Senegal n.1; Nigeria n.1; DR Congo n.1; Kenya n. 1; Ivory Coast n.1; Uganda n.1; Eritrea n.1; Sudan n.1; Africa n.1; Somalia/Baravenes n.1).
- Black Caribbean n.1 (Jamaica n.1).
- Middle Eastern n.29 (Kurdistan n.12; Iran n.7; Afghanistan n.6; Iraq n.2; Palestine n.2).

6.1.2 Gender

The gender split within the sample as a whole was almost equal, with 49 (51%) respondents being male and 47 (49%) female. However with the sub-groups examined the gender balance was very different. In the region of 60-70% of members of each group were women except the Middle Eastern group where only 7% were women and 93% men.

	Western European	**Eastern European**	**Asian**	**Black African/Caribbean**	**Middle Eastern**
Male	n.7 (33%)	n.6 (29%)	n.4 (36%)	n.5 (36%)	n.27 (93%)
Female	n.14 (66%)	n.15 (71%)	n.7 (64%)	n.9 (64%)	n.2 (7%)

Background information from Bridgegate indicates that in relation to some minority communities this imbalance may reflect a genuine inequity between male and female migrants.

6.1.3 Faith

The religion of respondents to the questionnaire was declared in every case and the precision with which interviewees answered suggested that faith is possibly a motivating factor in many of the lives of respondents.

	WE	EE	A	B	ME	Total
Muslim	1		11	2	24	38
Shi'a Muslim					2	2
Sunni Muslim				1	2	3
Hindu	1					1
Christian		4		6	2	12
Pentecostal				1		1
CofE				1		1
Catholic		16		2	15	33
Multi Faith				1		1
none		1			3	4
	29	21	11	14	21	96

6.1.4 Age

The age of respondents within the sample group varied dramatically, the youngest being 17, the oldest 80. These figures need to be read with caution as they may reflect the knowledge base and contacts of the interviewers. However, the differences between groups are very marked – with a real spread of ages across established populations, but a concentration of much younger people amongst the newer migrants. The census information is not able to give any direct comparison but anecdotal evidence from Bridgegate staff suggests that these differences are real and are an influential factor within those populations.

Age	WE	EE	A	B	ME	total
< 19	1	1	-	1	5	8
20 – 24	3	5	2	1	10	21
25 – 29	2	4	3	3	5	17
30 – 34	2	4	2	4	7	19

35 – 39	1	2	2	1	1	7
40 – 44	1	2	1	-	1	5
45 – 49	3	2	1	2	-	8
50 – 54	2	1	-	2	-	5
55 – 59	1	-	-	-	-	1
60 – 64	1	-	-	-	-	1
65 – 69	-	-	-	-	-	-
70 – 74	1	-	-	-	-	1
75 – 79	1	-	-	-	-	1
80 – 84	1	-	-	-	-	1
n/a	1	-	-	-	-	1
Total						96

It is clear from this breakdown that the majority of respondents fall into younger age brackets with 67% being under the age of 40.

6.1.5 Employment Status

Respondents were not asked about this aspect of their lives directly. In discussion with the interviewer group it was decided that to ask for too much personal information would be to give a suggestion that the anonymity of the interview process might be fatally compromised. However some individuals did give information as to their employment. Out of this seem to emerge some interesting trends.

The longest standing populations in our sample appeared to be embedded within the fabric of the working life of the city and appear to be active in all strands of Peterborough's employment life.

It would appear that the majority of the Eastern European respondents have travelled to this country in order to work and that while their employment may not be all they would wish, the vast majority have visas and are in full time employment, as one commented:

> *"I started like almost everybody from my community working in an agency and now I'm working direct as a factory worker"*

By contrast the working lives of the refugees from the Middle East appeared much more fragile. Our sample corroborates anecdotal evidence that this segment of Peterborough's population is heavily reliant upon benefit and that this situation is troubling, as the following comment illustrates:

"If we were allowed to work I would feel like a normal person"

	WE	EE	A	B	ME	Total
Employed	10	17	3	5	9	44
Self-employed	-		2	-		2
Unemployed	2	-	-	1	4	7
Training	-	1	1	1	2	5
Unpaid work	-	1	-	1	1	3

6.1.6 Housing

As with employment not all respondents indicated their housing status. Where they did there seems to be some further indication of a divide between a long standing population with a wide and integrated community network and a newer population in much less permanent accommodation.

	WE	EE	A	B	ME	Total
Own home						
Council					2	2
Shared/rent House		10			1	11
Live with family	6	4	5	1		16
Homeless					1	1

6.1.7 Findings within the different BME communities

Western European

It was reported to the research group by Bridgegate staff that within Peterborough the minority Western European community falls into two distinct groups. There is a long established Italian community, many members of that community living in Britain for upwards of 40 years. More recent migrants from the poorer parts of Portugal who have travelled to this country in order to work have joined these. Both these communities are represented among these interviewees.

Among the interviewees 10% had lived in England for 45 years or more, with a further 29% having been born in England. The remainder had migrated to England much more recently, with 29% having arrived within the last 5 years, and none having removed to this country more than 7 years ago. The age banding of this group was also much wider. Responses therefore reflect the knowledge and values across a wide spectrum of the population.

When asked about the preoccupations of their community this group described a wide variety of the concerns of all citizens – health, housing, work and money. This group also mentioned integration (14%) and generational factors as issues (10%). However in response to this open question, a comparatively large number of interviewees, some 38% mentioned drugs as an important issue, and when asked specifically about the prevalence of drugs in this community the figure rose to 76%, as the following comments highlight:

> "I work with many Portuguese and I know that some of them, mostly young people take drugs and alcohol"

> "There are too many Portuguese that are drug and alcohol users"

Mention was made of all the drugs of misuse, with 43% noting cannabis, 29% heroin, 29% cocaine. This compares with only 10% who mentioned crack as a drug known in this community. Ecstasy (14%) amphetamines (10%) and LSD (5%) were also mentioned. As with other newly arrived migrants in this research sample there was some sense that for newly arrived individuals, drugs of choice are influenced by the prevalence of certain drugs within the country of origin:

> *"In Italy I am aware that Cocaine is used and heroin…Last time I was in Italy there was a big cocaine war going on. Easy to ship in through Sicily to Naples"*

The majority (71%) stated that they felt young people to be most at risk of drug misuse. Respondents also said that problem drug misusers faced a variety of difficulties, with health and mental health

problems being at the forefront of people's concerns (38%). Crime was mentioned by 43% of respondents with 19% of these referring specifically to fighting as an issue. 81% commented that they felt that drug misuse would lead individuals into trouble with the law. Whilst 43% of respondents indicated that such involvement would lead to the imprisonment of a drug user. Despite this, several interviewees commented that the law in relation to drug misuse was too lenient:

> *"The law here is too soft. They should change the law"*

Answers to more specific questions revealed a relatively low level of information amongst this group with 62% saying that they did not know the mode of administration of these drugs. However there was considerable variation in respondents' knowledge about the availability of services. Some individuals (33%) held specific information:

> *"There is lots of agencies – FRANK…Bridgegate, and youth workers are all aware and trained to pass on young people to help"*

But other interviewees (38%) knew little or nothing:

> *"I don't know but if I had problems with drugs I don't know where to go. But if I had problems with alcohol or tobacco I know where to go. There's no information about drugs"*

24% of respondents mentioned this lack of information as a barrier to take up of services. In addition to this perceived paucity of information, 19% mentioned family problems and isolation from the wider community as springing from drug use. Comments about the breakdown of social fabric were very poignant:

> *"All sorts of problems, people stealing, cheating to get what they need. Homeless people living in misery, marginalised at the society eyes"*

> *"Breakdown of family relationships and broken marriages. Older generation haven't got a clue how to cope with it – they try to keep it behind closed door – bury it away and avoid accepting it is a problem"*

This situation may create a tension for this community in relation to drugs. 24% of respondents stated that problems were mostly dealt with within family and community units:

> *"Older ones maybe go to priest, but don't like going to organisations outside – prefer to keep it in home."*

As a barrier to service delivery this fear of isolation was mentioned by 33% of interviewees:

"The fear and the shame of the police and the shame of being marginalised"

In overcoming this 43% mentioned improved information and education as supporting good service delivery. 24% of interviewees suggested that outreach and education within the community might facilitate take up and lead to a more healthy and open dynamic within this community in relation to this issue:

"A lot more awareness/education about what drugs are about and what services offer. Raise awareness to reduce stigma. Encouraging communication between generations to learn together about drugs. Perhaps through the Roman Catholic church"

Eastern European

The group of 21 respondents from Eastern Europe was composed of 10 Lithuanians, 8 Poles, 2 individuals from Slovakia, and 1 from the Czech Republic. The relative security of status possessed by these interviewees – who can live and work legally in Britain, after a year gaining access to benefits – led to their being more willing to discuss their own situation. As a result the researchers gained more background information about this group.

The majority of these (71%) were women, with six male interviewees. While a small number of these individuals were plainly settled permanently in Britain - with two people stating that they had lived in Britain for upwards of 10 years – the vast majority were relative newcomers. 76% of interviewees had lived in Britain for two years or less, many of these stating that they had originally travelled to the UK to work and raise money, as one commented:

"I am aware there are many Czech people coming now to work and they don't integrate…Often students on gap year and only here to make money to take back"

This is borne out by the employment and housing status of these interviewees. 71% were working in unskilled situations despite a number of individuals with degrees and management experience from their home countries). None were unemployed.

In the time of their stay here a number had established roots and were now living with family, however the largest proportion (52%) were living in shared rented accommodation. It is possible that this lifestyle, level of disposable income and lack of family oversight influences drug use within this population. Indeed the respondents perceived younger people as more at risk of drug use (95%):

"Younger at risk from drugs more. Older people are more at risk from alcohol".

One respondent did comment that this might change as this community establishes itself within Peterborough:

> *"Children of these migrant communities…would be displaced culturally and need to fit in"*

The preoccupations of this group centred upon improving their situation, with better jobs (62%), more money (57%) and home ownership (19%) being of a priority. 14% said that one of the main issue for the community at present is having fun.

The majority of these respondents (52%) felt that drugs were an issue with a further 28% mentioning alcohol use as a factor in people's lives.

> *"People are taking drugs because they can afford it. The wages are better than in their own country"*

Overwhelmingly the drugs mentioned were not the drugs of greatest investment within the Home Office Drugs Strategy (Home Office 2002, 2004). Instead this group seemed to report extensive recreational use of dance drugs. Heroin was not mentioned by any respondents. While cocaine was mentioned by a small number (14%) this was as powder cocaine, not crack cocaine. However 81% described cannabis as a drug of choice; 38% mentioned ecstasy; and 33% noted amphetamines as in use by this community. 57% mentioned alcohol and 38% cigarettes.

As a corollary to this, injecting was not identified as a problem within this community, with drugs being smoked and swallowed as an alternative:

> *"People smoke drugs. I haven't seen them injecting or smelling drugs"*

This is in contrast to descriptions of drug misuse in the mother country, where respondents reported a wider variety of drugs used, still with an emphasis on cannabis, amphetamine and ecstasy use (76%, 52% and 33% respectively) but also including heroin (24%) and poppy milk (10%), as the following comments illustrate:

> *"In Lithuania people usually are using much more drugs than here. I think its heroin as well"*

> *"Drug users who doesn't have much money are using the cheapest drug made out of poppy milk"*

Levels of drug use by Eastern European migrants was not identified as problematic with respondents indicating instead that this community experiences difficulties in relation to alcohol use:

"I think here in GB its alcohol. Because people are rich and some of them never had any money in Lithuania. It makes them crazy. They don't know what to do. How to have fun"

However when asked specifically about drugs leading individuals into conflict with the law, respondents suggested a type of acquisitive crime which is associated with substance misuse as opposed to violence and street crime traditionally ascribed to drunken behaviour:

"People commit crime to fund their habit and violent/gang crime competitive dealers"

"Using drugs always cause problems, also problems with the law. I've heard about people who steal money (even from their families) to get drugs"

Levels of knowledge within this community appeared to be quite good. 81% said they would advise individuals with problems to seek help and the vast majority of these used the description "drugs service":

"I would try to take to drug service for therapy. If necessary I would use force to take him there. Because I think drug users don't realise how big problem they have"

However there was some feeling that individuals would not seek help (38%), or that help is best given by friends and family (38%):

"Very small number of drug users turn for help to a drug services"

"Usually they asked for help people whom they trust: family, friends"

"I think they would have some concerns about confidentiality and attitude and if their employers might find out"

There was some indication that language barrier mitigated against finding information and seeking help (48%):

"I think there are a lot more options here but may not always be aware of what those options are. Partly due to language barriers: many Czech migrants have little English"

When explicitly asked respondents declared a low level of knowledge about services (71% stated they knew nothing). However in discussion a higher level of understanding emerged and this knowledge extended to some extent to the sentencing and rehabilitative processes outlined by the current drug strategy. While some 52% suggested that problematic drug misuse would lead to an individual's incarceration or other punishment, 43% stated that involvement in the criminal law would lead to help and support, with one individual suggesting that this might occur via a community penalty:

"They are being forced to go to rehabilitate in the hospital."

"It's fantastic. There is a lot available. The fact that in the UK they look at holistic approach rather than punitive"

Perhaps unsurprisingly there was some confusion as to the legal status of cannabis:

"I know that you can smoke grass it's not a crime. And you can have some grams of this drug in your pocket. It's not illegal"

Exploring the barriers to take up of services, there was some mention of shame and fear (43%), but the majority of respondents highlighted a lack of appropriate information (43%) and a sense of the cultural barrier which language presents (52%):

"Because they don't speak English. I don't think they would ever say they need help. If somebody will come I think it will be friends of relatives to ask what they do with a friend or relative drug user"

Perhaps with this in mind the advice of respondents in increasing penetration rates centred on information giving with 71% mentioning better publicity and a further 19% highlighting the importance of television and newspaper in this regard. 29% suggested that this might be underpinned by outreach work – through schools, with families and community meetings. Two respondents suggested that the employment of native speakers would enhance services:

"Information, loads of information. This is the only way to enable people to go to drug services for help"

"Encourage people to talk about drugs and health, alcohol and health"

Asian

The Asian community in Peterborough is well established and the majority (73%) of respondents were British Asians. The remainder had lived in Britain for approaching 30 years. The employment and housing of respondent's status reflected this. All respondents who made a declaration were established with family, all were in employment with 27% stating that they ran their own business.

For this group of respondents many of the community's preoccupations seemed to centre upon the emotional and spiritual tensions attendant upon assimilation over a number of generations. Interviewees highlighted a loss of culture and threats to faith as being of crucial importance (64%).

Gender and generational issues were the focus of attention of 45% of respondents. 55% described prejudice and an experience of racism as a preoccupation:

> *"A dissipation of culture and loss of cultural values is a real threat for most people in our community"*

From the outset a discussion of drugs highlighted these pressures. One respondent made an oblique reference to the devastating effect, which drugs can have on faith:

> *"They were selling drugs in the car park of the Mosque – heroin – cannabis. But I heard this – not sure if it's true"*

All interviewees confirmed that drugs are an issue within the community with extensive use of cannabis (mentioned by 91% of respondents), heroin (73%) and crack/cocaine (64%):

> *"Absolutely loads of drugs in the community. Dealing vast amounts of cocaine particularly 17-24 years old. About 20-30 dealers within this area"*

Despite this awareness drug misuse remains an unspeakable subject:

> *"They 'brush it under the carpet'. The community I come from thinks if you don't talk about it then it doesn't happen. No openness and aware of what's happening outside."*

As with other communities interviewed, these interviewees suggested that young people are more vulnerable to substance misuse (91%). There was some concern among respondents that this is an incremental process and that while in the past girls and young women were protected by cultural norms, this is no longer the case:

> *"I always thought girls were more protected. But I have seen women and girls using so both are at risk. I have heard about and seen girls parked up and using drugs meeting dealers/boyfriends. Girls are repressed so they get some freedom and then meet boys and use drugs. It's an escape and it's a way to rebel."*

> *"There was a trend years back that boys smoked weed but now they've moved on to heroin and girls have picked up the trend and taking weed. Also the fact that weed is smoked openly and is like the latest fashion for school kids"*

Of the drugs used within this community Heroin was identified as the most problematic (45%):

> *"All these things make people lose control and are being used to mask and avoid real issues that young people are faced with – cultural and family religions – difference in generations."*

But there was an acknowledged issue with excessive cannabis use:

> *"I think heroin makes more of an impact. But I think cannabis is so widely used (I would say 50-60% of young males up to 19 years are using it daily)"*

Interviewees reported a wide variety of modes of administration of drugs, with both smoking (18%) and injection of heroin (18%) reported.

In response to general life issues, respondents stated overwhelmingly that they would approach family for help and advice (73%) with a further 36% saying they would seek the assistance of an Iman. This changed markedly in relation to the problems that drug misuse causes. In this case 55% said they would do nothing. A further 27% said that the response would be to send a drug misuser to Pakistan for help:

> *"If parents did find out they would probably ship them back to Pakistan"*

> *"But with money out in Pakistan they can get anything so drugs are more accessible"*

In this case only 27% said that it would be to family that they would turn, with a further 18% saying that they would consider this option, but would gauge levels of trust before doing so. Furthermore interviewees reported an understanding that any criminal involvement resulting from drug misuse would be frowned upon within the community. 45% suggested that individuals would be shamed as a result:

> *"If they go to prison the community would look down on their family. So it would affect the whole family and how the community viewed them"*

No respondents suggested that such involvement might have the positive impact of galvanising an individual to engage in treatment, though interviewees did report knowledge – albeit an arms-length knowledge – of services. There was a sense that such services are not culturally competent:

> *"I don't think there is much help available for people, especially people from my community. Their needs are not met and their problems are not taken seriously"*

> *"If a Pakistani girl was on drugs she could not go and ask for help because there is nothing available for women only"*

Despite this perception of a punitive community response, few of these respondents themselves expressed a negative attitude to drug misusers, with 91% of interviewees suggesting that they themselves would support an individual to obtain professional help:

"I would find out about counselling and advise them to go to an organisation that deals with this matter"

"Ask them how and why they started doing it. Could be a lot of reasons – perhaps other problems in their life caused it."

A respondent commented:

"If you have a drug problem and admit it there is help for you here. But people from our community might not realise that because of the way it is at home in their country of origin. They might be worried that there is no confidentiality and that if they go for help the information they give would be shared. Which would bring shame. There is no such thing as confidentiality in our country of origin or culture"

This sense encapsulates the responses from interviewees as to why members of this community do not approach services. Unlike the newer community from Eastern Europe, language and education were not perceived as an issue. Instead the notion of shame was mentioned by 64% of individuals, with a further 36% mentioning fear as inhibiting drug users. This was accompanied by 64% who mentioned fear of exposure and a lack of confidentiality as barriers to take up. Sangster et al (2002) point out the possibility of developing a workforce, which reflects the community, it serves as being a route towards cultural competence. In this case it would seem that this will not serve the purpose:

"They don't want people from their community to find out what they are doing. Also if someone from their community was working there this could be seen as a threat because they might feel they will tell someone"

"I don't think it would help to have Pakistani people working in the drugs treatment agencies because it would make drug users more scared to approach them for help…these workers might tell other members of the community"

In overcoming this issue respondents suggested that workers should be briefed about issues of culture, and offer services within an appropriate framework (perhaps women only, for example), but that there should not be an attempt to link Asian participants with Asian staff:

"It would be no help to have people working in the treatment agency who are from this community. But it would help if workers had an understanding of language and culture and religious and family pressure"

"I think it would be easier if the workers weren't Asian or at least not connected to that user's community. I think it is better to talk to any English person 'cos they won't be so 'Asian' in mentality. I think it should be situated somewhere discreet so people are not seen accessing. It is important to have a knowledge of our culture/religion but I really do no think they should be Asian."

Publicity and education were also perceived as important (64%) – offered almost as a bi-product to the take up of other services (GP's, pub, clubs, mosques and community centres all being mentioned by respondents) offering an opportunity for broadening attitudes within the community in a routine way. Offering outreach in this 'one stop' way might also allay service users' qualms about any visit to a drugs service not being 'discreet':

"People need to be told over and over again about confidentiality…I think also more awareness should be done in the community that these services are available to help so use them!"

Black African/ Black Caribbean

Information from Bridgegate staff suggested that the majority of migrants from the continent of Africa have travelled to this country as refugees and are a relatively new population. This is supported by this sample. While one individual had lived in Britain for twenty years, of the remainder 69% had lived in Britain for 5 years or less.

By contrast the representative of the Caribbean community – and only one such individual was interviewed within this research, had been resident in Britain for 40 years.

The continent of Africa is enormous and the experiences of individuals from within its borders are potentially very different. However some commonalities exist. 69% of interviewees in this group mentioned housing and 38% work as being important issues for their community. These respondents had in common with the refugees from the Middle East the fact that their residence within the UK was often uncertain and fragile. These interviewees made reference to that as a major preoccupation amongst members of their community (23%) with a further 31% mentioning issues of isolation as important.

Interviewees within this group distanced themselves from drug use. Heroin was not mentioned as a drug of misuse by any respondent. Cocaine was mentioned by 23% and crack by 8%. In contrast, Cannabis was mentioned by 31%, alcohol by 62% and cigarettes by 69%. In addition the comments of these interviewees seem to serve to distance them from others who might present problems to the host community and by implication for their immigration status:

"Back home the highest drug is cannabis. We don't have addiction problem. Even here there is no drug addict in my community"

"I have Nigerian friends who do use drugs" (speaker is Eritrean)

"Not women. Women who smoke are those born here"

Comments upon drug use in the home country revealed more extensive substance misuse amongst the African population with comments on alcohol misuse dropping to 15% and mention of heroin use rising to the same figure. Cocaine use was noted by 31% of respondents and cannabis by 38%.

In contrast the interviewee from the Caribbean made mention of cannabis and cocaine use in this community:

"Cannabis taken as a tea very popular as a herb in food. Obviously smoked. I think cocaine is sniffed."

This respondent commented upon the cultural and social reinforcements, which support drug use within the Caribbean community:

"A lot of men it's a habit from younger days – and younger boys sit and smoke with dads. But also women do it as a part of social engagement with their partners"

Such meshing of drugs into the social fabric of life was evident in this respondent's discussion of her home country:

"Yes, we grow marijuana in Jamaica. We grow it on windowsills as plants. Even grandmother would do that and boil it for headaches and stomach upsets"

Despite a relative denial of drug misuse, there was some recognition that drugs do cause problems within this community. There was also some recognition that drug use is exacerbated by the problems individuals face in their social situation:

"Men [are at risk] because of depression, anxiety, unemployment"

The health and mental health problems attendant upon drug misuse was noted by 46% of respondents. 15% of interviewees described family problems as stemming from drug misuse and 23% mentioned money problems. The fact that these issues are frequently linked was also noted:

"Scruffy, tires, not walking properly. They can start thieving to pay for their habit"

The Caribbean respondent echoed these issues:

"Cannabis causes lack of focus and motivation. Quick fixing to cope with problems instead of facing them"

Knowledge of the existence of voluntary drugs services – as distinct from DIP programmes – was relatively high within this group:

"I know where to find help – on websites, telephone directory…it's whether people want it and that's about motivation".

This was the case even where individuals had no concrete information about drugs services in their area:

"It's fantastic, there are places where drug users get help by giving them clean needles. If you are adult they can counsel you. They listen to their need"

62% stated that they perceived drugs as leading to crime and a further 46% specifically mentioned fighting as a problem. 84% of respondents suggested that such involvement with the law would lead to an individual being sent to prison. Only 7% had any knowledge that the legal system could lead to treatment.

85% of individuals acknowledged that these attitudes are informed by their knowledge of the treatment of drug misusers in their home country. Here the descriptions of abuse were universal, with prison, flogging and death mentioned by all interviewees:

"They would be arrested charged imprisoned. They wouldn't be given treatment they would just be put in prison"

"They torture people, nails removed. Swear to god I seen it. They will never do it again. If they young people they in a room with knee high water, they can't sleep at all. Just stay in there all day. Hardly get fed"

"They kill you!"

In common with the other recent refugee populations this group mentioned looking for support to specialist refugee organisations rather than mainstream health or social networks. 54% mentioned New Link and Red Cross as sources of support as opposed to 15% saying they would look to the GP and 15% to family for help. In all however 71% said that they felt individuals did need help in combating drugs problems.

Despite some recognition of the problems and an understanding of the agencies available it was felt that there were barriers to take up of services. 62% mentioned a lack of appropriate information. 62% described fear and shame as inhibiting individuals and a further 23% described drug treatment ads having an impact on immigration status:

> *"They may be frightened that they will be found out by the law and sent back…they may not want to admit they have a drug problem because of shame/stigma. May not think people would understand"*

In overcoming these problems, information was seen as crucial (54%) as was providing education (38%). In addition this group of interviewees placed a premium on outreach work (mentioned by 46% of respondents).

As with other groups reassurance as to the confidentiality of information was mentioned as important. Comments on this, and on harnessing the minutiae of individuals' cultural experience were encapsulated by the British/Caribbean respondent:

> *"Having another African/Caribbean worker in services would provoke fear around exposure, confidentiality. So I think outreach into communities to raise awareness – using alternative methods. Music is important to my community and so I think awareness could be incorporated in rap or other music"*

Middle Eastern

There were 29 respondents within this group. Of these 93% were male and 7% female. 14 of the interviewees identified themselves as Iraqi and of these 12 were Kurdish. 7 were Iranian and 6 from Afghanistan. The 2 remaining respondents were Palestinian.

Not all respondents declared their length of stay. Two members of the sample had lived in Britain one year or less, but the majority – 74% of those who made a declaration on this topic stated that they had lived in Britain over four years. None had been resident for more than six years.

These figures bear out information reported from Bridgegate that this section of Peterborough's community is composed in the main of refugees many of whom fled Iraq following the first Gulf War. This population is largely composed of men at present, that constituency only changing as individuals receive leave to remain and are joined by family. At present many of Peterborough's Iraqi Kurds have only temporary leave to remain, on humanitarian grounds.

More than any other group, the responses of these individuals were dominated by a feeling of unease and a sense that saying or doing the wrong thing would dislodge them from an already precarious position. When asked, 45% of respondents mentioned achieving some guarantee of status as the crucial issue for their community at present:

> *"UK will be sending lots of Kurdish home. 15 last week! This will cause big unrest for my people"*

Perhaps as a consequence, there was considerable denial that drugs use and drug problems exist at all within these communities; that substance misuse is a problem only for the host community. One respondent described themselves as a drug addict, but others stated categorically that drug use was not an issue:

> *"Afghani people don't use drugs…Use tea and cigarette. Too much tea"*

> *"Kurdish don't like this, we only have problem living here"*

However the emotional complexity of these answers was approached by one respondent who stated:

> *"I do not hear or see it in the Kurdish community…I see English people deal behind my house"*

But later in the same interview confided that:

> *"I have tried heroin…I have used cocaine"*

This group identified a much wider range of substances as being used problematically by this community than other respondents. Chief among these were cigarettes, which were mentioned by 51% of respondents. A further two individuals commented upon the use of Naswar, a tobacco based drug taken by mouth. Alcohol was mentioned by 48% of individuals:

> *"Consumption of alcohol is high among my community due to lack of alcohol in our mother land (Iran). They want to consume alcohol as a new experience"*

Cannabis was mentioned by 31% of interviewees and heroin by 21%. It is of interest that in describing heroin use several respondents were specific in saying that opium rather than heroin is the drug of choice and that the mode of administration is via a form of 'hot knives':

> *"I use opium as I used to consume in Iran. I use pot and heating a wire or a metal to make a fume out of opium."*

Several respondents made connections between the drugs of choice in Britain and those, which are available in the mother country:

> *"It's mainly opium as my country is quite close to Afghanistan, the main importer of opium"*

> *"Naswar is the most common, used by women and children as well"*

It was heroin and opium, which interviewees felt caused most problems within their communities, with a total of 31% identifying these as problematic.

Other drugs – ecstasy, amphetamines – were not so well known, while crack and cocaine were not mentioned at all. By contrast tea was mentioned by 10% of interviewees.

While the majority of respondents did consider that drug use did lead to problems with the law (76%) there was great variety in the types of offences identified, with fighting and vandalism being associated with drug use by these communities. Once again the repercussions of these actions were refracted through the prism of an uncertain, refugee status:

> *"They are arrested by police and they are held in prison. It may result in bad reputation within the police force and consequently for getting the 'British Nationality'"*

Perhaps unsurprisingly given the composition of the community as a whole, respondents to our interview perceived men, and young men particularly as being at risk of drug problems. Many identified the rootless and slightly disengaged nature of their communities as fostering that risk:

> *"Young men that have come over here are mostly single and more prone to become drug user"*

> *"There are not so many women from my community here; I think men, specially younger one and particularly ones with immigration problems"*

Respondents identified a range of support networks, which could help with general problems. Some individuals describing mainstream health and statutory organisations (council, job centre, library) others identifying organisations particularly centred on the needs of refugees (New Link, Red Cross, Refugee Council). However the issue of trust in the system was identified as a barrier:

> *"They don't trust or understand the system"*

> *"There isn't any help. You will become isolated and nobody wants you. It's the end of the world"*

Perhaps for this reason many interviewees said that for those with drug problems the answer was simply to stop (66%):

"Quit it by a strong determination"

Though some interviewees did indicate the difficulty involved and the fact that outside help is required (52%), only one respondent stated that they considered drug use to be indicative of other underlying problems.

These answers, and also answers to questions about the way drug users are treated once within the system may suggest a low level of information within this community. 59% of respondents said they had no knowledge of the help available locally to drug users:

"This is the first I have heard about help in Peterborough. Before this, nothing"

55% stated that if individuals became involved with the law, they would go to prison, as one commented:

"Going to jail forever. I think only jail"

Indeed 41% stated that this lack of information was the factor, which inhibited individuals in pursuing help. However, responses may also indicate an elision of ideas about responses to drug misuse in Britain and in the country of origin:

"In the time of the Taliban they could cut off your hand if they caught a criminal."

72% of the 29 respondents described their views as being shaped by their experiences of justice and by their knowledge of drug misuse at home:

"They are treated as non-trusted people…such cheap people. There is discrimination against them in my community"

"I have been imprisoned and tortured in Iran so I would cry if I went near a police station. It would terrify me. Law here is better. I am not scared to see police in the street if they do not speak to me"

Shame, fear and embarrassment were mentioned by 93% of respondents as an inhibiting factor:

"This causes shame for Afghani people. If family know, this is bad. They want to keep it secret"

In overcoming these inhibitions respondents felt that it was important to be explicit to the point of being repetitious about the confidentiality of services and that there are no connections between

drugs services and central government. 28% of interviewees suggested informal approaches, with a further 10% suggesting that this type of information might be offered alongside services, which individuals might 'legitimately' take up. As one respondent commented:

> *"Just to give me assurance that you have no link with the government or police. If anybody comes don't ask for name or ID. Try to make a meeting to educate people so offer food and small talk"*

6.2 CONCLUSIONS AND DISCUSSIONS FROM THE QUESTIONNAIRES

6.2.1 Factors Increasing Risk of Drug Misuse

As can be seen from the findings above the groups within this sample are very disparate with markedly varying cultures and life experience. Indeed, the life histories show that even within groups the individual experience is unique.

Launching 'Tough Choices' the next step in the Government's Drugs Strategy, Charles Clarke highlighted the importance of responding to this individuality (Clarke 2005) and at the point of presentation to services this is the challenge, which drugs workers must meet. However there are trends from the foregoing material, which can be incorporated into service provision in order to encourage earlier presentation at services and enhance both engagement and retention.

6.2.2 Family and Social Networks

In a recent report for the Greater London Authority, Patel et al (2004) delineate the factors, which might precipitate drug misuse among refugees and asylum seekers in the Greater London Area. The characteristics of some of the refugee and asylum seeking communities within Peterborough bear comparison with the findings contained within that report. As has been noted, the migrants who have fled to this country to escape abuse at home - and particularly among those from the Middle East – are disproportionately young men. In all the groups approached in this study individuals identified young men as principally at risk of developing drug problems. Disconnected from the reference points provided by family and social networks, these young men might be especially vulnerable:

> *"A close and supportive family can function as a protective factor against problematic drug use amongst young people. Young refugees and asylum seekers without families in the UK are therefore particularly vulnerable to a number of risks closely associated with problematic drug use." (Patel et al 2004 p xvi)*

Sangster (2002) comments further on this. Here attention is drawn to the fact that drugs of choice are influenced by the prevalence of substances in the originating culture – and this was reflected in the responses of the majority of respondents interviewed for this report.

6.2.3 Poverty

As has been seen in the literature review many of the prima facie indicators of poor health & social exclusion, including drug misuse, are connected to social deprivation and these factors bite hardest on BME communities. Such susceptibility might be compounded by known risk factors of drug abuse

among young people: poverty, social exclusion and drug misusing peers (SEU, 1998, Jones, 1996, NTA 2003, Patel 2004). Moreover Sangster (2002) draws attention to the use of drugs by asylum seekers as a mechanism for self-medicating against the horrors of past experience (see also NTA 2003).

Local policies for the management of individuals and groups of asylum seekers dispersed to Peterborough under government policy were not available to the research team. The fact that that these groups have moved to Peterborough relatively recently means that they did not appear with any accuracy on the census declarations. It is not known whether the wards of the city in which refugees have been housed are ones where poverty and social exclusion pose problems. These are areas, which the DAT may do well to investigate and form alliances or establish policy which might prevent or minimise the potential harms to this group.

6.2.4 Unemployment

As has been pointed out above the links between unemployment and drug misuse are well documented (Haw, 1985; Peck and Plant, 1986). Amongst the interviewees approached for this report, a number were unable to work due to their unresolved asylum status and others – particularly those among the group of Eastern European migrants – were employed in unfulfilling roles which in some cases did not realise their potential, as one commented:

> *"Originally I've come to work as an engineer, but I have not been able to find any relevant job with my special skills in the industrial field…I have been working in a warehouse as an assembler for nearly four years"*

Taking steps to support the integration of migrant groups into the working life of Peterborough might prove a strong protective factor against drug use.

6.2.5 Barriers to the take-up of Services

Despite these apparent risk factors, this report has identified a number of barriers to individuals approaching services.

6.2.6 Confidentiality and shame

The single most significant barrier to service provision amongst this sample would appear to be fear of a lack of confidentiality. While this manifested itself in different ways among different groups of interviewees it proved to be a consistent theme for the majority of respondents. A large number of commentators have written on this issue (Abdulrahim et al 1994, Mistry (1996) among many others).

In the case of the interviewees from Eastern Europe the need was for reassurance that information would not leak out to be discovered by employers. For many in the group of Middle Eastern respondents the priority was that engaging with services should not jeopardise their immigration status. Across groups the notion on the shame associated with drug misuse was mentioned coupled in some cases with a sense that professionals have no real investment in maintaining privacy. Khan & Ditton (1999) report similar findings – the fear (sometimes substantiated) that visits to a GP become an item of gossip, which brings humiliation upon the whole family. Bashford et al (2000) showed findings from Shropshire, which indicated that distrust of services by the Black Caribbean community could be traced to fears about the misuse of the Mental Health Act in relation to drug misusers.

Among the interviewees in this study, a distrust of service providers was mentioned, but also relevant was the fact that each minority community within Peterborough is small, and the prospect of ostracism, there is no sense that other social networks could ever be forged (Patel 2004).
Respondents felt that publicising an anonymous helpline number might allow people to seek support and form long-arm relationships as a precursor to seeking treatment.

Confidentiality issues have a particular significance within the assessment process for the Drugs Intervention Programme. Where one assessment is undertaken at the start of a process of intervention, then passed between professionals the individual concerned loses control over the information. For members of minority groups to have faith in this process, clear, explicit safeguards for the security of information must be in place.

6.2.7 Generational and Family Issues

Just as isolation from family networks was identified as a potential risk factor for some of the communities interviewed, the more established groups within Peterborough identified the gap in understanding between generations as being an inhibiting factor in approaching services.

Information from these interviewees did not bear out findings from other studies (for example Bashford et al (2001)) that increasing numbers of young Muslims are abandoning the norms of family and mosque in order to embrace a street based youth culture. However there was a sense that values are in the process of being reconfigured within a new context and that this creates tensions for community members across generations. Both the Asian community and the Italian community identified family as a real source of advice and support in times of trouble.

However when the 'trouble' in question was that of drug misuse, that avenue was closed by the lack of knowledge and the attitudes of older generations. Perera (1998) identifies the ease with which young drug misusers from these communities can exploit this ignorance and denial to disguise their use. To some extent this is borne out by the respondents to these interviews:

> *"Drug problems seem to be kept quiet in my community"*
>
> *"They wouldn't access help unless it got really bad; if their parents or someone older in the family decided to forget taboos and decided to put [the] issue in the open"*

6.2.8 Needs based vs. Strategically Targeted Services

Reviewing the literature on drug service provision in 2003 the NTA concluded that limited resources, lack of knowledge about patterns of drug use and low numbers of BME groups were obstacles to the provision of vibrant and responsive services for minority communities.

This report suggests a further barrier: that the understanding of drugs and drug misuse within minority communities in Peterborough is not congruent with the demands of the Drugs Strategy. During the course of the 20th century drugs policy has swung back and forth between an understanding of substance misuse as an issue most affecting health service provision and the concern of the criminal justice system (Yates 2000). The current trends lead to a creation of policy focused around those drugs, which lead to the highest levels of harm resulting from crime.

Treatment services orientated around this priority command greater investment than ever before with a consequent reduction in waiting times and an improvement in the overall quality of treatment. However as can be seen from the responses above the cultural and religious demands upon minority communities suggest an interpretation of 'drugs' which goes far beyond the confines of current policy – embracing tobacco, alcohol and tea. Moreover, while the literature concerning the involvement of refugees in crime is limited, what does exist suggests that contact with Youth Justice/Offending Teams in parts of England is "surprisingly low". (Stanley K 2001 in Patel (2004).

A similar example – which chimes more strongly with the existing literature – was the smoking of heroin within the Asian community. Siddique (1992) suggests that this preference is influenced by traditional modes of administration in Pakistan. Sangster (2002) points out the fact that in services orientated around injecting users, smoking is often advocated as a harm reduction measure. Operating this principle with communities where smoking is widespread is inappropriate.

Equally the drugs mentioned as being in use by members of groups from Eastern Europe are not core to the delivery of the drugs strategy. The individuals in this group of respondents appeared to be

employing dance drugs, largely recreationally. Their aim in travelling to England is not long term integration. Some engagement of this community might be seen as advisable however as in the longer term a community using drugs in this way might prove to be more vulnerable to the influx of 'crystal meth' into the UK.

Models of Care (NTA 2002) does make some suggestion that commissioning should be needs led. Services, which hope to engage sympathetically with these communities, should strive to acknowledge these differences within the compass of service provision and consider developing services, which operate – at least in part – in accordance with priorities set by the target populations.

6.2.9 Developing Services within Peterborough

6.2.10 Awareness and Information

As mentioned above Tyrer's study shows low levels of drugs information being held by BME communities. Improving information was mentioned by all groups of respondents in this study. The emphasis here though was that such information should be appropriate. In isolating what 'appropriate' means to them, respondents touched upon the provision of leaflets in the language of their mother tongue and suggested that these should be made available within mainstream services, where anyone interested could pick them up unobserved.

However one cannot assume that the translation of a leaflet into a myriad other languages will facilitate the dissemination of information. Sangster et al (2002) points out that migrant populations are under pressure of drug use from the drugs prevalent in the home community and from those within the host community. Any information must reflect the context of use within individual communities. Indeed as these respondents point out, there is scope for publicity beyond paper-based media, with the use of TV and radio (NTA 2003) offering a potentially wider audience – and it should be borne in mind that the penetration of leaflets is dependent upon literacy levels in the mother tongue. (Arora and Khatun 1998 in NTA 2003).

Web–based media were also cited as potential sources of information by respondents. Some sites – most notably www.talktofrank.com – were already known. Investigations by the research team suggested that these resources do not offer services in a way, which might maximise access for minority groups. A large number of drugs, which were described by interviewees as influencing their community –opium, poppy milk, Naswar –, receive scant attention here. Furthermore while the site is clear that information can be provided in a huge range of languages, the language of the site itself is English. In the context of communities where confidentiality is of such a premium the Internet offers

an untapped opportunity for providing information to hard-to-reach groups in a way which is private, accurate and responsive:

> *"Having an online forum on a website where people could make contact for help without being seen or exposed. So you could work with that person without any recognition and move it forward until they felt OK and safe to come in"*

6.2.11 Outreach within Families

Younger members of the Asian community within Peterborough appeared relatively knowledgeable about drugs issues. Several commented that they would welcome this information being disseminated within the community in order to improve information and discussion across generations. Undertaking this education themselves was not within the capacity of these respondents and a number hinted at the fact that any education needs to be pursued very gently: within existing discussion groups that will not alienate community members, and possibly employing the social aspects of sharing food as an emollient:

> *"I think a lot of information needs to be advertised re: drugs & also information for parents so they could access help and look out for the signs because I think it tends to be the families that cause problems when they find a member is using drugs. They need to be educated that this is a culture in certain age groups and help is available"*

Sangster (2002) suggests that this desire is shared by parents of Asian drug misusers, who seek to accompany young people to appointments, both to offer support and to gather information. Within this group of interviewees there was no information provided as to whether services provided at a family or an individual level might prove most fruitful. Further, more targeted work would be required before and conclusion could be reached.

Perera (1998) suggests that any education should include information about the dangers attendant upon returning drug misusers to Pakistan. This was a response mentioned by several of the interviewees within this sample, and clearly remains an issue within Peterborough.

NTA (2003) reports that many of these issues are addressed within a series of videos aimed at South Asian parents, when evaluated by the Home Office the medium of video was shown to be well received provided the setting is right and the workers delivering any education are well trained (DPI 1998).

6.2.12 Outreach within Faith Groups

While a handful did describe themselves as multi-faith or 'lapsed' Catholic the vast majority of respondents orientated themselves within a faith group. In reaching minority communities, dialogue with faith leaders would seem to be crucial. So many commentators stress the importance of cultural appropriateness in designing literature and services for minority groups (Sangster et al 2002) that to fail to collaborate with religious leaders is to risk interventions acting in conflict with religious beliefs (Chaudry et al (1997)). NTA (2003) points out both the pitfalls and the benefits of such engagement and these are echoed within this group of respondents – that the confidence and guidance of religious leaders and communities is a source of strength but also that this information, once shared can move into the public domain.

6.2.13 Forging Links with Community Groups

In addition to faith communities, interviewees did have contact with a wide variety of community groups. These varied between communities – newer groups being much more focused around New Link, Red Cross and other services specifically for refugees while the established communities were linked to mainstream services – schools, job centres etc. Frontline health services were mentioned by minority groups of all types. A number of respondents suggested that links could be forged with such groups – partly to enhance information and offer services as part of an holistic package and also in order that drug treatment can be accessed discreetly.

6.2.14 Workforce Planning

The issues attendant upon workforce planning are complex and multi-faceted. A large number of commentators suggest that staffing should reflect target communities (Khan & Ditton (1999), NTA (2003) Sangster (2002) among others). In this research contributors were clear that there is a real need for services to be able to understand and act upon the concerns and cultural orientation of service users. A need for service providers to offer treatment services in a range of languages was also highlighted. However strong caveats were placed upon the employment of staff from within minority communities to work with those community members – it was felt that gains in terms of cultural competence were at the expense of a loss of trust (see also Bently and Hanton 1997). It was the suggestion here that white staff who have an intimate acquaintance with the needs and the language of minority groups be employed.

Nevertheless the need for representative and diverse workforce is pressing and there is scope to employ staff from the widest range of community groups, across the full spectrum of service hierarchy (Sangster 2002) and to offer cross-cultural training (Abdulrahim et al 1994). In this way service users

are reassured about confidentiality; crude ‘matching’ worker and service user are avoided and the diversity of services themselves is continually enriched.

6.3 CONCLUSIONS AND DISCUSSIONS FROM THE LIFE STORIES

The life story data is drawn from a sample population with fundamentally different characteristics from that of the questionnaires. The information here is drawn from six in-depth interviews. Four of the interviewees were men and two women. The age range is from 22 to 41. In terms of ethnicity/race one woman was Italian/Pakistani the other woman was Irish/English from the travelling community. One of the men was born in England of Miri Puri parents; one was Portuguese, another born in England as the son of Jamaican parents but raised in America and the other having a Scottish mother with Irish Catholic heritage and a Caribbean father.

The life story volunteers were already attending Bridgegate for help with their drug use. The drugs of choice involved were alcohol, solvents, speed, cannabis, heroin and crack. Heroin was the one drug common to all interviewees except the one raised in America and his drug of choice was crack. In contrast, the questionnaire data derives from a population not directly connected to Bridgegate.

Only one respondent to the questionnaire stated that they considered drug used to be indicative of other underlying problems. Not surprisingly, this view is in direct contrast to the life story data (drawn from people from a variety of cultural backgrounds) where although drug addiction was seen as a highly significant problem in its own right it was nevertheless linked to other problems for the individuals concerned.

Drugs were linked to a variety of problems including low self esteem; problematic relationships; childhood emotional, physical and sexual abuse at home and in the care system; acquisitive crime; prostitution; domestic violence; confusion over mixed race identity; rejection from family and community because of drug use. In addition, it was clear that drugs were being used as a form of self medication for some individuals in escaping from physical, psychological and emotional pain. One female interviewee summarises the situation in describing her first use of:

> *"It was warm, felt safe. You just blanked everything. I have never felt like that. It was mad, just mad……but when I use now it never takes me back to that place, where I first picked up".*

The impression from the questionnaires that local BME communities in Peterborough, had little knowledge of the help available locally to drug users was supported by the life story data where low levels of information about drugs was seen as problematic in many of the communities from individuals providing the life stories. This was compounded by high levels of denial and minimisation in relation to drug problems in the communities involved and a tendency for them to ostracise individuals for their drug use.

The notion that Asians do not use drugs, promoted by community leaders of the South Asian community has been noted by Perera (1998), and Patel (1999) who conclude that such denial has tended to act as a barrier to developing appropriate services. Similarly, the importance of stigma and shame regarding drug use in minority ethnic communities has been identified as a barrier to uptake of services. Abdulrahim et al (1994); Abdulrahim (1998); Gooden (1999).

Poly-drug use with an escalation of drug use linked to acquisitive crime was again not surprisingly, a common theme in the life story data. The involvement of heavy alcohol consumption, in conjunction with drugs was also described. In common with most people suffering from addiction, numerous unsuccessful attempts to come off the drug of choice were described and relapse was common. Many people expressed the view that the addict's own motivation is crucial to success in stopping taking drugs, but that support in terms of the confidential, one-to-one counselling at Bridgegate was seen as a key component in the process.

Counselling on a one-to-one basis was seen as the most helpful form of treatment by all those interviewed. They felt that this was the only way that drug users could explore themselves and fully understand their own issues, which would then provide appropriate and safe support and challenge to help them move forward and make changes. Interviewees wanted councillors, who understood the cultural, religious and family issues for BME communities. Frustration was expressed by several people about the fact that they had not been able to access appropriate help when they felt motivated to change and the need for reduced waiting times in accessing scripts and detoxes were common themes.

Drug services have been severely criticised for failing to meet the needs of black and minority ethnic communities Awiah et al (1990); Perera et al (1993) Chantler et al (1998); Dale-Perera and Farrant (1999); Nefertari and Ahmun (1999), with services deriving from a model designed to deal with white male heroin use in the 1980s Sangster (1997). Drug services have also been criticised for a form of institutional racism for functioning in isolation from their local community with a ' white ' image reflected in their employees, clients and general surroundings and décor in terms of a lack of welcoming positive cultural symbols for black and minority ethnic groups. Hence the importance of having black workers in drug services has been stressed in terms of cultural competence.

It is interesting to note that these generally accepted views contrast markedly with the comments in the Peterborough sample in which isolation from the community is valued in preserving anonymity and confidentiality and where language and an understanding of black culture is seen as a far more important than the colour or ethnicity of the worker. However, whilst the importance of cultural

competence, appropriateness, sensitivity, or specificity may be referred to it is not always clear what these terms mean in practice.

One key issue stressed by the life story interviewees was the importance of having drug workers in treatment agencies, who speak your language, but preferably not from your local community, for fear of breaches of confidentiality. This was particularly the case with the South Asian (Pakistani-Miri Puri) interviewee, who felt that having a worker from the local Miri Puri community would probably, put potential clients from the community off attending because of fear of exposure. He said that there was a feeling that there was no such thing as 'confidentiality' in their community, because it is so small and tightly knit together. It was also the case that the black African/Caribbean clients did not feel that service providers needed drug agency staff to be the same colour, but that they should have staff who had a clear understanding and knowledge of the cultural issues for black people. This finding is of particular interest because it is often assumed that delivering ethnically sensitive services involves matching workers to clients in terms of race and colour.

The Portuguese service user, in particular felt that it was important to have someone working in the treatment service, who speaks Portuguese as many of the migrant workers here have limited English skills making understanding and accessing the full range of treatment services difficult.

The Traveller service user had mixed feelings about drug agency workers from the travelling community. On one hand, feeling such a worker would at least understand and empathise with the issues around culture and language, but on the other feeling that if the worker was known locally to their community there might be fear around exposure. Issues of trust and confidentially, have also been identified as particularly important in relation to black and minority ethnic communities Abdulrahim et al (1994), Abdulrahim (1998).

Interviewees wanted agencies to have firm boundaries and rules, which challenge manipulation and encourage service users to take responsibility for their own treatment and progress. Interviewees expressed the view that once a week contact with the treatment agency is not enough for some drug users to stay motivated and make changes. There needed to be daily contact at least for the initial stages.

The need to break with drug using friends and establish a new lifestyle with a network of non drug using friends was a key theme. The view was expressed that drug users who are contemplative and motivated to make changes, need a place where they can talk and socialise with other people who are “clean” or working to maintain a “clean” status. Most of those interviewed said that it is hard to make friends and develop new social circles outside familiar drug using groups. Open access and self run

groups such as a ' buddy ' system, where they can contact each other for support outside the working hours of treatment agencies was suggested. Some expressed the view that the "buddy" should be an ex-user.

Other key themes were the need for help with issues such as housing, employment, developing new interests and social activities to occupy time outside of the familiar drug using routines and help prevent relapse.

There was willingness amongst those interviewed to become involved in working to fund raise for projects like Bridgegate on a voluntary basis or to assist with other activities. It was felt that this would help raise self-esteem and provide an avenue for developing skills for future employment, as well as a feeling of giving something back and "ownership" of the project itself.

It is interesting to note that the life stories of the two female interviewees had many issues in common both with each other and with many other women who misuse drugs. Becker and Duffy (2002) cite a number of studies which highlight particular issues associated with problematic drug use among women especially pregnancy and childcare, sex-working, sexual health needs, past experience of sexual and physical abuse and mental health needs.

Both of the women in this study had experienced an extremely disrupted and painful childhood and had turned to alcohol and drugs at an early stage to escape from their problems. Heroin was their drug of choice and their addiction was mainly funded through shoplifting and prostitution. Social Services had intervened to remove their children to protect them from harm, but both were motivated to come off drugs in the hope of getting their children back. Both women had low self-esteem and had been involved in self-harm and both had been rejected by their family and the local community.

It is worthy of note that three of the six life story participants have been involved with the Drugs Intervention Programme via the 'Nene Project' and that all three commented favourably on it whilst comments about the Community Drugs Team are more variable:

> *'I have come out of prison and the NENE Project put me straight on to Methadone and helped me.'*
>
> *'I think that my Methadone Script and the Nene project helped me a lot by giving me counselling and helping me to run around places. For example, taking me to drug interviews, coming to doctors with me to get my scripts, coming to talk to landlords and official people with me.'*

'Do you know what I think would help? I'm with CDT for my script, but I think the Nene Project are doing well at the moment, they are taking people fishing - giving activities to do.'

'I am with CDT and I can't get none of that… My husband can't get none of that. I would love to go to the gym; he would love to go fishing; I'd love to go to the cookery classes… You know what I mean? I am a brilliant cook! I'm a Traveller, I have learnt to cook and clean. I'm brilliant at it, but we can't get on these activities.'

'I was on the Nene Program but they stopped us, and yet we are both prolific offenders and they won't let us go back on there…Sorry but they have to sort it out…Because I can't get out of bed in the morning at the moment because there is nothing to get up for. No activities, nothing to motivate us'.

There are also some negative comments about the length of time taken to access detox facilities at CDT but it is not clear how far back in time some of these comments refer to and it may be that the situation has changed. Nevertheless, this is a very important issue, which could benefit from a review of current policy and practice:

'Now when they cancelled my detox and said they couldn't do it for another week, my girlfriend said, "No, I've had enough…if you don't stop using within this week, we are finished." Which I didn't, so she kicked me out. 'Then the CDT said, "We can't do your Detox now because you haven't got anywhere to live." So, I haven't got anywhere to live because I have been kicked out because I didn't get my DETOX in time. They said, "Maybe we will be able to give you a hospital one, can you come down to the hospital?" So I came all the way down to the hospital and to try and find somewhere to live in Westwood. Walked all the way down there and they saw me for about 10 - 15 minutes, they gave me an assessment, I walked all the way back to my flat and the next day they told me, "You have to wait another two weeks before we can get you a hospital bed." 'I waited another two weeks and by that time I had started to inject, and then they told me because I had fallen out with my girlfriend they couldn't do it. They kept making up excuse after excuse and they couldn't give me my detox. As far as I am concerned, if I had got help at that time, then I wouldn't have as many problems as I have and wouldn't have gone to prison.'

The facilities and interventions available at Bridgegate also seem to be well received:

"….and as far as the help Bridgegate has given me, they have helped me with Counseling. When I need to speak to someone, there is always someone available at Bridgegate to speak to me".

'I find Bridgegate helpful for being able to come and talk to the worker, use the telephone to make appointments, and get condoms. We just talk to them, even if it isn't about drugs, just normal things like shopping; what we have done; where we have been, "Have you seen the new film that's just come out? etc" Just normal stuff - we just talk.'

'Yes I knew I could get Hepatitis or Aids through sharing, because Bridgegate gave me some leaflets. And I got to know about clean needles cos I got them from there too.'

The life story data is drawn from a sample population with fundamentally different characteristics from that of the questionnaires. The information here is drawn from six in-depth interviews. Four of the interviewees were men and two women. The age range is from 22 to 41.

In terms of ethnicity/race one woman was Italian/Pakistani the other woman was Irish/English from the travelling community. One of the men was born in England of Miri Puri parents; one was Portuguese, another born in England as the son of Jamaican parents but raised in America and the other having a Scottish mother with Irish Catholic heritage and a Caribbean father.

The life story volunteers were already attending Bridgegate for help with their drug use. The drugs of choice involved were alcohol, solvents, speed, cannabis, heroin and crack. Heroin was the one drug common to all interviewees except the one raised in America and his drug of choice was crack. In contrast, the questionnaire data derives from a population not directly connected to Bridgegate.

Only one respondent to the questionnaire stated that they considered drug used to be indicative of other underlying problems. Not surprisingly, this view is in direct contrast to the life story data (drawn from people from a variety of cultural backgrounds) where although drug addiction was seen as a highly significant problem in its own right it was nevertheless linked to other problems for the individuals concerned. Drugs were linked to a variety of problems including low self esteem; problematic relationships; childhood emotional, physical and sexual abuse at home and in the care system; acquisitive crime; prostitution; domestic violence; confusion over mixed race identity; rejection from family and community because of drug use. In addition, it was clear that drugs were being used as a form of self-medication for some individuals in escaping from physical, psychological and emotional pain. One female interviewee summarises the situation in describing her first use of Heroin:

"It was warm, felt safe. You just blanked everything. I have never felt like that. It was mad, just mad……but when I use now it never takes me back to that place, where I first picked up".

The impression from the questionnaires that local BME communities in Peterborough, had little knowledge of the help available locally to drug users was supported by the life story data where low levels of information about drugs was seen as problematic in many of the communities from individuals providing the life stories. This was compounded by high levels of denial and minimisation in relation to drug problems in the communities involved and a tendency for them to ostracise individuals for their drug use.

The notion that Asians do not use drugs, promoted by community leaders of the South Asian community has been noted by Perera (1998), and Patel (1999) who conclude that such denial has tended to act as a barrier to developing appropriate services. Similarly, the importance of stigma and shame regarding drug use in minority ethnic communities has been identified as a barrier to uptake of services. Abdulrahim et al (1994); Abdulrahim (1998); Gooden (1999).

Poly-drug use with an escalation of drug use linked to acquisitive crime was again not surprisingly, a common theme in the life story data. The involvement of heavy alcohol consumption, in conjunction with drugs was also described. In common with most people suffering from addiction, numerous unsuccessful attempts to come off the drug of choice were described and relapse was common. Many people expressed the view that the addict's own motivation is crucial to success in stopping taking drugs, but that support in terms of the confidential, one-to-one counselling at Bridgegate was seen as a key component in the process. Counselling on a one-to-one basis was seen as the most helpful form of treatment by all those interviewed. They felt that this was the only way that drug users could explore themselves and fully understand their own issues, which would then provide appropriate and safe support and challenge to help them move forward and make changes.

Interviewees wanted councillors, who understood the cultural, religious and family issues for BME communities. Frustration was expressed by several people about the fact that they had not been able to access appropriate help when they felt motivated to change and the need for reduced waiting times in accessing scripts and detoxes were common themes.

Drug services have been severely criticised for failing to meet the needs of black and minority ethnic communities Awiah et al (1990); Perera et al (1993) Chantler et al (1998); Dale-Perera and Farrant (1999); Nefertari and Ahmun (1999), with services deriving from a model designed to deal with white male heroin use in the 1980s Sangster (1997). Drug services have also been criticised for a form of institutional racism for functioning in isolation from their local community with a ' white ' image reflected in their employees, clients and general surroundings and décor in terms of a lack of

welcoming positive cultural symbols for black and minority ethnic groups. Hence the importance of having black workers in drug services has been stressed in terms of cultural competence.

It is interesting to note that these generally accepted views contrast markedly with the comments in the Peterborough sample in which isolation from the community is valued in preserving anonymity and confidentiality and where language and an understanding of black culture is seen as a far more important than the colour or ethnicity of the worker. However, whilst the importance of cultural competence, appropriateness, sensitivity, or specificity may be referred to it is not always clear what these terms mean in practice.

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6.4 DRUGS INTERVENTIONS PROGRAMME DATA

Overall the data provided by the DIP for this study relates to four tables for the period April 2005 – September 2005. These tables are; ethnicity of persons subject to drug test on charge; ethnicity of all persons producing positive drug test results; ethnicity of all persons assessed by the DIP; and ethnicity of current DIP clients.

An analysis of key data relating to ethnicity and the DIP for this period shows the following:

- A total of 118 people were assessed by the DIP.
- The ethnicity of all persons assessed were 80.5% White British; 7.6% Other White, 10.2% Non-White, and 1.7% Not Stated.
- 93 clients were currently engaged with the DIP in September 2005 (latest figures).
- 79.6% of clients of these were White British.
- 8.6% of these were Other White.
- 11.8% of these were Non-White.

Whilst this data fulfils the Home Office data return requirements for the DIP, and provides necessary information for the DIP, it is extremely limited in providing any light on Peterborough's new and emerging BME communities and their engagement with the DIP.

Similarly the DIP's current retention rate of 65% does not include a breakdown by ethnicity, nor is there any DIP data available or ethnicity and DIP attrition rates.

The current ethnicity categories used by the DIP are the 16+1 classification provided on the seventeen page Drug Interventions Record restricts self-classification of ethnicity to categories which do not fit with Peterborough's 'new' and emerging BME communities which this report has highlighted.

This is despite of strong anecdotal evidence from drug professionals and others in Peterborough that there is a growing population of migrant workers in Peterborough, for example, the Portuguese community, is rumoured to 5,000 strong, in addition to the estimated 2,000 asylum seekers and refugees. These groups and others are currently excluded from the present recording arrangements.

7. RECOMMENDATIONS

7.1 Local recommendations

- A strategy for disseminating information about drugs and drugs services to hard to reach BME communities in Peterborough needs to be developed. The strategy is likely to require the cooperation of elders within the communities in terms of the availability of leaflets etc, especially on heroin.
- To enhance the written information available to minority communities – providing leaflets in a wide range of languages which not only translates the information available to white British users, but which also takes into the context of use within the target community and the drugs of choice for those communities.
- To raise awareness of the risk factors, which impinge upon the different specific minority groups, and to forge links with such partners as will most effectively ameliorate those risks.
- To ensure that accurate and recent data is available about the numbers and whereabouts of minority groups within Peterborough to ensure appropriate linking with potential partners.
- To consider the development and publicity of an anonymous telephone helpline to offer a first contact for members of minority groups.
- To consider protocols for the transmission of information between staff in the DIP programme. To balance the agency need for streamlined assessment processes with the client need for the security of their personal information.
- For the DIP to consider mechanisms - possibly in collaboration with partner agencies - for developing drugs prevention and treatment initiatives which extend beyond the confines of the Drugs Strategy (Home Office 2002, 2004, 2005) in order to increase the knowledge of drugs within minority communities and to engage those communities at the level of their own understanding of 'drug misuse'.
- To consider the engagement of the Eastern European community's use of dance drugs, ensuring that information about these drugs is provided to appropriate agencies in the full range of Eastern European languages
- To support DIP service users by engaging in awareness raising and education across generations within Peterborough's established minority communities
- To forge links with those community groups who are the natural sources of support for Peterborough's minority communities.
- To reduce waiting times for prescribing and detox need to a minimum.

- To explore the extent to which services for the Asian community could usefully be offered to families as well/instead of on an individual basis
- To ensure that members of the Asian community are aware of the dangers of returning young substance misusers to Pakistan for a 'cure'
- To engage and collaborate with the full range of faith leaders in enhancing service provision bearing in mind the 'shame' attached to drug taking in many of the communities involved.

7.2 National recommendations

- To consider publicity via other media – TV, radio, video.
- To improve and diversify the information available to drug users on the World Wide Web.
- To provide drugs information in a range of languages. To offer web based supports to drug users who may need to make an initial anonymous contact and information.
- To take steps to ensure that the workforce within drugs services and the promotion of staff within projects is developed to reflect the community.
- Drug agency workers need to speak the languages of the local BME communities, but preferably not be from the community.
- To put in place a thoroughgoing cross-cultural training programme to support the knowledge and understanding of staff.
- Develop a protocol concerning how drugs services treat issues of confidentiality not only in relation to drug use, but also in relation to immigration status.
- Revise the existing Drugs Interventions Record so that 'new' and emerging BME groups are included.

7.3 Further Research

- In building on the findings of this study, further research into individuals from Peterborough's BME communities and their experiences, both successful and unsuccessful, of the DIP.

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Beyond Boundaries: offering substance misuse services to new migrants in London

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TERMINOLOGY AND DEFINITIONS

Readers may be supported by these clarifications of the terminology used within this report:

Refugee

> *According to the United Nations Convention on Refugees (1951), Article 1A, a refugee is a person who has 'a well-founded fear of persecution due to race, religion, nationality, political opinion or membership of a particular social group or political opinion, is outside the country of his [sic] nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it'*
>
> *(UNHCR, 1996 p.16).*

Asylum seeker

An asylum-seeker is a person who has submitted a claim for refuge under the conditions outlined above, and whose claim has been recorded but not yet decided (The Nationality, Immigration and Asylum Act 2002, part 2, 18).

Accession Eight (A8) Nationals

> *On 1 May 2004, ten countries – Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia – joined the European Union (EU). From that date, nationals of Malta and Cyprus have had full free movement rights and rights to work, throughout the EU. Prior to enlargement, existing EU member states had the right to regulate access to their labour markets by nationals of the other eight countries – the 'Accession 8' or 'A8'. The UK Government put in place transitional measures to regulate A8 nationals' access to the labour market (via the Worker Registration Scheme) and to restrict access to benefits.*
>
> *(Home Office, 2007 p.3)*

Black and Minority Ethnic (BME)

> *'We are very conscious that various terms are used to refer to the many diverse communities in England. We prefer the term Black and minority ethnic groups/communities. This reflects that our concern is not only with those for whom 'Black' is a political term, denoting those who identify around a basis of skin colour distinction or who may face discrimination because of this or their culture: 'Black and minority ethnic' also acknowledges the diversity that exists within these communities, and includes a wider range of those who may not consider their identity to be 'Black,' but who nevertheless constitute a distinct ethnic group.'*
>
> *(Patel et al., 2004 p.16)*

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1. KEY FINDINGS

Eligibility

1. Currently all A8 migrants are entitled to emergency, primary care (including access to a GP) and treatment which a GP deems clinically necessary [see page 38]
2. A8 migrants may have access to secondary care if they have the 'right to reside' in this country [see page 41]
3. Rules concerning the eligibility of A8 migrants for health services are transitional and restrictions will cease in 2011 [see page 42]

Needs

4. Unaccompanied minors arriving in the UK to seek refuge are particularly vulnerable to drug use [see page 77]
5. On average ten years elapses between the arrival of a new refugee group of migrants in the UK and their engagement with statutory services [see page 66]
6. Issues of stigma and shame are significant for some migrant communities [see page 74]
7. The simple needs of homelessness and unemployment among A8 migrants may become more complex if left unaddressed [see page 58]

Information Recording, Sharing and Use

8. The NDTMS (National Drug Treatment Monitoring System) does not currently label ethnicity accurately enough to conduct sufficient ethnicity analysis [see pages 44, 67]
9. Arrest referral and treatment services report that A8 migrants are keen to engage with drug treatment provision [see page 53]

Numbers and levels of newly-arrived populations in services

10. Numbers of vulnerable A8 migrants are small in proportion to the whole migrant population [see page 82]
11. Other than in small pockets, services are managing levels of new presentation of A8 migrants [see page 82]
12. There appears to be a tendency among homeless services to overestimate the numbers of A8 migrants presenting [see page 82]

Substance Misuse and Solutions

13. The type of open access service found in tier two, and in particular low threshold prescribing services, work well for A8 migrants [see page 60]
14. The drugs of most frequent use among refugee communities are not necessarily those of highest priority in the Drug Strategy (Home Office, 2002) [see page 70]
15. The skills, qualities and talents of refugees, asylum seekers and A8 migrants are under utilised

[see pages 88, 89]

16. Individual frontline agencies are keen to collaborate with drug services at a local level [see pages 90]

17. Second level Homeless agencies are keen to collaborate with the NTA (National Treatment Agency) at a strategic level [see page 89]

2. BACKGROUND TO THE STUDY

Over the past five years research has emerged into the substance misuse needs of minority populations (Sangster et al., 2002; Becker & Duffy, 2002; Fountain, et al., 2003 among others). There is every prospect that as the field develops these findings will be integrated into service delivery and treatment services will begin to orientate themselves around the needs of a more diverse population.

However these research projects have focused in large part upon established populations – women, Black British and British Asian communities - who are embedded into the structure of society. The literature relating to newer populations is sparse. Hard data as to the numbers of migrants is not available (Tyrer et al., 2004) and without this as a starting point, understanding levels and type of need is mere guesswork.

Some initial work has been undertaken, exploring drug misuse of asylum seekers and refugees (Patel et al., 2004; Muslim Youth Helpline, 2006) and other studies have examined specific drug use (Havell, 2004). Currently the Surrey University Centre for Research on Nationalism, Ethnicity and Multiculturalism is researching the labour trends of new migrant workers from EU Accession countries (Eade, Garapich, and Drinkwater, 2006). There is a pressing need to draw together and follow up these studies: providing information about the needs of new populations; informing service providers on issues of engagement and retention and offering a framework for the development of services which can respond to the changing patterns of London's demography.

It is axiomatic to say that the voices of newly-arrived populations are rarely heard and that gathering their opinions is not a straightforward process. Many migrants are not in touch with mainstream services: some because they fear the forces of the establishment, others because their residence is uncertain and they fear that advancing a controversial view would prejudice their case; many simply because they see themselves as transient. Moreover it cannot be assumed that interviewer and interviewee share common assumptions and language in relation to drug use – and this goes beyond issues of mere translation, to touch upon an individual's subjective experience.

Parveen, in Harding (1995) argues that the low take up of services may be due, in part, to the fact that services are lacking in 'ethnosensitive' structures, i.e. ones which prize the:

> *Values, lifestyles, and religious and cultural inspirations of all the various ethnic components of British Society…In the absence of such an ethnosensitive approach to practice, members of*

minorities will at best find themselves seriously disadvantaged, and at worst be wholly excluded from all those public services to which they have a right, as citizens, to access.

(Parveen, in Harding, 1995 p1)

During the early part of 2006 the Centre for Community Research (University of Hertfordshire) undertook a related study on behalf of Peterborough Drug Action Team (DAT)/Home Office (Mills et al., 2006). The team's experience in working with these newly-arrived groups indicated that a direct approach to these individuals is not possible and if attempted might be counterproductive. The researchers overcame this challenge by collaborating closely with a treatment provider within the DAT and undertaking interviews via research trained outreach workers from new/minority communities. Using this process detailed qualitative data was gathered from a variety of minority communities (both established and newly-arrived) about perceptions of drugs and levels of need among previously 'unreached' communities.

A significant finding of the Peterborough study was that the data currently gathered routinely within DATs is not equal to the task of monitoring newly-arrived populations. A clear example of this is the fact that ethnic monitoring categories – based broadly upon census categorisation – make no provision for delineating individuals whose homes may be as diverse as Poland and Iran. The category of 'white other' must serve for all.

This research project involved collaborating with DATs to develop monitoring solutions, which will generate accurate data for the project and will continuously refresh the data available about changing populations in London.

However the information gathered from Drug Action Teams represents only part of the picture in relation to new communities, since only those individuals who are either in or on the fringes of treatment are known. To provide a proper response the research triangulates these findings against the knowledge and understanding of groups and agencies in the wider community in order to incorporate new insights into communities and thereby extend and enrich the potential for engagement and retention.

3. AIMS AND OBJECTIVES OF THE PROJECT

- To provide baseline information as to numbers in treatment and levels of contact with services.
- To identify newly-arrived populations, estimate the size of these communities, and map these within the 32 London Boroughs and the City.
- To highlight, where possible, substance misuse issues within the populations, including access and provision, entitlement to health and social care and experience of local treatment systems using both quantitative and qualitative research methods
- To establish existing levels of service provision and to demonstrate good practice, where it exists
- To canvass Treatment services about their current level of service provision, their perceptions of local need and the gaps which are emerging due to London's dynamic population.
- To provide recommendations for future NDTMS collection of ethnicity statistical information and best practice for working with newly-arrived populations with substance-misuse issues.
- To provide examples of good practice with newly-arrived populations where it is found.

4. NEW MIGRANT COMMUNITIES, NEEDS AND SERVICE PROVISION: A REVIEW OF THE LITERATURE

This review of the current literature demonstrates the work that is currently being undertaken into the needs and levels of service provided to new migrant communities.

New migrants often show patterns of high residential mobility early after their arrival in the UK (Robinson and Reeve, 2005). A survey of New Deal for Communities (NDC) residents found that over one quarter of those applying for refugee status in the UK had moved residence three or more times in the preceding five years, comparable to 9.7 percent of all NDC residents (Cole et al., 2006). This frequent moving has been highlighted as particularly common among people who are seeking or have been granted asylum (ibid) and presents difficulties for services trying to engage with them. Research in other UK cities have found that where new communities are not integrated into social networks there appears to be an increased risk of substance misuse (e.g. Mills et al., 2006).

Some of London's boroughs are even reported to experience annual population mobility above 35% (Travers et al., 2007). It is reported that among newer populations there is an increasing need for significant public service support and many councils make associations between increased costs and the arrival of new populations in their borough. A report commissioned by London Councils suggests there is powerful evidence to indicate:

> *… that a number of boroughs act as an 'escalator' for people, investing heavily in them when they first arrive (for example with language skills and housing) before those individuals move on and are then replaced by new ones who require councils to start afresh in building them into the city's economic and social life.*
>
> *(Travers et al., 2007 p.4,)*

Of course, it is realistic that councils will incur extra costs associated with the tax administration, translation, language teaching and homelessness new populations may bring, but unfortunately England's centralised local government funding system means that London's local authorities struggle to reap the benefits of increased tax bases and economic activity associated with migrant and mobile populations (Travers et al., 2007). Short-term, targeted responses from central government are accused of ineffectively addressing structural issues (ibid).

The Audit Commission (2007) make suggestions on how the government and regional bodies can assist local areas to respond to the challenges of emerging populations by developing regional strategies, and coordinating their own activities to support local areas with data and information so they can prepare for future increases in migration. Under such circumstances this responsibility may fall to the

National Treatment Agency (NTA). They also recommend teaching English to adults (Audit Commission 2007).

However, the Audit Commission suggests that local authorities (which of course include Drug and Alcohol Action Teams) are responsible for maintaining an understanding of how their local areas are changing by monitoring data and intelligence to respond swiftly to emerging problems. To do this local authorities are also encouraged to work jointly, and this includes working with faith and voluntary groups, employers and housing landlords who often have the best links to migrants. The Audit Commission suggests local authorities address language, advice and information needs and that they need to be active in modifying services to meet the needs of their changing populations. This is particularly relevant to treatment services because drugs knowledge and awareness has been found to be low in hard to reach BME communities (Mills et al., 2006).

Additionally, it is important to make sure local authorities minimise local tensions by dispelling myths (Audit Commission 2007). These myths will also need to be clarified so local authorities can address their own preconceptions, such as, public and local authority concern surrounding the costs of migrant workers. These concerns may be unwarranted, because in reality, migrant groups place fewer demands on public services (Travers et al., 2007), perhaps because these groups also tend to be young (83% aged between 18 and 34) with no dependent children (Sriskandarajah et al., 2005). So although there are highly visible costs to local authorities, associated with particular households, to account for these concerns, such as translation services and specialist support for the homeless (Travers et al., 2007), observations confirm many recent migrants (particularly those on labour migration programmes and from the EU accession countries) are making relatively large contributions to the public purse (Sriskandarajah et al., 2005). While the contributions of earlier arrivals may also be increasing as they integrate into society (ibid).

Many migrants from the accession eight (A8) countries arrive at Victoria Station in London, from there a number have been seen to move on to look for work, a particularly common destination is the London Borough of Hammersmith and Fulham (Morris, 2004).

The East European Advice Centre found that their clients' practical knowledge of how to survive in the UK is quite limited and feelings of helplessness can often arise if the few centres where they access cheap or free resources (food, shower facilities and spare clothes) cease to do so (Morris, 2004). Although this group often know how to register with Jobcentres and apply for a Construction Industry Scheme (CIS) card or National Insurance number, crucially, they also found this group are often unaware of where to access medical help other than at hospitals. Furthermore, even where homeless

centres hold specialist health services including nurses, doctors, drug and alcohol services, mental health services or one-to-one work with clients, uptake by East Europeans is described as sporadic and this is attributed to language barriers and thus showing the problems associated with engaging this client group (Morris, 2004). Many of the sample in this study had alcohol misuse problems pre-migration (ibid). Much like the Audit Commission (2007), Morris' research proposed the following steps to improve the support available to this vulnerable East European population; literature translation, improving access, fully informed publications about the migratory experience, better links among all relevant agencies, and further monitoring of the situation of East Europeans (Morris, 2004).

Additionally Morris (2004) found that among this sample of Poles alcohol consumption (rather than drugs) was identified as a serious problem (13 of a sample of 30 had alcohol problems) and many agencies supporting homeless people suggest that Poles drink more than the other Eastern European clients they work with (e.g. Homeless Link, 2006). A West London team working with street drinkers reports that 14% (7 of 50) of their rough sleeping clients were A8 nationals (St Mungo's, 2005), all of whom were street drinkers. The same report also found that Polish clients were most likely to be living in squats.

The Department of Communities and Local Government's (DCLG, 2006) Statutory Homelessness Statistical Releases do not publish the nationalities of those they define as both homeless and entitled to local authority assistance, an omission shared by the National Drug Treatment Monitoring System (NDTMS) at the time of this report. Even where entitlement is established, homeless people with substance misuse problems often live extremely chaotic lives and find it particularly difficult to recognise their own support needs, seek help and tackle their situation (Randall, 1998). This combination of vulnerabilities and where A8 nationals have no recourse to public funds means they are particularly vulnerable to rough sleeping. The Simon Community considered at least 30% of central London's rough sleepers to be from A8 countries in August 2006 (McLaughlin, 2006).

The proportions of hostel residents from Black and Minority Ethnic (BME) groups have increased since the early 1990s and there has been a marked increase in drug misuse since 2000 (Warnes et al., 2005). In 2004, snapshot surveys of hostel residents by St Mungo's and Thames Reach Bondway reported that 68% and 15% of residents had substance misuse problems, respectively (Warnes et al. 2005). Almost 20 per cent of hostel occupants in Westminster were born overseas (half of which arrived seeking asylum), however, this demography is changing and concerns about homelessness and rough sleeping among A8 migrants are increasing (Travers et al., 2007).

A research paper by the House of Commons Library (Hansard, 2006a) suggests that A8 nationals have made relatively few demands on our welfare system. Between May 2004 and June 2006 A8 nationals made 1,777 applications for Income Support, 4,083 applications for income-based Jobseeker's Allowance and 83 applications for Pension Credit (ibid). Of these, Polish (43%) and Czech (19%) nationals made most of these applications and overall 29% of all applications were made in London (ibid). However, failure to satisfy the Right to Reside and Habitual Residence Tests means that most applications were disallowed (87%), with only 768 applications (13 percent) allowed to progress for further consideration (ibid). The entitlement to public services for migrant populations from A8 countries is not clear-cut and many other populations also suffer from differing levels of access to many services.

A survey of London's homeless services found that 28% cited a need for substance misuse services among their A8 clients (Homeless Link, 2006). That between 40% and 45% of these service providers also highlighted a need for emotional support, alcohol misuse and mental health issues among their A8 clients may also be cause for concern among drug service providers, especially when taking into consideration there are some indications of support needs increasing (Homeless Link, 2006). From the Homeless Link study five of the service providers who indicated this increase generally agreed that there is a group who are emerging with higher support needs after spending a considerable amount of time in the UK experiencing, among other things, the typical problems associated with entrenched rough sleeping; these include alcohol and drug use, and mental health problems (Homeless Link, 2006). Two outreach teams also highlighted a need for more support for A8 nationals arising from increased drug use (ibid). The following statement from a Homeless Day Centre signifies a need for further investigation into the substance misuse in A8 nationals.

> *Alcohol problems are now universally visible amongst these clients,*
>
> *amongst male clients who have been here 6 months [or more] crack use is encountered. Some experimental heroin use.*
>
> *(Homeless Link, 2006 p.34)*

Subsequently, the pervasiveness of alcohol misuse in newly-arrived populations may indicate a potential for alcohol to act as a gateway to the misuse of other substances (e.g. Kandel et al., 1992, Bailey, 1992, Csémy, 1999).

Recent research into A8 nationals in the UK is largely focused on labour trends and public service provision (e.g. Sriskandarajah et al., 2005, Audit Commission, 2007, Anderson et al., 2006, Gilpin et al., 2006); however this work has limited application to drug service provision because little is known

about the substance misuse of A8 nationals in the UK. There is a pressing need to draw together and follow up these studies to provide information about the needs of new populations (Audit Commission, 2007); informing service providers on issues of engagement and retention and offering a framework for the development of services which can respond to the changing patterns of London's demography.

As the flow of migration continues, so to does the potential for those with substance misuse needs to migrate. As the largest contributor to the UKs migratory inflow over recent years (National Statistics website, 07/03/2007) there is potential for the substance misuse problems of Poland's population to have the largest impact on London's services. 'Polish heroin' or *Kompot* (a strong, easily-produced opiate derived from poppy straw) is believed to have originated alongside the acknowledgment of substance misuse as a social problem in Poland in the mid-1970s (Biernkowska & Skupinski, 1989; Krajewski, 1997; both cited in Krajewski, 2003). At approximately 5-10% of the price of real heroin or cocaine in 2003, it is easy to see why Kompot was the drug of choice for the majority of Polish opiate users before Poland's accession into the EU; both amphetamines and marijuana were also believed to be growing in popularity at this time (Krajewski, 2003). Estimates of opiate users in Poland grew from 20-40 thousand in 1993 (Sieroslawski & Zielinski, 1997; cited in Krajewski, 2003) to 32-60 thousand in 1998, there was also an increase in use of 'brown sugar heroin' among Poland's 'better-off' and 62.4% of those entering treatment in Warsaw in 1999 were for problems with smokable heroin (Sieroslawski, 1999; cited in Krajewski, 2003). Poland has had harm reduction measures in place since 1997, this includes methadone prescription and needle exchanges, however, an increasingly punitive approach to drug use by the Polish government left the legal status of harm reduction strategies precarious and resulted in more proactive policing strategies that increasingly targeted and even resulted in the 'harassment' of drug users (Krajewski, 2003). An amendment to the Regulation on substitution treatment in May 2004 increased the availability of methadone programs and may have signified a move to a more treatment-oriented service in Poland (Reitox National Focal Point, 2005). Moreover, treatment services across the EU accession countries are likely to follow this move as it is in accordance with the aims of the EU Drugs Strategy 2005-2012 to reduce drug demand:

> *… through the development and improvement of an effective and integrated comprehensive knowledge-based demand reduction system including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration measures within the EU Member State*
>
> *(Council Of The European Union, 2004 p.10)*

The current literature identify homelessness, language barriers, alcohol misuse and public service entitlement to health and social care as key issues for newly-arrived populations, particularly those from the European Union accession countries. However, substance misuse in London's newly-arrived populations appears to be an under-researched area. Little is known about how migration is affecting substance misuse in these populations. There are many unclear areas, firstly surrounding the prevalence and types of substance misuse within newly-arrived populations, but also whether migrants are bringing their domestic substance misuse patterns with them or adopting those found in London. These areas need clarification before services are able to respond appropriately to the needs of London's new populations.

5. METHODOLOGY

Background

This research project has its roots in observations made to the NTA by London borough information managers, commissioners and other stakeholders. Locally, DATs have noticed that the demography of boroughs is changing and that migrants from the new European Union countries are beginning to approach drugs services. Questions were raised about the eligibility to services of these migrants and about best practice in service delivery. Data on the subject data is proved to be still in its early stages, indeed a report by the Audit Commission (2007) published during the research period was able to cite only one other study in the area. This population remains relatively new in the UK (the A8 countries having acceded only in 2004) and the vast majority of individuals have no need to make any call upon drugs services.

In addition the NTA requested that existing research into the location and needs of other newly-arrived communities, refugees and asylum seekers, be investigated.

Given the funding available for the project, the time limitations (i.e. by March 2007) and the challenges in engaging with 'hard to reach' groups, a Rapid Appraisal Approach was deemed to be the most effective method for initial information gathering.

A Rapid Appraisal Approach was employed, a multi-method approach which constructed a desk-based profile of information sourced from existing statistical and documentary evidence. In addition to undertaking interviews with 'key informants', including representatives of drug agencies, community groups and organisations supporting newly-arrived groups, such as refugees and asylum seekers. Wherever possible, service users from these communities were interviewed as part of the process (see appendix two). The aim was to provide up to five case studies, where possible, to highlight areas of good practice, innovation, and potential for improving services across London.

The data gathering phase included the creation of a database of agencies, community and faith groups who serve newly-arrived groups.

Desktop survey

This is a multi-method approach which constructs a desk-based profile of information sourced from existing statistical and documentary evidence. This included government and local authority monitoring reports.

This data gathering phase involved creating a database of agencies, community and faith groups who serve newly-arrived groups.

In the case of this study the method was not simply a self contained process. Information from face to face interviews was followed up and employed to enrich the data gathered from the desktop survey. During the course of the research, the steering group requested information to clarify the eligibility to health and social care services of A8 nationals, refugees and asylum seekers; this was also constructed via a desk-based search of information sourced from existing documentary evidence.

Interviews with Key Informants

The findings in this report are divided thematically. In addition the findings relating to asylum seekers and refugees, and A8 nationals are treated separately. This separation in no way reflects a sense of a hierarchy of needs among groups. An accurate view of the composition of London's population is not known to either national or local government. The Greater London Authority is undertaking a piece of work at present to map migrant populations (Rees & Boden, 2006). A sample of London boroughs was generated by identifying those with existing challenges in working with new populations and by meshing this with the information gathered from the desktop survey inform practice London-wide. The Research Project steering group was consulted about the boroughs which might be useful partners. Key features were:

- a geographical spread
- need identified or an interest expressed in the research by the DAT
- diverse populations with known groups of new migrants

Using these criteria seven DATs were chosen as in figure 1.

Figure 1. Boroughs selected for research

- Barking & Dagenham
- Ealing
- Hammersmith & Fulham
- Lambeth
- Newham
- Southwark
- Westminster

In addition Hackney was highlighted as fulfilling the criteria. This borough was not selected to allow a good geographical spread that covered both north and south London, however information gathered in Hackney does inform this research.

Four broad groups of interviewee were identified: DAT joint commissioning managers, DAT information managers, council diversity officers & members of community groups. Interview schedules were prepared by the research team and agreed with the steering group. These schedules were reconfigured to meet the needs of the interview sample.

Initial interviews were undertaken with key personnel within the DAT in order to collect data about current practice and levels of information. Further interviews were undertaken within the DAT with staff holding particular responsibility for diversity and community engagement. These initial interviews triggered the involvement of treatment services which led in turn to interviews with wider community groups – some specific to new populations and others meeting broader support needs of vulnerable individuals. Interviews were undertaken with local authority staff in the selected boroughs and with key London-wide services (prison staff, second tier agencies). Finally interviews were conducted with service users in a variety of settings – self help groups, day centres and 'drop ins'. The majority of these interviews were undertaken 'face-to-face', however where circumstances demanded, interviews were conducted by telephone

In total of 43 interviews were undertaken as follows (fig.2):

Figure 2. Interviewees shown by employing organisation and job title

DAAT staff

Joint Commissioning Managers	-	4
Information/Data Managers	-	6
DAAT Managers	-	2
DIP Managers	-	2
Communities Coordinator	-	2

Drug Treatment Service Staff

Service Managers	-	2
Service Staff	-	3

Other

Voluntary Sector Staff	-	13
Local Authority Staff	-	2
Police	-	1
Rough Sleepers Services	-	2
Prisons	-	1
Service Users	-	3

Analysis of the data

A Framework Analysis was applied to the data. This allowed the pre-set aims and objectives of the research to be investigated, while also maintaining the integrity of the accounts and observations of the interviewees. This qualitative analysis uses five stages and was developed for policy relevant research (Ritchie & Lewis, 2003). Interviews were recorded and listened to by two researchers to breed familiarisation with the raw data; all findings and information relevant to the topic of study were then transcribed into statements. The *a priori* focus meant that any data relevant to substance misuse and service provision to migrant populations were extracted from the interview data and included in the identification of a thematic analysis matrix.

The thematic matrix was then applied to the data, the written accounts of interviews were systematically read and any instances of themes annotated.

The annotated data were then charted according to their relevant thematic codes. Abstraction and synthesis of subject areas then lead to the production of charts that consisted of the condensed summaries of interviewees' responses across a number of respondents.

The fifth and final stage of analysis was guided by both the original research aims and the themes that emerged. The charts were then explored to define concepts, link themes, create typologies and map the range and nature of emergent phenomena.

Research Project Steering Group

An important aspect of this collaborative research project was the establishment of a project steering group to monitor and progress the research. This group was composed of a Deputy Regional Manager for the NTA; the Drug Intervention Programme Manager, Westminster; Commissioning Team Member, Barking & Dagenham DAAT; Business Performance Manager, Barking & Dagenham DAAT; Temporary Data Manager, Newham DAAT; Community Involvement Officer, Newham DAAT; a member of London Voluntary Service Council and researchers from the University of Hertfordshire's Centre for Community Research. The group met on three occasions during the life of the project, and members received and responded to communication from the research team between meetings.

6. FINDINGS

6.1 Desktop Survey

This desk-top survey has drawn upon current, published data to provide a picture of the newly-arrived migrant populations within London. The Greater London Authority (Rees & Boden, 2006) are currently reviewing the methodology of how they aim to estimate London's new migrant population, at 97 pages long, in itself it stands as evidence of the complexity of tracking of such populations. The GLA propose to establish a National Migrant Databank, which will be developed as a rolling annual series of statistics to provide a sophisticated view of migrants that has not been available to date. The GLAs proposed datasets will map populations at UK, London-wide and Borough level (Rees & Boden, 2006).

ONS mid-2005 population estimates indicate a net gain of 116,000 people into the Greater London area in 2004 (Greater London Authority, 2006b). The Boroughs with the largest estimated net inflows were Westminster (13,200) and Kensington & Chelsea (12,900). Camden and Brent were the only other boroughs to receive more than 5,000 net international migrants (Greater London Authority, 2006b).

One estimation of the migration of overseas-born populations into London is a net increase of approximately 100,000 per year (Travers et al., 2007), with unofficial, and consequently uncounted, population movements almost certainly adding to this figure. Additionally, there is reason to believe that much of this uncounted mobility is likely to be by EU nationals who have no obligation to declare their movements (ibid).

After considering the differences that appear between the various methods used to measure the number of 'accession eight' (A8) nationals in the UK, the Institute for the Study of Labor (IZA) has suggested it is likely that in late 2006, the upper estimate of 500,000 workers from A8 countries is accurate (Blanchflower et al., 2007). However, with 41% of all WRS applicants not stating how long they intended to stay in the UK and 41% of those that did answer saying they did not know how long they intended to stay for (Home Office, 2007) there are problems assessing the numbers of these migrants still in the UK. The research by IZA does consider current data to suggest that as many as half of the migrants arriving in the UK since accession have not stayed permanently (Blanchflower et al., 2007).

6.1.1 The EU Accession Countries

On 1st May 2004, the UK Government established transitional measures to regulate access to the UK labour markets by A8 nationals. Regulation is via the Workers Registration Scheme and requires A8

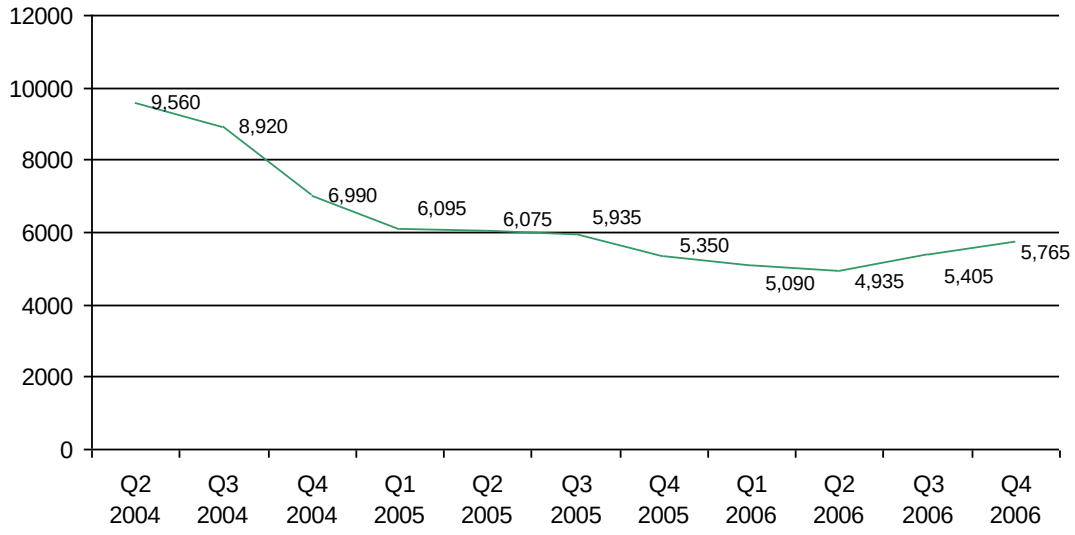
nationals to register within one month of the date on which they commence employment. Self employed workers do not need to do so; they do however need to register with HM Revenue and Customs.

Here the available data on the location of A8 nationals registering on both the WRS and for National Insurance Numbers (NINo's) will be presented within the context of the UK, London and where possible, London Boroughs. The pre-accession NINo applications for Bulgarian and Romanian nationals will also be considered.

The most recent Accession Monitoring Report (Home Office, 2007) identified the proportion of A8 nationals applying to work in London has fallen from 17% in the fourth quarter of 2004 to 10% in the fourth quarter of 2006. However, Figure 3 below shows that after initial highs, the number of registrations in London has been reasonably consistent since the beginning of 2005 (Home Office, 2007).

Figure 3 gives a good indication of the amount of A8 nationals working in London; it does not however provide any insight into the nationalities of those working in London. For an indication of the makeup of the nationalities of WRS applicants working in London we must rely on both the nationalities of all WRS applicants and the nationalities of NINo applicants (DWP, 2006) which is available for each London borough.

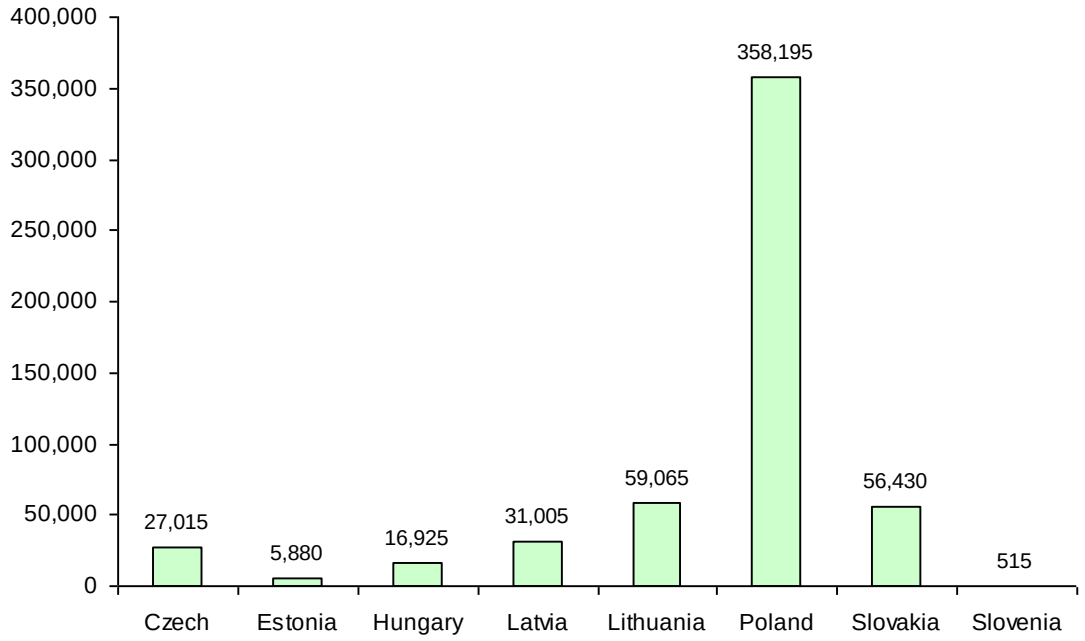
Figure 3. The number of quarterly WRS registrations in London, for the period May 2004 – December 2006



Source: Home Office, Accession Monitoring Report (May 2004 – December 2006).

Figure 4 below shows that from the date of accession until 31 December 2006, Polish (65% of the total) nationals made up the largest proportion of applicants to the WRS, this was followed by Lithuanian (11%) and then Slovak (10%) applicants. Applications from Polish nationals have been increasing since accession in 2004, with highs of 45,320 and 44,550 applications being reached as recently as the 3rd and 4th quarters of 2006 respectively. The International Passenger Survey estimates also found that in 2005 more Polish nationals (49,000) migrated into the UK for a period of at least one year than nationals from any other overseas nation (Greater London Authority, 2006a).

Figure 4. Nationalities of A8 nationals registered on the Worker Registration Scheme for the period May 2004 – December 2006



Source: Home Office, Accession Monitoring Report (May 2004 – December 2006).

Figure 5 (below) indicates that the numbers of nationals from Lithuania (*totals of 22,980 in 2005 to 16,815 in 2006*), Latvia (*totals of 12,955 in 2005 to 9,380 in 2006*), and the Czech Republic (*totals of 10,570 in 2005 to 8,190 in 2006*) registering to work in the UK are now falling since the busiest periods of 2005. The modest numbers of registrations from Estonian nationals (*totals of 2,560 in 2005 to 1,460 in 2006*) have also shown a decrease over the first two, full calendar years since accession.

There have been consistently low amounts of Slovenians (*just 515 in total since accession*) registering to work in the UK over the last two years.

Hungarian nationals have shown slight increase over the last two years (*from 6,355 in 2005 to 6,950 in 2006).*

Figure 5. The number of quarterly WRS registrations in the UK by nationality (excluding Poland), for the period January 2005 – December 2006

Source: Home Office, Accession Monitoring Report (May 2004 – December 2006).

NINo registrations by migrants from A8 countries made up 26% of all London-based registrations in 2005/06 (DWP, 2006). This figure has grown from five per cent (2002/2003), to eight per cent (2003/2004), then 20 percent in 2004/05.

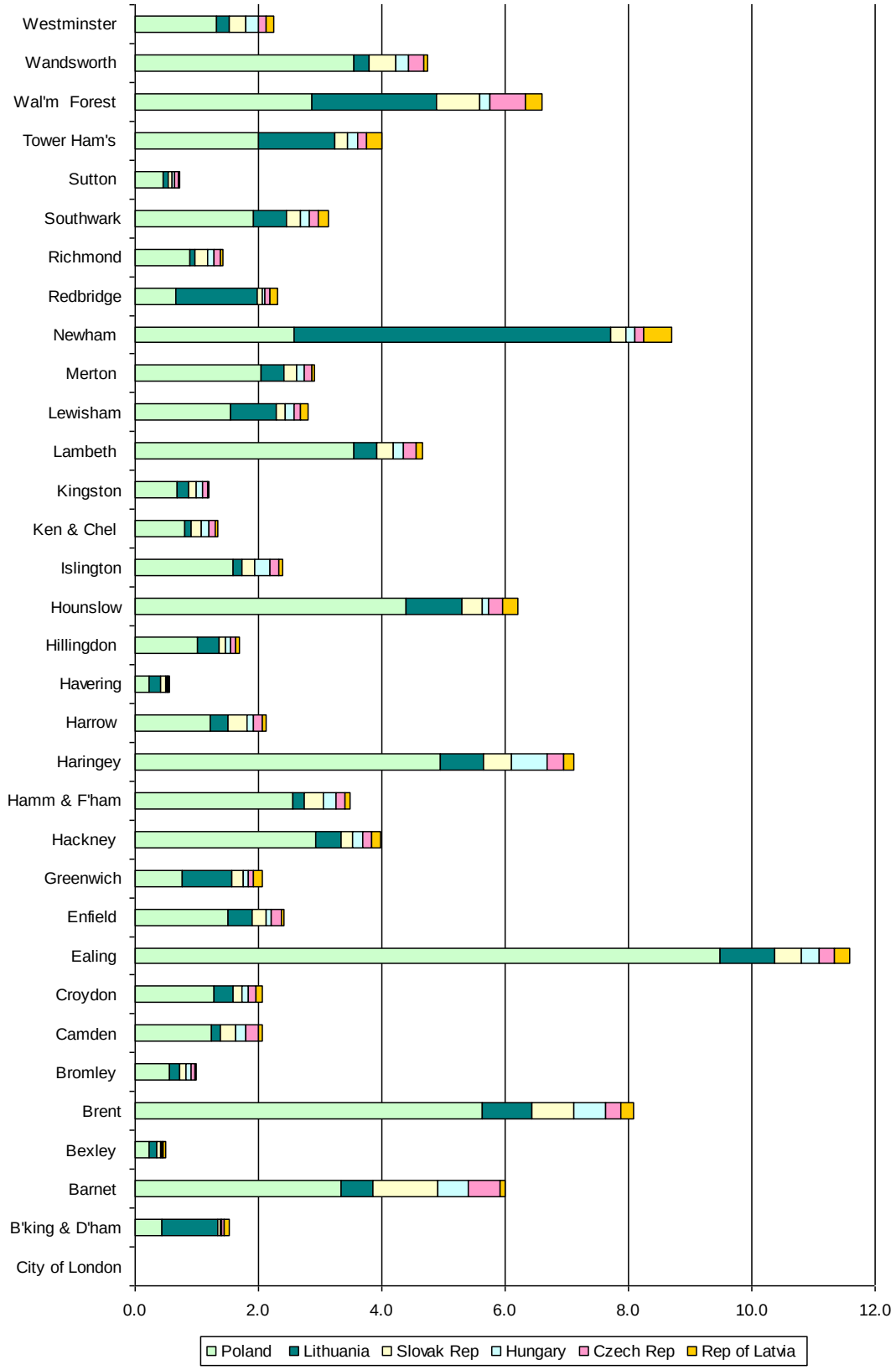
Poland and Lithuania have become larger contributors to the UKs migratory inflow since joining the European Union, although both countries had fairly high numbers of NINo registrations even before accession (DWP, 2006). Other countries had far lower numbers of registrations in London, including the Slovak Republic, which had the third highest number of applicants (DWP, 2006).

The newest accession countries (A2), Bulgaria and Romania, both had higher numbers of NINo applications in the past, before decreases in registrations in 2004/05 and 2005/06. The DWP (2006) believes that applications from these countries are likely to increase now they have been acceded into the EU. Comparisons between the number of Bulgaria's registrations before accession have been made to Lithuania, so it has been speculated that Bulgaria's post accession NINo applications may follow a similar pattern to Lithuania's (DWP, 2006).

The period of 2002/03 to 2005/06 saw an overall increase of 88,000 NINo registrations, with the accession countries accounting for over 54,000 of these (DWP, 2006).

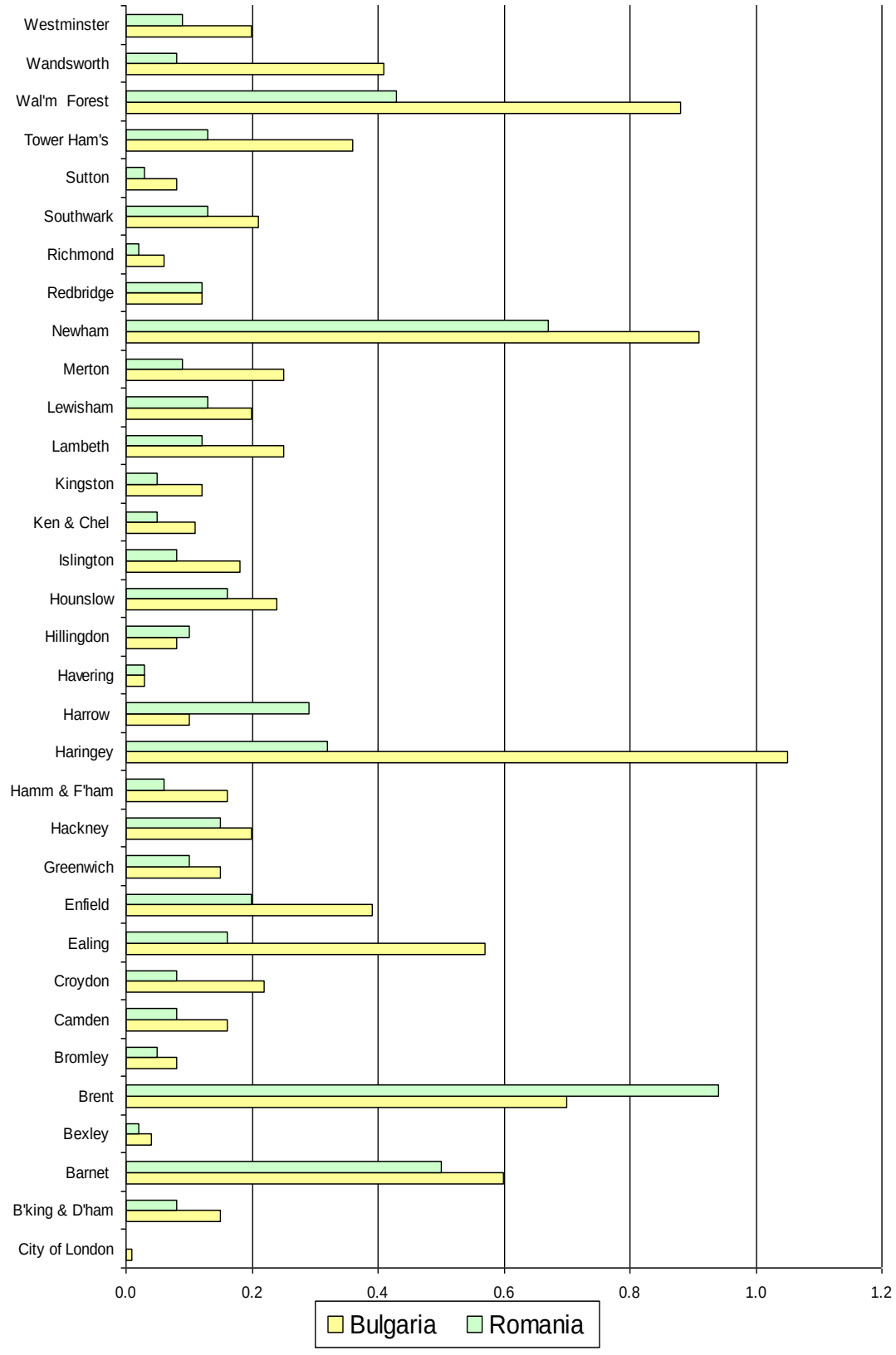
A clearer picture of the nationality of A8 migrants working in each London Borough can be seen from Figure 6 (DWP, 2006). Ealing, Newham and Brent all had over 8,000 NINo registrations from A8 nationals. However, the majority of A8 nationals in Ealing are from Poland, while according to these registrations Newham is host to the largest Lithuanian population. Figure 7 shows that Brent, Haringey, Newham and Waltham Forest are attracting the largest amount of A2 nationals, this is very similar to the pattern shown by A8 nationals (DWP, 2006). These figures provide a moderate insight into the settlement patterns of A8 and A2 nationals who have been able to gain employment in London, however, it is important to remember that many of the most vulnerable migrants are those who have not been successful in finding employment and so may go unrecorded in datasets such as these.

Figure 6. Nationality of A8 nationals NINo registrations in London, 2002/03 to 2005/06 by London Borough (thousands)



Source: DWP, 100% sample at 25th June 2005 from the National Insurance Recording system (NIRS)

Figure 7. Number of A2 nationals NINo registrations in London, 2002/03 to 2005/06 by London Borough (thousands)



Source:

DWP, 100% sample at 25th June 2005 from the National Insurance Recording System (NIRS)

The following Parliamentary question was put to the Secretary of State for the Home Office, asking:

> *…what estimate he has made of the number of workers from the EU accession states who have not registered under the Worker Registrations Scheme and are working in the UK.*
>
> *(Hansard, 2006b, ref: 40360)*

Tony McNulty, Home Office Secretary, gave the following answer:

> *There are…no figures or estimates available as to the numbers of accession nationals who have entered the United Kingdom and are working without registration.*
>
> *(Hansard, 2006b, ref: 40360)*

The methods of measurement discussed thus far do not tell us anything about the outflow of accession state nationals, however the International Passenger Survey and Total International Migration estimates do give some estimates of population 'stock' of A8 nationals in London or the UK (Greater London Authority, 2006a). In 2005, the ONS estimated 64,000 more A8 nationals migrated into the UK for a period of at least one year than left, compared with 49,000 in 2004 (ibid). Also, the number of A8 nationals migrating into the UK long-term, increased by over 50% between 2004 and 2005 (ibid). Such an increase can be explained by 2005 being the first full calendar year following the date of accession in May 2004 for which migration by A8 nationals could be estimated (Greater London Authority, 2006a).

In 2005, for the first time the increase in outflow of A8 nationals from the UK was notable, with almost 80% of this outflow occurring in the second half of 2005 (Greater London Authority, 2006a). The widely quoted figure of 600,000 entrants from A8 countries does not show how many remain in the UK at any one time. Martin Ruhs (cited in Drew & Sriskandarajah, 2007) estimates that the increase in the stock of A8 migrants in the UK is 212,000. Findings from the Labour Force Survey found less than half of those registered on the WRS were still in the UK (Commission for Rural Communities, 2007), while other research has suggested the disparity between net and gross flows in the UK and Ireland indicates that as many as two-thirds of A8 migrants have already returned home (Drew & Sriskandarajah, 2007).

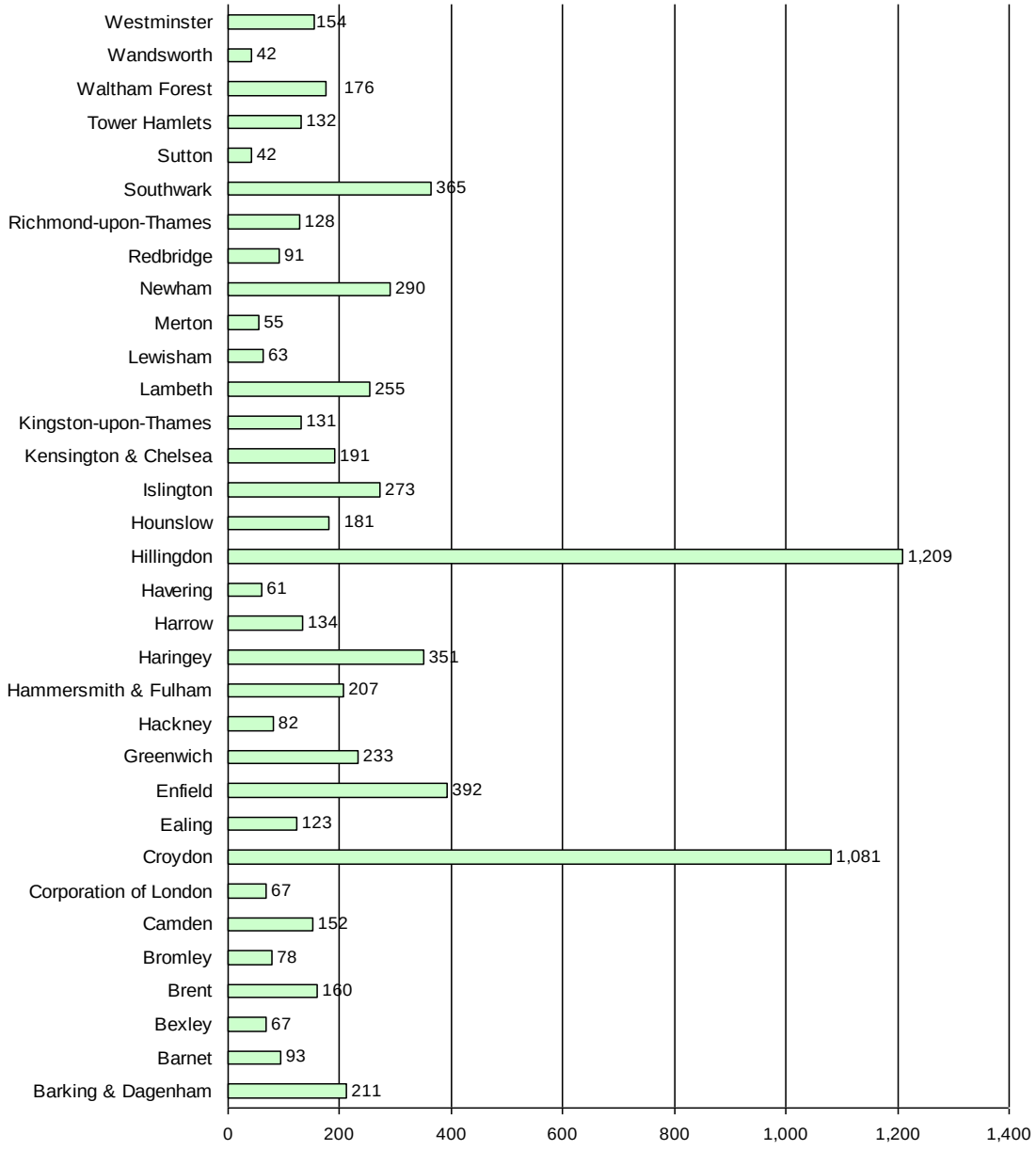
6.1.2 Asylum Seekers and Refugees

Data on the location and numbers of asylum seekers and refugees in London is disparate. The most comprehensive source available to map the numbers and locations of current asylum seekers in London is the London Asylum Seekers Consortium's (LASC) website dataset which contains the details of asylum seekers receiving support from local authorities or other accredited refugee support groups

(see figure 8). However, this source shows only the small group of those with 'current' applications. Further datasets show at the end of 2005 there were 11,300 asylum seekers in Greater London receiving support from the National Asylum Support Service (Home Office, 2006a). Of these, the most common origin nations were Turkey (1,375) Pakistan (1,320), Sri Lanka (1,125) and Somalia (1,075).

In 2005, the top ten countries of origin of asylum applicants in the UK were Iran, Eritrea, Somalia, China, Afghanistan, Iraq, Pakistan, Democratic Republic of Congo, Zimbabwe and Rwanda (Home Office, 2006b).

Figure 8. Number of Asylum Seekers receiving support from LASC, by borough



Source: London Asylum Seekers Consortium, 09/02/2007

The difference between the two categories of 'asylum seeker' and 'refugee' is only the status of their application to remain in this country (Migration Watch website a, 06/03/2007). There appears to be little reason to track refugees in the same way as asylum seekers outside of the means that the general public are recorded (e.g. Census, General Household Survey etc). The data on the locations of refugees within London boroughs is limited. One GLA (2001) report did provide tentative estimates that the cumulative total number of refugees and asylum seekers in London at the end of 2000 was between 352, 000 and 422,000, which was approximately one in 20 of the city's residents at that time.

Economically-active, newly-arrived populations can be located to borough level by NINo registrations as with A8 nationals above (see DWP, 2006). Excluding the A8 countries, the ten largest nationality groups applying for NINo's in London from 2002/03 to 2005/06 were India, Australia, South Africa, Pakistan, France, Nigeria, Italy, New Zealand, Germany, and Bangladesh (DWP, 2006). The top ten London boroughs of residence for all NINo registrations (i.e. including A8 nationals) were Brent (45,740), Newham (42,120), Ealing (40,890), Westminster (34,220), Wandsworth (32,860), Lambeth (31,660), Tower Hamlets (30,770), Haringey (29,940), Hounslow (29,480) and Southwark (28,770).

The CHAIN (Combined Homelessness and Information Network) database holds data on London's homeless population, including nationality and substance misuse needs. This data is available from the CHAIN research team, however a charge may be incurred depending on the request. The time and cost of this made obtaining this data within the context of this study prohibitive.

6.1.3 Entitlement

The services provided by DATs are subject to guidelines for the expenditure of public funds, these guidelines are in part provided by the Department of Health. For A8 and A2 nationals these state:

> *…visitors from these countries should not be charged for any treatment which becomes medically necessary during a temporary stay in the UK, other than normal charges that UK residents pay.*
>
> *Department of Health (2006, p.1)*

This excludes those who come to the UK in order to access treatment, however, guidelines do not say that a pre-existing condition cannot be treated and appear to place criteria for treatment on visitors' intent.

> *They do not cover situations where people come to the UK, without an explicit referral, in order to access treatment.*
>
> *Department of Health (2006, p.2)*

Homeless Link (website, 01/02/2007) have asked the Department of Health to clarify what this means to people from these new members of the EU and have the following guidelines on their website:

> *Any person living lawfully in the UK on a settled basis will be entitled to free primary medical services.*
>
> *Lawful residence in the UK rather than UK Nationality, payment of UK taxes and National Insurance contributions is the main qualifying criterion for receiving free GP treatment.*

The same rules apply whether someone is from an EEA country or non-EEA country.

Homeless Link (website, 01/02/2007)

They suggest that anyone residing in the UK can approach a local GP and ask for treatment, of course the GP has right of refusal as in all cases.

… detox services are available upon referral by a GP if the treatment is deemed to be clinically necessary.

(ibid)

It appears that Drug and Alcohol Services should be able to follow suit and provide treatments to A8 nationals if deemed clinically necessary. Such treatment appears to be limited to walk-in services and free access does not apply to in-patent care or registered out-patient clinics. However, these criteria are all based on visitor's rights. Where A8 migrants have been or are working in the UK there does not appear to be any valid reason for refusing admittance to health services.

Council Tax Benefit, Housing Benefit, Income Support and income-based Jobseeker's Allowance are available to those who have a *right to reside* and are *habitually resident* in the Common Travel Area (that is, the United Kingdom , the Republic of Ireland, the Isle of Man or the Channel Islands) (DWP website, 14/03/2007). Since accession, those arriving in the UK in the last 2 years must show that they have the right to reside and are habitually resident in the common travel area before they can obtain these benefits (ibid).

To confirm 'right to reside', EEA (European Economic Area) nationals must provide evidence of nationality and economic status, normally through the WRS (DWP website, 14/03/2007).

Habitual residence is likely to be awarded to EEA nationals who have been employed or self-employed in the UK or a relative of such a person, habitual residence must then be proven to the DWP decision maker, who will ask questions like these:

- *whether the applicant has worked in the UK*
- *how long the applicant has lived abroad*
- *why the applicant has come to the UK*
- *how the applicant plans to support themselves in the UK*
- *how long the applicant plans to stay in the UK*

(DWP website, 14/03/2007)

A person who has been in the UK for more than two years would not have to demonstrate a right to reside or be subject to the habitual residence test (Kennedy and Wilson, 2004). Right to reside is

awarded to those completing twelve months continued employment, the self-employed only have the right to reside while self-employed and if they cease to be self-employed they must also complete the twelve months registered work to obtain the 'right to reside' (ibid).

Where A8 migrants have been or are working in the UK there does not appear to be any valid reason for refusing admittance to health services. The following summary of a House of Commons Library Note is available from Migration Watch (website b, 06/03/2007):

> *Migrants to the UK from European Economic Area (EEA) countries who cannot take advantage of the EC law provisions may still be able to claim social security benefits. The Habitual Residence Test is applied to claimants of the principal means-tested benefits who have been resident in the UK for two years or less. It is a common law test – a question of fact on the balance of probabilities, to be determined by looking at all the circumstances in each case. The burden of proof lies on the Department of Work and Pensions (DWP) decision maker, that is to say that the presumption is in favour of the applicant.*
>
> *Migration Watch (website b, 06/03/2007)*

However, as long as someone is a 'worker', they may qualify for exemption from the Habitual Residence Test if they can satisfy the DWP decision maker that their employment is "genuine and effective" and is not on such a small scale as to be "marginal and ancillary" (Kennedy and Wilson, 2004). 'Worker' in EC law roughly means someone who is in the employment market (not self-employed or economically inactive), their work need not be full-time (Migration Watch website b, 06/03/2007). The transitional restrictions do place emphasis on a person's ability to demonstrate a 'right to reside', but, Migration Watch (website b, 06/03/2007) state that registration on the workers registration scheme makes workers:

> *…eligible for certain in-work benefits and social housing, whilst other benefits will become available when they have the right to reside [in the Common Travel Area] - after a 12-month [workers] registration period has been completed.*
>
> *Migration Watch (website b, 06/03/2007)*

During the initial 12-month period, if an A8 worker has a low income, Migration Watch (website b, 06/03/2007) suggests they may also be entitled to Housing Benefit and Council Tax Benefit. So in summary, social security is based on a person's ability to satisfy both the habitual residence and right to reside criteria. The Research Team did not locate any information that suggests healthcare entitlement above what is judged 'clinically necessary' should not be assessed in this way.

The Research Team were also unable to find any definitive source to clarify the entitlements of A8 nationals in the UK, however a reply to the UK Parliament from the European Commission says that:

The transitional arrangements set out in the Accession Treaty provide that current Member States may maintain restrictions on access to their labour markets by workers from new Member States under certain conditions for a maximum period of seven years. These restrictions only apply to access to the labour market, and not to access to social security benefits or entitlement to social advantages.

European Commission (website, 30/04/2004)

Furthermore, the European Commission notes that any restrictions must end in 2011, which indicates that restrictions to entitlement to health and social care will also end.

From 2011 onwards- seven years after accession - there will be complete freedom of movement for workers from new Member States.

European Commission (website, 30/04/2004)

Asylum seekers (with active claims or appeals) and refugees have no restrictions on medical care entitlements (Department of Health website, 06/03/2007).

6.2 Interviews: Findings Relating to Eastern European Migrants

6.2.1. Numbers and levels of newly-arrived populations in services

This borough feels very eastern European, very eastern European

Local Authority Policy Officer

This sense of growing numbers of European migrants was reflected in all boroughs visited. 17 respondents (40%) commented that the number of migrants from Eastern Europe was increasing. This was most evident amongst services for vulnerable homeless people, where the migrant service user group was estimated at 20-30% of the whole:

Last year one third of our homeless guests were homeless Poles

Night Shelter Worker

This anecdotal sense of service use reflects only partially research undertaken by individual centres and by Homeless Link. Both of these snapshots suggest that 15-16% of service users are from Eastern Europe, with the largest proportion originating in Poland.

In DATs and drug treatment services the picture emerging from this research proved slightly different. Repeatedly numbers attempting at access treatment were described as a “trickle” or a “few”:

we’re not seeing it at that level yet. But…I think it will start trickling [through] before too long

DIP Operational Manager

However when the opinions of workers in arrest referral were canvassed a sense of a growing trend emerged. Here numbers were described as "quite a few" and this is borne out by the figure that 10% of arrests within one central London police station are of A8 nationals.

This sense of an impending increase in demand for services was compounded by information from frontline homeless services that at the time of this research, migrants from Romania and Bulgaria were already presenting at services, although EU accession had occurred only two weeks before.

6.2.2. Information Recording, Sharing and Use

> *It's not coming up in the figures, but anecdotally people are saying it's happening in the services. We just haven't got our heads around capturing that data*
>
> *Information Officer*

In response to the potential increase in demand for services, interviewees in many DATs had sought to obtain information about numbers of potential service users and levels of need among new migrant groups within their borough. DATs first recourse was to NDTMS data and while this is gathered by all boroughs, many interviewees voiced frustrations with its limitations in providing the data which would answer their questions in this area. 50% of DAT staff interviewed voiced concerns that the NDTMS dataset was inadequate in this regard. It was highlighted that the categories are outdated – reflecting patterns of migration which are no longer current. Six respondents (38%) commented that the ONS census categories did not offer sufficient detail to enable satisfactory care planning for the individual or service planning for the organisation. Two information officers commented upon the fact that the NDTMS dataset is to change to include nationality data and one of these commented that the gathering of nationality is a simpler task than defining and gathering data about the more diffuse concept of ethnicity.

Interviewees at all levels of the process were concerned with this failure of transmission of information:

> *We do ask them to let us know if they have any new groups engaging. Especially ask them to monitor numbers of those failing to access on grounds of eligibility.*
>
> *Joint Commissioning Manager*

> *Need to guess what's out there and try to capture it*
>
> *Information Officer*

It's a terrible problem and we don't know what to do, but when you ask them for numbers they don't come back to you…system doesn't allow [them to gather] it

Information Officer

In seeking to supplement the data contained in NDTMS, DATs had a variety of strategies. Several DATs referred to the regular meetings which occur with services and requiring extra data gathering via Service Level Agreements. Two however commented upon the fact that the data gathered is not standardised. This leads to problems of mis-categorisation and difficulties in comparing information. A further three noted that any extra data places a burden on services:

Some difficulty with ethnicity monitoring lies with the NDTMS being the primary system, a lot of effort goes into collecting this information so it becomes difficult for services to operate a parallel system. Each additional field adds a reporting burden.

Data Manager

In two DATs interviewees highlighted Arrest Referral Workers as central to information gathering. However this process is not without limitations. Two staff highlighted the fact that the current DIR form does not allow staff to routinely gather the necessary information, nor are there prompts to the worker to request it – data gathering relied upon individual workers recalling agency imperatives in the interview setting. Furthermore it was recognised that tackling the wrong priorities at this stage can have negative consequences, alienating individuals from treatment:

Arrest Referral Workers take a lot of information from the police then go into the assessment because asking for information over and again undermines the assessment process.

Information Officer

Eight respondents in DATs (50%) commented on the need to collaborate with partners to refine data gathering. The partner most frequently mentioned was the police service (31%). Here the directness of questioning was seen as yielding information which while not fitting preset categories, had a subtlety which NDTMS lacked. Other partners mentioned as holding data were A&E departments, CHAIN database of homeless people in London and schools. The Local Education Authority was perceived as being conscientious in data gathering and therefore holding strong information about borough profiles. It was recognised that information sharing protocols must be robust in themselves and that these are subject to data protection legislation.

In some cases interviewees commented that the data gathering difficulties attendant upon this group are not unlike the problems faced generally: that individuals present to a variety of services and this leads to double-counting, that data is reliant upon self report, that clients as well as staff suffer 'survey

fatigue' and that some individuals do not wish to be monitored in this way. However the complexity of the issues relating to new populations are compounded by the fact that the population is unknown and that information gathering is begun from a basis of conjecture.

In meeting these challenges, interviewees highlighted the value of local needs assessments. Senior DAT staff in all boroughs were asked about the needs assessments they undertook. In some cases in depth needs assessments are planned or were in train. However some staff did note that current needs assessments are not as valuable as they might be:

> *Needs assessments get done, but do they then just sit on the shelf…Because 'this is interesting but it doesn't give us the evidence we need'…financial constraints or because of [the] philosophical clash between what the community wants and what the commissioners want the community to want*
>
> Community Engagement Officer

6.2.3 Substance Misuse among A8 nationals.

At this stage, firm data about levels of drug misuse among vulnerable migrants from Eastern Europe does not exist. However the research team were able to gather considerable anecdotal report from all levels of the treatment system.

From the first heavy alcohol use emerged as a significant factor for this community, with 27 (64%) interviewees commenting upon the prevalence of alcohol use. While alcohol use was clear among individuals in contact with homelessness services, there was much less evidence of drug use amongst these clients and there was considerable debate in interviews about the extent to which alcohol problems lead to drugs issues among vulnerable, homeless people. While one interviewee at a project for the homeless commented:

> *I wouldn't say its necessarily the case that alcohol use will move into class A drug use…I'm not convinced that…people who are heavy alcohol users move into Class A because…culturally it's very different*
>
> *Homeless Day Centre Worker*

An alternative view was voiced at another day centre where the perception was that alcohol use increased vulnerability because of its impact on judgement:

> *The first time people took drugs is when they were drunk*
>
> *Homeless Day Centre Worker*

Similarly there was little concordance as to whether individuals had drugs problems which predated their arrival in the UK, though a small number of interviewees (14%) indicated that they had formed

the impression that clients in contact with them had pre-existing problems. Certainly all the service users interviewed for this research, described substance misuse problems as having begun in their home country, though the range of substances did vary. Perhaps this issue is best encapsulated by the comment of one drug treatment worker:

> *You don't come here looking for work and just end up on heroin*
>
> *Treatment Service Staff*

A wide range of drugs were mentioned as being used by A8 nationals. Of these, the most frequently mentioned was heroin which was noted as a drug of choice by 40% of respondents. Crack use was mentioned by only a small number of interviewees (5%), however interviewees did note that information from the police might indicate a developing crack problem:

> *There's also been reports from the police that some of the crack houses or drug houses that they have been raiding have a large number of people who don't fit the normal i.e. they are A8 nationals*
>
> *Street Population Coordinator*

Although information about methamphetamine use generally is scanty, there was some mention of its impact on the Eastern European community, connected with popular culture:

> *Their culture in Eastern Europe is much more stimulant based*
>
> *There's less methamphetamine here… [so they] are trying heroin that is three times cheaper here than in Eastern Europe*
>
> *Arrest Referral Worker*

However other boroughs noted that migrants are influenced by drug use in their immediate area, with one interviewee stating that Polish migrants have been influenced in their choice of khat by the prevalence of that drug among the Somali community in that borough. The interplay of these issues of pre-existing substance misuse and contact with new substance misuse opportunities in London is shown in one case encountered by a Prison CARAT (Counselling Assessment Referral Advice Throughcare) Worker:

> *One prisoner was an ex-soldier in the Latvian army. After leaving he established a Heroin dependency at home in Latvia, but when he arrived in London he found that he was able to use both Heroin and Crack*
>
> *Prison Drug Service*

As noted later in this report, the restrictions on the availability of treatment services to Eastern European migrants mean that no firm indication can be given of the need for services. However interviews across London indicate that migrants from Eastern Europe are attempting to access treatment at all levels (needle exchange, arrest referral, prescribing, group counselling, DIP and prison-based schemes). One joint commissioning manager commented that the borough's DIP team is currently receiving two referrals each week and that the complexity of need observed in these clients match those of individuals in the Criminal Justice System who have a dependency issue. These needs appear to be complicated still further by the nature of the work undertaken by many migrants:

> *You have a situation where Russian men inject in their groin… because they are looking for cash-in-hand labour on construction sites…and they don't want track marks on their arms*
>
> *Treatment Service Staff*

In this case the drug treatment worker perceived a pressing need for education to counter such dangerous injecting practices.

Respondents in several settings commented upon the needs of women migrants. While 44% of migrants are female, only 10% of presentations at homeless services are by women (Homeless Link, 2006). Staff indicated that they felt this discrepancy was too large to be simply an anomaly. Staff questioned how vulnerable women without recourse to public funds survived and conjectured that in these circumstances vulnerable Eastern European women were drawn into the sex industry, with attendant vulnerability to drug use. This was borne out by staff in services who noted the vulnerability of women and described women as congregating together and being recruited for prostitution and by local custody reports (Hutson, 2006).

There was some indication among interviewees that treatment in some A8 accession countries carries a stigma. An example was given of a Latvian client who was unable to secure needle exchange or prescribing. The Arrest Referral worker concerned was told that any prescription must be declared to prospective employers etc. However another service user while commenting that treatment service were not of equal quality across Europe, said that he returned home for treatment. There was no indication in this research that individuals crossed Europe to seek treatment in a cynical manipulation of the system.

6.2.4 Eligibility, PCT response and the impact on service delivery

As can be seen from the desktop survey, guidance has been issued by central government concerning eligibility criteria for the treatment of A8 migrants. However the interpretation of this guidance varied dramatically between respondents and between boroughs. On one hand interviewees described

services offered to all with no restrictions, while on the other an arrest referral worker described a case where two individuals were in treatment, guidance emerged from the PCT and their involvement with services was ended.

Within most boroughs decision-making was undertaken on a pragmatic basis and clients in these boroughs were able to access not only harm reduction advice and needle exchange, but also prescribing services and open access counselling:

> *We may refer them for GP prescribing as it is primary care and tier two like needle exchanges. So open access services, plus anything from a GP. We wouldn't refer them onto anything structured, like a day programme.*
>
> *Joint Commissioning Manager*

In cases such as these the restrictions were viewed in the context of clinical decision-making:

> *We can't sanction that you use NHS money…on treating A8 nationals"…but… "Do whatever you think is clinically appropriate for that individual*
>
> *Joint Commissioning Manager*

> *the open access fits into tier 1/2 …where there isn't any hard and fast money being handed over. You can come for groupwork, you're not really taking someone else's place because they have got some spare capacity…in the spirit of trying to help the individual*
>
> *Police Officer*

Another DAT manager perceived the guidance as being further obscured by pressures to fulfil targets for overall numbers in treatment:

> *If it's free at the point of entry, who's going to argue with that?*
>
> *DAT Manager*

One Joint Commissioning Manager did highlight the discrepancies that can result from this flexibility:

> *PCT Interpretation of government guidelines varies, practice varies too….Detox entitlement is varied, as community detox is available. Some get it and others don't, we are trying to be more consistent with it, but there is not yet a locally agreed definition it's a bit ad hoc, all services [are] being pragmatic. But consensus is needed.*
>
> *Joint Commissioning Manager*

Residential rehabilitation was not available to residents of any borough owing to restrictions on Community Care funding however, in one borough inpatient detox was available provided this was not funded by the local authority.

Differences in practice are perhaps most clearly seen when refracted through the lens of the DIP process. One Joint Commissioner described a situation where individuals were referred to DIP at the rate of two per week and this principle held true for five of the boroughs involved in the research project however in two boroughs, migrants are denied access to provision. There was some sympathy expressed for a situation which drives this policy in a context of finite resources:

> *Resources are so tight – what does the DIP manager do. Let those clients into treatment and then a [local borough] client doesn't get in? That is a conundrum.*
>
> *Information Officer*

However the consequences for individuals are significant. Denied access to 'restrictions on bail' can lead to remands in custody. Interviewees were alive to this and perceived it as counter to the thrust of the programme:

> *Restrictions on bail is a large issue for us…We are meeting them, having a chat with them and they are interested at that stage. It seems bizarre, given all the strains on the prison system…that they are interested in treatment, more than happy to go on the restrictions on bail scheme; they can see the benefits of it, we can see the benefits of it…but we can't offer them.*
>
> *DIP Operations Manager*

> *'You've come to me…you're interested in treatment. I can't offer you treatment'. It seems to be going…against the ethos of the programme*
>
> *DIP Operations Manager*

> *The court process says a person is…suitable to have drug treatment. They are offending we therefore want to give them drug treatment to divert them out of their offending behaviour…and at the moment our hands are tied on that one*
>
> *Police Officer*

In one borough negotiations were in train to devise alternative local bail arrangements in some cases, however in another, information about levels of service provision had led to a reduction in referrals to arrest referral workers. Once in a custodial setting, individuals were in receipt of treatment. On release this came to an end as funding returned to local government.

Refusing services to individuals did appear to have an impact on staff who voiced frustration and concern at the level of unmet need:

> *Those clients are the ones who are so desperate for help.*
>
> *Arrest Referral Worker*

We would love to offer some of these guys detox who genuinely are sick of feeling sick every day

Deputy Rough Sleepers Manager

And the consequences of this approach:

This response isn't making the need go away

Arrest Referral Worker

Despite any restrictions interviewees did perceive a need for services for vulnerable migrants. Several interviewees commented upon individuals' desire to engage:

Outreach work indicates a growing need from A8 nationals

DAAT Manager

And this was echoed by the facilitator of a Narcotics Anonymous group:

They are a very small group, there are many more who need help.

Polish NA priest/facilitator

Except in specific areas, where A8 nationals appear to be settling in larger numbers there was no sense among respondents that this demand for services could not be met:

Not that much heroin use…just being absorbed

Deputy Rough Sleepers Manager

There has not been a swamping of any services.

DAAT Data Manager

Here as elsewhere it was evident that individuals perceived themselves as managing a scarce resource:

When they do have access it may have capacity issues depending on the level of need.

Joint Commissioning Manager

Even where demand was perceived as highest interviewees from homeless services made tentative comments indicating that need had reached a plateau. However this was countered by a rough sleepers manager who reported significant numbers of arrests of A8 nationals at a local police station and by interviewees who had noted the influx of individuals from A2 nations.

In responding to that need some interviewees did comment upon the similarities between British culture and the mores of Eastern Europe, and this was perceived particularly by organisations with a

Christian or Catholic ethos, some respondents did comment that further work was required before service providers could be confident that their treatment was culturally appropriate:

> *This is the live issue locally because it is visible and people are presenting at services and we can't always meet their needs in a way we would like*
>
> *Joint Commissioning Manager*

In developing creative and culturally competent services, lack of access to public funds was again prohibitive:

> *No recourse to public funds is the biggest problem for A8 nationals trying to access treatment. For example, the DAAT wanted to provide a holistic response to trafficked sex workers, however no help could be provided.*
>
> *DAAT Data Manager*

A further impediment was the informal nature of the tier 2 services for which migrants are universally eligible. One worker commented that while the service has a duty to provide interpreters, this is not feasible in the context of needle exchange and this was echoed by staff within both groupwork and day centre programmes:

> *They have access to the…language shop that is good for one to one sessions but there are difficulties with group work.*
>
> *Criminal Justice Intervention Team Staff*

Despite these difficulties some respondents reported success in penetrating and engaging migrant communities through GP prescribing or low threshold prescribing services:

> *Low threshold prescribing service, no appointment, quick prescription for methadone…has attracted many new communities we were not aware of even the [street outreach] team haven't. We had one eastern European guy come in, then he brought a small group of friends the next day.*
>
> *Joint Commissioning Manager*

Similarly there was some evidence to indicate that services were attempting to make good use of expertise at their disposal via secondments or the translation of leaflets into new languages in order to identify and engage with treatment naïve communities.

One interviewee commented forcefully on the benefits of engaging new migrants in existing services:

> *I know personally… two A8 people …really chaotic drug users who were probably in and out of [the] custody suite 4 or 5 times a month…and were stabilised on methadone. Stopped*

committing the burglaries they were committing to feed their habit. They were given B&B accommodation just to stabilise them both of the ended up working…money coming in. B&B packed up…and they ended up in a squat…but they go to work…and are receiving a script. As far as I'm concerned they might be …working illegally and living in a squat…the fact that they are getting scripted [means] they are not committing burglaries…From what was…4 or 5 times a month in our custody suite in the last 6 months nothing at all

Police Officer

6.2.5. Related Needs of Eastern European Migrants

This policy has been hugely successful for 99% or more than 99.9% it's just a small proportion…and a small proportion of that…that are in a really bad way that are entrenched

Deputy Rough Sleepers Manager

A number of interviewees were at pains to point out that this group of vulnerable migrants represents only a tiny percentage of those who have migrated to The UK following the expansion of the EU in 2004. As can be seen from the desktop survey, the majority are registered, economically active and integrating within the wider community:

This must be set against the contribution which a great many migrants make to the economy and the life of the country. That's a given. To ignore it would be hypocritical and racist

Homeless Day Centre Worker

A second group emerged from these findings. These individuals appear to be characterised by a lack of preparedness for life in a new country and the high levels of competition for work within the UK marketplace:

The common denominator with that group is that they have come pretty unprepared

Homeless Day Centre Worker

With regard to this group the main need was seen overwhelmingly as housing, with 46% (16) of respondents commenting upon housing and homelessness as being a contributor to individuals developing other difficulties. Five respondents (14%) commented that information about British systems and bureaucracy would offer considerable support to this group:

Sometimes for people it is nothing other than they are new to the country and they need help to navigate their way around the system and they are quite able to do so with a kind of signposting

Joint Commissioning Manager

In addition the need for support into employment was perceived as a key need by 23% of interviewees (8 respondents):

> *They are economic migrants so they just need some help getting into work*
>
> *Deputy Rough Sleepers Manager*

The nature of the work undertaken by migrants was seen as an additional aspect of instability. Those working on gangs, if not selected for work were perceived as vulnerable to street drinking:

> *They have problems with housing, an article in the Gazette recently showed Polish people are sleeping in parks, drinking cans of beer in the morning and being picked up by builders for work in the mornings.*
>
> *Drug Service Staff*

This was borne out by the comments of one service user who said that if he is working he doesn't drink, but when he has no work he drinks and if he is drunk he can't work.

This group was seen as posing challenges for some services that were approached for support by individuals who are not vulnerable but were seeking to maximise their income:

> *A lot of quite fit, healthy, working men using services mainly as a cost cutting method and they're not necessarily vulnerable individuals, although there are one or two vulnerable individuals using the services as well*
>
> *Alcohol Coordinator*

> *I was there a couple of mornings and there were people in the queue…for breakfast who were…banging on the door saying come on let us in, we've got to get to work*
>
> *Homeless Day Centre Worker*

During the course of this research, centres were in the process of developing protocols to identify those who are in genuine need.

In the main individuals in this group were perceived as finding routes into employment and stability and the picture of homelessness here was seen as transient:

> *Mostly people come in…they may sleep rough for a while, but they …get into the work scene.*
>
> *Communities Coordinator*

However several interviewees sounded a note of caution that if these needs were not met there is a risk of street homeless migrants developing more complex needs, in particular being attracted into drug misuse as a result of their housing vulnerability:

Time spent on the streets is the worst thing anyone can do

Homeless Link

Furthermore research (Homeless Link, 2006) indicates that 50% of homeless A8 nationals have been in this country for more than six months suggesting that if work plans fail migrants do not immediately return home.

This research project identified another, much smaller group: those individuals with complex and entrenched difficulties, requiring significant intervention. As with many other drug users this group was identified as having complex and pre-existing problems predating their migration (11%). However in this group the difficulties faced were compounded by the process of migration and integration itself:

Drug and alcohol issue is normally a symptom of the underlying issue of what it is like to move from one place to another

Drug treatment Service Staff

One interviewee stressed the fact that the Polish community in London is not of itself a homogenous group:

With the Polish community, from what we understood there are different, community groups within this community. So there are the ones who come to England before or slightly after the Second World War. They are usually considered to be the upper-class of the Polish population. Then, we have the ones arriving before '89, and then the ones after 2004 and I think the biggest conflict is between the ones arriving before '89, not accepting the ones after 2004, so there is a fracture within the community as such

Communities Coordinator

Moreover the nature of British life was seen as very different from that in Eastern Europe, leading to isolation and depression:

People feel isolated, they work, sit home alone, then drink to enjoy and liven up dullness. In Poland for example, you come home from school or work, you have friends, family it's different. People who care about you, you can go to. Here, no, they have no one. Here, there is a huge need for a community centre or something to bring people together.

Polish Voluntary Sector Worker

However while treatment staff posited reasons why migrants might be drawn into a drug using lifestyle, firm conclusions were impeded by language difficulties. These were highlighted by 16

interviewees (46%) and the need for more in depth needs assessment to refine perception was referred to by 6 interviewees (17%):

> *When something new comes up as an emerging issue…how do you respond to it…If it's A8 nationals with heroin problems we can deal with the heroin problems and as we work with them… get other agencies that do care management, that do other types of support services…but [if it's other needs] it's quite difficult to know how to respond to it*
>
> *Joint Commissioning Manager*

6.2.6. Towards Solutions

Despite the frustrations faced, individuals at all levels were engaged in finding solutions to the issues presented by this new group. Interviewees were asked specifically about the ways in which services might develop to find appropriate and creative solutions to these new challenges. Some were already possible within current working practices; improved monitoring and information gathering via self definition has been mentioned above. One Joint Commissioning manager posited the idea that other types of data, not routinely collected – for example the amounts treatment services spend on interpreters – might offer much earlier indications of changes in the demography of a borough.

For some interviewees small alterations to existing frameworks for practice were seen as potentially beneficial. Improving prescribing for this group was mentioned by six respondents (17%):

> *An individual's life can be stabilised with a one off bit of treatment.*
>
> *Police Officer*

In some cases treatment of this type was seen as urgent:

> *If someone is engaging in high-risk injecting then prescribing is an emergency*
>
> *Arrest Referral Worker*

And while in one borough GP prescribing was described as time limited other respondents viewed this intervention as both positive and cost effective. In one borough good use had been made of a low threshold prescribing service (offering rapid access to methadone prescription:

> *Low threshold prescribing has been successful, so to expand it seems to be a way of pulling these people in. One guy then brought his four mates.*
>
> *Joint Commissioning Manager*

One drug treatment worker did question the value of prescribing alone, viewing connections with therapeutic intervention as crucial, however ongoing therapeutic intervention linked once again to issues of language and staffing. Using ESOL classes and other language to improve access to services

was highlighted by 17% of respondents. And poor access to information, education and systems was seen as a factor by nine interviewees (26%):

> *any support from any service…really desperate for something…someone to guide them through a minefield*
>
> *Arrest Referral Worker*

Eight respondents (23%) went beyond this however and in their responses explored mechanisms for engaging new communities, with a further interviewee commenting specifically on the need to make connections with faith groups (26% total). While offering grants to build capacity within new communities was mentioned by two respondents there was recognition of the fact that such engagement does not always have a financial basis:

> *Eastern European groups need support to develop…A community must organise itself, but it requires support and resourcing. …Serious community development is needed with these communities to help them. Ad hoc self-organisation is occurring, but support is needed, not necessarily financial.*
>
> *Refugee Worker*

> *It's more for agencies to reach out than communities to act.*
>
> *Treatment Service Staff*

For eight respondents improving outreach and the employment of staff from minority groups was a component of community engagement. Two Interviewees mentioned using seconded staff to add cultural competence; however another interviewee said that the numbers of service users from A8 countries was not sufficient to require a full time employee. Four further comments related to the training need among existing staff and the extent to which this can be met by recruitment from within minority groups.

Two respondents commented that while drugs services are orientated in large part around a crime and disorder agenda, the needs of new communities may not fit this agenda and a further nine referred to the need to work in partnership in order to resolve problems. Two further interviewees mentioned the importance of forging links with alcohol services for this group:

> *Crime and disorder partnership is the wrong focus because this is nothing to do with crime or disorder. It's about wider social care*
>
> *Joint Commissioning Manager*

Seven interviewees (20%) mentioned the forging of partnerships at a strategic level as key in solving problems in the longer term. Most perceived this as developing pan-London strategies, however for

some solutions occurred at a national level and one respondent described opportunities for using British expertise in the drugs field to develop solutions across Europe.

For four interviewees, an extension of the national 'Reconnections' programme (DCLG website 07/03/2007) was viewed as being viable. Two mentioned the work of the Barka Foundation (McLaughlin, 2006) (a Polish charity which has offered support to vulnerable Poles in this country) and a further two described extending the process whereby homelessness charities engage with individuals to encourage them to return to their area of origin and resolve problems where they have greatest social capital:

> *what you needed to do was to properly engage with people, develop a relationship and then through that relationship say 'look, this is not where you are best served…this is not where you have the greatest social capital…we need to link you back to your area*
>
> *Homeless Day Centre Worker*

Many of the respondents interviewed were keenly aware of budget restrictions and eight (23%) commented upon mechanisms for funding any developments in services. Several saw themselves as gatekeepers of a scarce resource. One interviewee felt that at the outset hypothecating money is of importance:

> *There is a need for ring fenced money if any is going to be spent on this group.*
>
> *Council Policy Officer*

However four interviewees viewed any spending as revenue neutral, with savings being made in other areas (A&E presentations and police service being specifically mentioned). One interviewee referred to the 'Invest to Save' project report prepared by the City of Westminster (City of Westminster, undated). In developing services interviewees were aware of the risk of creating a 'magnet' drawing new need into an area. Four interviewees commented specifically upon this with one commenting on the undesired consequences for all concerned:

> *The consequence would be an influx of individuals who are struggling in their own country and want to travel for services. They would inevitably be cut off and then people would be coming for services which no longer exist*
>
> *Homeless Day Centre Worker*

Interviewees were keen to develop flexible and local solutions to emerging challenges. Some felt that doing so created tensions with the central monitoring of services. In some cases this was presented as burdensome for organisations required to operate within an evidence-based framework:

There is always a reporting burden when trying to record more information; amending the NDTMS is preferable to additional local criteria, which would double the required monitoring and performance management.

DAAT Data Manager

Another respondent felt that creativity in both information gathering and planning was stifled by a centralised approach:

The treatment plan is a national pro forma you have to fill in and it's not that useful a document locally. [It] reports back on KPIs – waiting times and numbers in treatment…All my chief exec. is interested in is those two – if we're not hitting that there are implications

Joint Commissioning Manager

How do we empower our organisations to be enabled to say 'this is an issue for us, we a starting to record this for ourselves'…rather than systems feeding the beast of the NTA

Joint Commissioning Manager

A tension was seen as existing between mainstream and community based solutions:

The osmotic pressure is towards mainstreaming, is towards generic services… So there is this tension between generic and specialist community provision

Community Engagement Officer

One DAT manager commented on the possibility of resolving this by means of locally held budgets:

It's about having a flexible funding stream that you can use to meet the most newly identified needs rather than having to scrabble around for that

DAT Manager

Two interviewees commented upon the fact that the regulations on eligibility for services will change in 2011 as the restrictions on access to health care fall away:

One of the strange things about this is that …in 2011 the rules around benefits have to be regulated across the European Union anyway. So you won't be able to have these barriers

Homeless Link

In some respects this change in eligibility was seen as a resolution of the problem:

This is an interim arrangement from a policy point of view it will resolve itself in 2011

Homeless Day Centre Worker

6.3. Interviews: Findings Relating to Asylum Seekers and Refugees

6.3.1. Numbers and levels of newly-arrived populations in services

The responses of interviewees varied when discussing the numbers of asylum seekers and refugees in the boroughs visited. Five interviewees commented that the demography of the treatment population matches that mapped by the last census in 2001, however a further three individuals commented that the treatment population is not in line with the overall demography of the borough. There was some recognition (commented upon by 6 respondents) that borough populations have changed since that time:

> *There is an increasing BME population in the borough, with various refugee and migrant groups*
>
> Local Authority Diversity Policy Officer

And in some cases changed dramatically – Barking and Dagenham for example was reported as shifting from a 10% minority population to a current level of 23%. Moreover changes are amplified in some sections of the population and in some cases boroughs were reported as having larger minority youth populations. Three DATs in this study mentioned the existence of large Somali communities in the borough:

> *Large immigrant populations are common in the borough. Initially this was with South Asian… then the Somali community increased about one and a half years ago*
>
> *DAAT Data Manager*

However a refugee forum in one of these boroughs described the local Somali population as only the third largest new minority group in the area. When asked about the discrepancy the staff gave this explanation:

> *It takes five, six, seven years maybe from when the conflict is at its height to when communities are settled enough to set up community organisations…it then takes four or five years for those community organisations to develop enough for anybody to know what they're doing*
>
> *It takes maybe 10 years before local authority start to recognise that they have got a big community*
>
> *There are about 15 Somali organisations in [the borough], and it's only really in the last two or three years that they … have started being heard*
>
> *Refugee Worker*

Such changes were described as being extremely difficult to map accurately.

> *There aren't statistics, they don't exist*

Refugee Worker

While the Home Office gives boroughs figures relating to the number of asylum seekers dispersed to that area, once an individual's application is granted there is no more requirement to make a declaration of one's whereabouts than applies to any other citizen. These population movements were perceived as having an impact upon London:

> *once people get their status, they are moving to London from wherever they've been dispersed to*
>
> *Refugee Worker*

This then impacts upon particular areas of London to which individuals migrate for work – the Thames gateway and Olympic site being specifically mentioned by respondents to this research.

There are in addition numbers of undocumented migrants whose location is completely unknown. Some treatment services did comment that they believed that the borough hosted unmet need

> *Changes in the ethnicity profile are relatively new to the borough, while the profile of the borough is changing, the treatment population isn't.*
>
> *Joint Commissioning Manager*

Though the complexity of the issue is hinted at by staff in one DAT who commented that a recent needs assessment had revealed that the local Somali community was in fact almost twice the size recorded in previous figures. However the needs assessments undertaken by one borough did not appear to be able to inform decision-making in other boroughs; ownership of the material being perceived as of primary importance in order to provide leverage for accessing funding:

> *I can't believe for a second that the needs of [this borough's] Somalis [are] different from [that boroughs]… but [we] need ownership.*
>
> *Joint Commissioning Manager*

6.3.2. Information Recording, Sharing and Use

> The census categories do not satisfactorily represent the diverse range of cultures in the borough
>
> Joint Commissioning Manager

Mechanisms for measuring demography – both the census and the NDTMS categories - were described as inadequate:

We have a list of community groups that identify themselves in terms of faith or ethnicity of approx 150 so many different cultures are present. We prefer to talk about trends in treatment because knowledge is limited on more specific needs within these communities.

Joint Commissioning Manager

Interviewees commented that it is the tendency of datasets to generalise in a way which does not assist services in teasing out the complex dynamics of ethnicity:

Needs in the Somali community are a world away from needs in the Francophone central African community and the way we collect data…in no way reflects that

Community Engagement Officer

Equally it was seen that there is scope for data to be misinterpreted:

The DIP uses a more detailed form and are then put onto the Home Office one by an admin member of staff. So an Indian British could be put into Indian or British.

DIP Data Manager

There is a level of inaccuracy – partly about what they tell you and partly about how that's recorded

DAT Information Manager

Two interviewees commented that even if gathered information was not necessarily illuminating:

Emerging trends of new populations accessing services may not indicate new instances of usage.

DAT Data Manager

Some DATs described treatment services as attempting to gather other data but with little consistency

There are some additional data in services, but this is not comparable as they are not uniform… the spreadsheet from our prescribing services has birthplace.

Joint Commissioning Manager

Indeed there was some questioning by interviewees as to whether communities are so diffuse and change so dynamic that absolute accuracy is simply not possible. Nevertheless one interviewee from the race equalities council commented forcefully on the requirement to develop and constantly review monitoring tools to develop data gathering mechanisms which reflect communities rather than agency priorities:

People define communities in ways which are more convenient to organisations than to communities

Refugee Worker

Some respondents did indicate that soft information can be used as a guide; for example suggesting that the number and size of asylum seeker communities in a borough can be used to make an assessment of the potential refugee population. One respondent commented that demand for ESOL is also an indicator:

> *We are becoming a real multi ethnic borough. This includes Africans, Somalis, eastern Europeans even before accession. [The borough] is seeing increases more oriented to EU and Russian communities, [and] has … African communities from the west, east, central, horn, Somalia and very few Ethiopians. We know this because we provide English lessons for foreign speakers*
>
> *Refugee Network Staff*

However it was recognised that the gathering and sharing of information might in itself be threatening to some service users:

> *For refugees, some worried that information sharing – they will engage at drop-in, but won't go any further*
>
> *DIP Operational Manager*

Moreover some interviewees commented upon the assessment skills of arrest referral workers in gathering information, despite any shortcomings in its use:

> *drugs worker not only looking at those standard demographics and levels of drug use but they are going to look at physical and mental health and what the client expects to get out of treatment…if you are a good assessor you would be trying to drag those things out and it's very difficult to translate that kind of information from an assessment form and from the drug workers head onto a database that can be analysed*
>
> *DAT Information Manager*

Four interviewees commented upon the importance of needs assessments in assisting DATs to understand and respond to emerging communities and in justifying expenditure:

> *We are commissioning some research with an aim of in depth qualitative analysis of the needs of the community*
>
> *Joint Commissioning Manager*

6.3.3. Substance Misuse Needs and Treatment Response.

The drug mentioned most frequently by interviewees in this study as being used by members of new migrant communities was khat. This drug was mentioned by 10 interviewees (29%) and a strong association between khat use and the Somali community was reported:

> *There is some Khat use in Somali community*
>
> *Joint Commissioning Manager*

> *Class A drug use in the Somali community pretty much non-existent. But khat use is endemic running at about 80%.*
>
> *DIP Operational Manager*

Interviewees voiced the view that what had been a drug of social use in Somalia had been changed, by changed circumstances and that use was now problematic:

> *Khat use might be social in Somalia, but here the psychological impact of war, disappointment etc may end up in mental health issues.*
>
> *Treatment Service Staff*

The social – if not the criminal - consequences of khat use being highlighted:

> *When it is chewed all night it breaks the family structure. A man killed his wife recently after heavily chewing Khat; the community are speaking up now, particularly women as it affects them most*
>
> *Treatment Service Staff*

> *Khat is increasingly used by young people, it is easier to access than smoking, even school children use it. It is accepted for teenagers becoming 'men' to use it.*
>
> *Treatment Service Staff*

There was compelling debate about the extent to which addressing the use of this drug and its concomitant problems was the responsibility of DATs:

> *Khat use not illegal, but has severe negative impact on the lives of many users and their families. Do we do nothing about it or do we do something about it and about the wider health impact…Do we not do something about this? Of course we do*
>
> *DAT Manager*

> *It's been put to us that we should be doing something about khat. But in terms of our agenda around heroin/crack it's not on the agenda and actually the problems that are coming from it are very different – while it has an impact on individuals and families…I don't doubt that there*

is a need there …providing structured drug treatment for people who are chewing khat in response to feelings of isolation and being a minority within our community…having post traumatic stress disorder, having mental health issues. I can see the need. The issue then is when you are told that the only solution to that need is providing drug treatment…and making those people come off that drug…instead of going right back to the beginning and thinking systematically about how we support any emerging community, any settling community in our borough

Joint Commissioning Manager

One treatment service working under the aegis of the DAT was engaged in work in this area:

[This organisation] is educating about careful use of Khat, they released a leaflet in English in Somali.

Treatment Service Staff

In another area that role had been taken over by the Community Mental Health Team.

Khat use in the Somali community is being tackled by the set-up of specific clinics in the CMHT

Treatment Service Staff

The other drug mentioned by respondents as being chosen by minority groups influenced by drugs prevalent in the home community was opium which was described by one treatment serviced as being the drug of choice of the Iraqi community. Here however the emerged a sense that individuals make a transition into other drugs that is influenced less by the other drug users around them than by drug availability:

[Opium] dries up…so if you are not accessing the opium then heroin is your next thing and then its crack. Once you move off opium and onto heroin there's no going back. You can't get value for money

Treatment Service Staff

There was a strong sense among these respondents that young people are particularly at risk. The vulnerability of this group was mentioned in particular by 5 respondents (14%):

a lot of pressure on young people from refugee backgrounds to…'be' from the country they are in

Refugee Worker

This pressure was seen as being compounded by the fact that unaccompanied minors cannot benefit from parental advice and stability:

No one to give sound advice… [Young people] could go into all sorts of things

Refugee Outreach Worker

While for refugees there are no restrictions upon interventions and access to treatment is equivalent to any other citizen, it was noted that this is not the case for populations which are hidden – whether because their asylum application has been rejected or because none has been made:

> *Some clients are here without status can have assessment and reduction help and self detox but they can't be referred on anywhere until they have the right to remain, we will work with them but the health service will only give A&E*
>
> *Treatment Service Staff*

> *Once your asylum application fails you're in difficulty.*
>
> *Refugee Network Staff*

This situation was observed as being compounded by the fact that some asylum seekers are distrustful of government based services, while others fear that the admission of a drug problem will adversely affect their application:

> *Fear drives exclusion from everything*
>
> *Race Equalities Policy Officer*

In responding to observed substance misuse needs among minority groups DATs had developed a range of strategies. Some described themselves as being very active in engaging communities and developing particular services to forge earlier connections:

> *When we have community meetings here we sometimes get four or five coming, but if you go to a religious fair or event and take a stool and let people know what you offer it can be very effective. We are going to see faith leaders with the police next month.*
>
> *Treatment Service Staff*

> *There is an ethnic minority group that focus on drugs, including carer's support, education and community engagement in [the borough].*
>
> *DAT Data Manager*

However issues of language were noted by (11%) contributors to the research, and there was awareness that this was a persistent feature of each individual's treatment journey:

> *Issues of language follow all non-English speakers right through the system*
>
> *Treatment Service Staff*

Four (11%) interviewees commented upon the stigma which can exist in some communities about drug misuse and which complicates the situation for individuals accessing treatment:

> *Barriers for accessing services for Muslim community [are] considerable*
>
> *Community Engagement Officer*

Other respondents commented upon the fact that communities themselves are very small and that fear of exposure drives individuals to attempt to seek treatment outside their immediate area. In these circumstances the consequences of exposure were described as being beyond repair:

> *because [the] only people they have to turn to for all their needs…are members of their own community and those members – just as in any community – tend to be…critical about drug use… [it's a] handful of people, but they are very excluded people…excluded from their own community as well is excluded - simply because of being asylum seekers or refugees – from the community at large and on top of that the exclusion any drug user would face from certain services*
>
> *Refugee Worker*

Some respondents expressed uncertainty as to how to act for the best:

> *You are less likely to outside your community to seek treatment, and if all… drug services are run by Somali people that causes a barrier, but on the other hand the old argument with the Bangladeshi community is that… you were more likely to go outside you community if you really wanted help as there was a distrust of the level of confidentiality and stigma you would suffer if you went to Asian specific services*
>
> *DAT Manager*

While for others solutions had been discovered by a mixture of creativity and serendipity:

> *There's an English nurse works for [the] health team. She's married to an Iranian she lived in Iran for a while so sometimes she'll do us a favour…[Iranian clients] are very willing to engage with her…more so than somebody from their own community…you can get a Farsi speaking Dr or whatever. But she's a white English woman and speaks Farsi and it's far easier. You get a lot more out of it*
>
> Treatment Service Staff

The complexity of community response was overlaid still further by comments from one refugee community agency which drew attention to the fact that some communities have experience of drugs having been used as a weapon of war:

> *Those countries where there has been a lot of drug use associated to conflict – take Sierra Leone, for example, Liberia particularly…It's inconceivable that those communities are not aware of the issues related to drug misuse, because it's completely been part of the conflict there*
>
> *Refugee Worker*

6.3.4. Related Needs of Asylum Seekers and Refugees

Respondents from many services spoke about the fact that drugs problems are not isolated, but are nested within other social and personal problems. These included the simple resolution of immediate discomfort:

> *It is the illegals that often turn to alcohol and heroin to get through the night,*
>
> *Treatment Service Staff*

Housing and homelessness was mentioned by four (11%) interviewees while unemployment was noted by 5 (14%). Needs such as these are common issues to be resolved during the treatment process. However respondents also commented upon needs which are specific to new migrant groups. Four interviewees (11%) commented upon the experience of "migration trauma" with a further three making specific mention of mental health issues as precipitating drug misuse (20% total).

> *You are…magnifying vulnerability with migration…. Migration exacerbates people's problems by ten times.*
>
> *Treatment Service Staff*

However not all issues raised were seen as a product of migration. One DAT mentioned a situation in relation to Rwandan sex workers and the assumption that this must be a result of their current situation:

> *but in fact they were engaged in prostitution at home and see it as a way of accessing finance*
>
> *DAT Manager*

Particular issues were raised in relation to refugees and employment. Undocumented migrants were described as being in an invidious situation in relation to finance. Unable to claim any benefits they used other means including drug dealing to survive:

> *Some will deal. How do you expect them to pay the rent? Some people will deal…a little bit of cannabis…whatever. It's a way of living, surviving….not entitled to anything off the welfare system*
>
> *Refugee Health Worker*

However even for refugees whose status is resolved employment was not seen as a straightforward matter:

The people who will be escaping are prominent: trade unionists, politicians, academics, teachers and their children…we know that 90% … [of] refugees are in the country surrounding the countries they are fleeing…who are the ones that get here? They are the wealthiest ones

Refugee Worker

This was borne out by staff in one DAT whose needs assessment had revealed that while 48% of the local Somali community are educated to degree standard or above, 48% of the community is unemployed. Refugee workers did note that placing individuals back in employment is not as straightforward as simply converting qualifications – adults who have faced torture, perhaps because of their position experience many issues which inhibit their employment. Nevertheless it was expressed forcefully that the skills and talents of these communities are underutilised:

the potential of refugees in this country…to support and develop the country economically is enormous

Refugee Worker

It was noted that this is particularly the case with young people whose families have sheltered them from much of the conflict and who may have experienced less trauma as a result but whose potential is unrealised. Young people were also seen as being placed in risk situations in their housing and living circumstances:

For unaccompanied minors…they are mixed with young people leaving care from this country who are very…streetwise, and have a completely different background and many unaccompanied minors come here as children who have been quite privileged in their own countries who've had…relatively sheltered lives… They come here and they mix with…the complete opposite…put into shared accommodation with young care leavers who've got all sorts of other problems…

Refugee Worker

It was stated that this places an unnecessary burden upon already vulnerable people who are impelled to 'fit in' with their new situation.

Even where young people are supported by family there are pressures which place them at risk and respondents described the requirement to meet conflicting demands:

The conflicts that young people brought up here have with integrating with their peers but wanting to please their elders

Refugee Worker

As precipitating guilt and confusion which can lead to drug use.

6.3.5. Towards Solutions

Some respondents mentioned the translation of leaflets into minority languages. However one respondent did comment that

> *Cultures are traditionally informal – not literature based, so it's best to talk to people rather than give them handouts*
>
> *Refugee Outreach Worker*

The importance of facilitating conversations with and within families about drugs was noted as important by staff in both drugs and refugee services. It was indicated that where drugs information sessions with young people and their parents had taken place these had been well attended and fruitful.

The importance which interviewees placed upon actively engaging communities has been mentioned above. Indeed one respondent suggested that a requirement to engage with the community should be placed in Service Level Agreements. In addition the aspiration of developing an integrated service model was highlighted, whereby people from different communities would be able to access services together possibly at a single venue:

> *Because they are culturally sensitive and respond quickly. They advise on any problem rather than turn away and they have drop in services to improve access…empower people with knowledge and advice and they tell them where to go. They make calls for those with language difficulties.*
>
> *Treatment Service Staff*

However two respondents stressed that services must not make assumptions about need and offer generalised responses:

> *for new communities the needs will be different, the response should be different.*
>
> *Refugee Network Staff*

This notion that drug services might not be at the centre of any solution, but that such services are an important part of multi-agency solutions was a repeated motif from interviewees:

> *not hanging the problems on SM but recognising the SM problems*
>
> *DAT Manager*

Seven respondents (20%) commented upon multi agency collaboration as being a key feature of future working:

How do we use the same resources in an effective way which is flexible…to …diversity and the dynamics of that diversity…it will lead you and lead you and lead you to multi-agency cooperation

Race Equalities Policy Officer

In relation to refugees, this notion of working beyond existing boundaries was perceived as most important not only because in some boroughs communities are vanishingly small but also because community organisations do not perceive themselves as borough based:

Many organisations would say they don't have a [borough] remit. They see themselves as national or even European. Certainly we have organisations who see themselves as national.

Refugee Worker

Quite a big Zimbabwean community here. [There is] no Zimbabwean organisation, but there is a Zimbabwe organisation in North London, which represents Zimbabweans from [this borough] too

Refugee Worker

This was perceived as particularly important where drug use creates difficulties for individuals, but not ones which lead to crime:

Most of our money comes from the Home Office. With that we have to report to Crime and Disorder Reduction Partnership. The linkages aren't there with crime

Joint Commissioning Manager

Two JCMs mentioned the aspiration that all services could be delivered via the mainstream:

We don't need completely separate systems for different groups as long as we have the right supports & cultural competence.

Joint Commissioning Manager

However this was at odds with a view that some communities are not ready or able to access services in this way

It's a complete fantasy to think that the Somali community are going to start accessing our services any time in the next five years…because it's not just about turning up at a service, it's feeling comfortable enough to stay with the service"

Community Engagement Officer

Despite this view the recruitment of a representative staff was seen as a mechanism whereby staff training needs could be met a cultural competence continually refreshed until such time as mainstreaming of services was possible:

> *Use specialist stuff as a bridge into mainstreaming*
>
> *Community Engagement Officer*

In addition to this communities were identified as holding many solutions in their own hands, if only they could be empowered in collaborative work with services:

> *Working with refugee led youth groups. Supporting them to support each other would be a really good way to provide information and support around drug use. If community groups were properly resourced and properly linked in, which is a two-way thing…it's about statutory services wanting to work with them…[That] could maximise what is being done with relatively small amounts of money*
>
> *Refugee Worker*

7. DISCUSSION

In undertaking this research the team met, at every stage of the process, individuals who were keen to offer a sound and responsive service to new communities in their boroughs. Equally they described the impediments at structural, policy and practice levels which can prevent this. It is these impediments that this discussion seeks to address.

Information from the Desktop Survey shows the extent of migration by A8 nationals and the difficulties in mapping this movement accurately. Although the numbers of vulnerable migrants are extremely small in proportion to the whole, without firm data there remains a risk of escalating the extent of the need. This can be seen in the fact that homeless services, when interviewed, overestimated the numbers of service users as almost twice that indicated by other research (Homeless Link, 2006).

It is possible that this inflation of numbers is influenced by the sheer destitution and desperation observed by workers in these agencies. Staff repeatedly expressed frustration at their inability to make any inroads into the needs of individuals who approach them: benefits are denied them and roads into social housing are closed.

Workers in these services perceived a considerable problem with alcohol use among A8 nationals, but no corresponding drug problem. As yet numbers presenting at drug treatment agencies are not large and though some police stations report large numbers of arrests these represent arrests for all offences, not simply 'trigger offences'. Despite these small numbers, fears about swamping of services can be seen in the response of some boroughs to the influx of migrants. It is likely that this will continue to be the case while the funding of services to meet this particular need remains at a local level.

The numbers of Asylum Seekers across London and their distribution within boroughs are rather easier to map and this was shown within the Desktop survey. However these figures by no means offer a full picture and the demography of boroughs is changing in a way that DATs – as other statutory services – are not aware of. Not only are there unmeasured communities, but those communities lie beyond the reach of services for an estimated ten years. During that period individuals' needs go unmet and communities potentially develop a feeling of alienation and introspection. The research would suggest that it is vital to collaborate as early as possible in the engagement of community groups empowering them to find their voices in requesting culturally appropriate services.

The findings of this research project indicate that current information systems are unequal to assisting services in gathering proper information in managing and developing services in relation to all migrant groups. The 16 categories in the current NDTMS dataset limit the extent to which DATs can monitor existing minority populations. In relation to migrants from Eastern Europe these categories offer no data at all. Equally separate data gathering at a local level places an extra burden on frontline staff and, it is argued, could undermine the assessment process in its early stages. In addition to the inadequacies of the dataset, the research team observed that information systems broke down on occasion within the DAT. Information officers made efforts to collect data, including information concerning unmet need. However this demanded extra work from staff engaged in a separate task without offering proper prompts. Efforts of this type of data gathering yielded few consistent results.

It is worth noting that 'nationality' is only a small component of the wider concept of 'ethnicity' and that issues of faith and culture play an important part in this. Indeed nationhood itself is a complex matter – perhaps particularly so for fleeing migrants. Formal monitoring can play only a small part in collecting this information. In engaging clients and gathering data the skills of staff are paramount and should be supported by the most flexible tools available. The research team recommends development and regular review of a data gathering tool which combines quantitative data with the self-defined view of service users.

At a local level, opportunities exist for building partnerships to supplement this data – with police, local authorities and schools - providing a sound and consistent basis for estimates of need. It was pointed out that robust protocols are required and advice is perhaps best given on these from the centre. In addition it is noted that treatment services themselves hold other data and anecdotal evidence of changing demography. The research team would suggest that evidence such as this be given due consideration as an 'early warning' of changes in demand for services.

It would appear from this research that though boroughs have undertaken fuller assessments of community need these have only a local impact. Boroughs appeared to have limited faith in assessments undertaken elsewhere in London and where findings were in conflict with agency priorities some comments indicated that they were disregarded. The research team would suggest that in a context of limited resources needs assessments should be undertaken in a way which allows findings to inform decision-making across boroughs, allowing subsequent research to refine rather than repeat research. More in depth findings might allow a body of knowledge to grow up which can challenge agency priorities for some minority groups. The NTA is perhaps well placed to explore the devising of a formula for local research which would add to the robustness and transferability of resulting findings

This research appeared to identify three very broad groups of post 2004 A8 migrants. The first have settled successfully and make a significant contribution to the life and economy of the UK. A second group appears to be less well prepared for transition to a new country and with poor skills in English and little financial backup its members are vulnerable to exploitation. Unless housing and employment are presented quickly these individuals fall quickly into complete destitution as they have no recourse whatever to public funds. The needs of this group fell outside the scope of this research project, however interviews and the City of Westminster 'Invest to Save' pilot project would indicate that the input of initial employment and language support would enable members of this group to make a proper transition into the life of the nation and save a great deal of human suffering.

The researchers did observe a third group. While much smaller in number its members did appear to have much more entrenched problems. Staff in homelessness services recognised the difficulties they present as being analogous to those of other rough sleepers: health and mental health problems or drug and alcohol use. It would seem to be members of this group who are presenting at drugs services. The extent to which drug misuse was a pre-existing problem could not be ascertained firmly. Certainly patterns of use appear to be different in Eastern Europe with a stronger focus on stimulants and 'crystal meth'. It would seem that on arrival in this country alternative drugs present themselves and migrants are influenced by their new circumstances. As a consequence treatment services reported both crack and heroin use by A8 nationals.

It was noted with concern that some of the injecting practices of A8 nationals described by treatment services were extremely dangerous – for example injection into the groin. This was compounded by the fact that interpreters were not freely available at needle exchanges. As a consequence, although harm reduction services are ostensibly available to A8 nationals in all boroughs, it is unclear to what extent these have any impact. Urgent attention should be given to ways in harm reduction information can be disseminated to A8 migrants. Either via leaflets, web based media or through the recruitment of specialist staff. Neither should the issues surrounding crystal meth be overlooked: should this drug become prevalent in the UK, migrants may prove to be particularly vulnerable by virtue of patterns of use at home. Leaflets themselves are not sufficient however and some communities were described as being influenced less by written media and more by discussion. For these communities education and discussion sessions were described as having been well attended and collaboration with community groups in offering these is suggested.

Few women were among this group of A8 nationals. This reflects the numbers seen by homeless services. However the research by Homeless Link (2006) indicates that the total number of migrants is of equal gender. Assuming that levels of preparedness are the same between genders, this might

suggest that female migrants, if destitute are susceptible to exploitation within the sex industry with the drugs problems that prostitution can catalyse.

There is an apparent contrast between this and descriptions of prostitution among some African women, in that it was suggested that this second group had been active in prostitution prior to migration. The research team would suggest that it would be wrong to infer from this that the needs of this group are any less and that in both cases women are driven into the sex industry by adverse circumstances. Sexual exploitation is not a lifestyle choice. Services and policy makers should be alive to this and to the harms – both drug related and social – that are caused to women as a result.

Of course the three groups of A8 nationals outlined above are not completely discrete. Unemployment can lead to homelessness and street life leaves individuals at risk in many ways. In particular some respondents were concerned about the extent to which alcohol users are drawn into Class A drug use. For many the relative cheapness of heroin was an obvious trigger. However this group does appear to be relatively older than the majority of A8 migrants with established cultural mores and personal values. No firm evidence was gathered to suggest the extent to which alcohol can act as a 'gateway drug'. This information might be an important plank in assessing future need and is worthy of research in its own right.

The drug of choice among refugee groups has potential to be much wider, though in this research project only khat, marijuana and opium were mentioned. It would seem that the choice of drug is influenced at least in part by the prevalence of that drug in the home country. In the case of khat, this is not a drug mentioned within the drug strategy and this poses some difficulties for DATs in considering how best to proceed. However there was some evidence observed of initial drug use leading the use of drugs of greater harm (most particularly in the case of opium). Furthermore the importance of engaging new communities earlier has been pointed out above and an aspect of this is acknowledging the harms caused to communities by drugs according to the priorities set by those communities. The reassessment of the Drug Strategy in 2008 presents an ideal opportunity for this thinking to be considered at the highest strategic level (See also Mills et al., 2006).

In this research the vulnerability of young asylum seekers and refugees was identified as being of particular importance. These findings echo those of Patel et al. (2004). The vulnerability of sheltered young people entering British youth culture should not be underestimated and attention could perhaps be given to the proper placement of young asylum seekers, the empowering of young people to support one another and to the possibility of mentoring as a protective force. Action of this type

lies outside the remit of drug services, but the tripartite collaboration of community groups, children's services and drugs organisations might reap benefits.

In responding to the needs of A8 nationals boroughs had widely differing policies. While all offered emergency care and harm reduction advice access to other services was very limited in some boroughs. As can be seen from the Desktop Survey, guidance on eligibility is open to interpretation, however the research team did not find guidance which suggested that A8 migrants should be debarred from services automatically nor was there firm evidence that drug services are overwhelmed by new service users. Some boroughs were able to offer prescribing via GP/shared care arrangements and this together with open access and low threshold prescribing services appeared to be successful for this group. It is ironic that in the borough where regulations were most stringently interpreted GP prescribing is limited to 12 weeks for all. This option might be reviewed as a relatively cheap, stabilising treatment for A8 nationals.

Restricting access to services by definition results in the restriction of access to the Drug Interventions Programme. As a consequence, in some areas of London drug misusing A8 nationals are remanded in custody. The premise of the DIP is that expense on treatment is recouped nine-fold by savings in other areas. Of course any such savings occur at a national or at least pan-London level, while DIP funding remains a local expense. This creates a tension for local authorities. Nevertheless savings are not based on nationality and closing DIP to A8 migrants would seem to be economically foolhardy and against natural justice. It is recommended that this decision is reviewed.

However drug treatment was only one aspect of the needs of this migrant group. The majority of A8 nationals, experiencing a hiatus in their employment have only simple needs which could be swiftly and cheaply resolved. However the way in which work is organised, with 'foremen' selecting workers on a daily basis leads to an inherent instability in employment into which alcohol and drug use can rush. Moreover A8 nationals do appear to be undertaking work which is below their capacity. Both the Commission of the European Communities, (2006) (cited in Homeless Link, 2006) and Drew & Sriskandarajah (2007) comment on the fact that in general, the skills and qualifications of A8 nationals are higher than is common in the labour markets of the older EU members states (the EU15) into which they are entering. In fact, ten percent fewer migrating A8 nationals have low-level qualifications compared with those held by the population of the countries to which they have travelled. This is to some small extent borne out by the fact that one Polish volunteer contacted during this research was working in a shoe factory despite being a qualified Social Worker in Poland. The research team suggest that expertise of this type might be channelled by the better recruitment and training of volunteers

within drug treatment and that this would be beneficial for all concerned. There exists a thriving Polish press in London and this might be utilised most effectively.

In relation to Asylum Seekers and Refugees this situation would seem to be even more acute. Findings from this research seem to indicate that there exists a real misunderstanding about the qualities and potential of refugees and once again this might be developed within drug treatment services to offer practical support for individuals and empowerment for the whole community.

Although the stresses which lead individuals into drug misuse and the consequences of that use were recognised by treatment services as being similar to those among the existing treatment population it must be acknowledged that 'A8 nationals' are not an homogenous group. This research highlighted differences of experience between and among nations. For example the previous treatment experiences of a Latvian client were described as being much more restrictive and subject to moral opprobrium than those described by a Polish respondent. Equally the treatment needs of a Polish person who arrived in the UK prior to 2004 cannot be assumed to be the same as those of migrants arriving more recently. In developing and rolling out treatment services more research into these communities' needs is required.

In responding creatively to the needs of new communities, interviewees offered a range of solutions. There was considerable debate however, about the extent to which drugs services are central to those solutions or whether in fact drug misuse in new migrant communities is a product of the experience of migration and a symptom of the social exclusion that migrants face. It was questioned whether drugs services orientated increasingly around local Crime and Disorder Partnerships can offer appropriate services to communities where need is not expressed through crime.

Answering this question was not within the scope of this research and further research is needed. In discussion with policy makers in other sectors the research team did meet with considerable goodwill and expressions of the desire to negotiate responses at a strategic level. An example of this might be the desire of one borough's Race Equalities Council to work with the NTA as part of its borough regeneration programme to build solutions to drug misuse into all regenerated structures, policies and service provision. Further still, there may in fact be scope for Europe-wide partnerships.

More locally both commissioners and services providers voiced a strong desire for finding multi-agency or cross-borough solutions. This was seen as good practice. Moreover, in a context of finite resources collaboration between DATs, with community groups and amongst partner agencies offers the greatest synergy in service provision. Such collaboration might allow the recruitment of peripatetic workers or volunteers from minority communities by boroughs where the nucleus of that

community is not of sufficient size to allow DATs to take such steps alone. This might be particularly beneficial in relation to some migrant communities, where the community itself is vanishingly small and individuals respond best to staff who have language skills but are not from their own community (Mills et al., 2006). The workforce pool of staff with these composite skills and attributes is inevitably small. Moreover cross-borough working might support clients who feel most comfortable seeking treatment outside their own area.

In fact DATs, having already embraced a multi-agency, partnership model are well placed to participate with other sectors in developing culturally competent services orientated around social need, of which drug misuse is a component. Engaging in discussion might allow DATs to offer services to those communities whose drugs of choice are not highlighted in the Drug Strategy (Home Office, 2002), whose primary focus is upon heroin and crack cocaine.

For some A8 migrants it was felt the issues they face could best be resolved with the support of family and community. An extension of the now national 'Reconnections' scheme was proposed whereby A8 nationals would be engaged and encouraged to return home, only considering future migration once they were in a position of strength. Here again there is scope for the NTA to collaborate as a drugs agency within the wider social care agenda.

Many of the solutions proposed above involve, to a greater or lesser extent the devolution of power and money to a more local level. The pursuance of these solutions was seen as on occasion cutting across the targets and performance indicators of a centralised monitoring agency. This creates a tension – the requirement of evidence being offset against the desire for timely action. Overall however commissioners expressed themselves as being steeped in agency priorities and perceived themselves as gatekeepers of services to be trusted with flexibility in this regard. However this flow cannot be only one way. Services and DATs themselves must think actively about changing demography and use existing mechanisms (for example treatment planning) to feed the information gathered back to the centre in order to highlight need and galvanise change.

8. CASE STUDIES: CONTRIBUTIONS TO GOOD PRACTICE

This research had hoped to provide case studies of DATs good practice at addressing at tackling the substance misuse needs of new populations. However, such practice was found to be too new and too diffuse to derive full 'how to' examples of how to best meet the needs of London's newest migrant communities. One small case study is included. In addition some characteristics of early work with these communities have been derived from the findings and appear to constitute what so far is being interpreted as good practice across statutory and voluntary sectors.

Drug and Alcohol Action Programme (DAAP)

DAAP work primarily, but not exclusively, with Black and minority ethnic communities on education, community cohesion and service provision. The programme has formed strong links with all aspects of its local community, including religious and voluntary groups, schools, businesses and the police. They research and promote culturally appropriate services and aim to meet the diverse range of language needs present in the borough. Their focussed work to date has been with African, Caribbean, Somali and South Asian communities in Southall and other parts of Ealing. Southall has a long history of being an area where new communities settle.

DAAP has become aware of problems A8 (mostly Polish) migrants are facing in the area; this information has come from the police, media, and outreach work and through general experience of living in the borough. There have been reports of rough sleeping, heroin, khat and heavy alcohol misuse.

They now have Polish speaking volunteers to aid work with people from these communities. They have also been sure to produce literature in Polish as well as their normal range of African and Asian languages for their most recent 'Drinkwise' initiative.

DAAP will help or appropriately refer anyone who attempts to access their services; they aim to see people on the same day of an enquiry, make calls for those with language barriers, work with whole families and provide support during waiting periods in order to aid the retention of service users who may not be confident accessing the treatment system alone.

DAAP appear to have been able to provide a systematic framework for coping with the substance misuse needs of new communities. Their policy of addressing cultural and language needs has

provided them with a framework with which they can approach the needs of the new polish migrants in their area. They have done this, as the have done with other newly-arrived African and Asian groups, by drawing on the local knowledge and resources of the community. The emerging outcome in the Somali community appears to be an empowerment to speak out and address the issues on their own terms, for example there is an increasing volume in the voice of Somali women with concerns over the links between khat misuse to domestic violence and family breakdown.

Characteristics of Good Practice

- Low threshold prescribing services have been found to attract people from new communities. There were reports of methadone treatment resulting in successful interventions in cases were people were committing high volumes of acquisitive crime. However, the success of this response raised questions on how long prescriptions should last, which led to a feeling that this was not addressing the underlying causal problems of people's substance misuse.
- The secondment of a Polish Police Officer was viewed as a good method of communicating the enforcement of UK laws and norms. However, this had not yet occurred in any of the boroughs investigated in this research and there were not any reports of seconded addiction professionals.
- Drawing upon the skills and knowledge of local communities has proven successful for the charity and voluntary sector. Homeless and other voluntary sector groups have recruited both paid and voluntary employees to help engage with A8 migrants. Polish volunteers were reported in one drug service.
- Active community engagement was reported in many boroughs. This typically included linking in with existing networks and community groups to identify need. While this proved successful on many occasions, there were many reports of the lack of representative bodies for newly-arrived groups preventing engagement.

9. CONCLUSION

There are three main conclusions from this research. Firstly; that if policy makers and service deliverers are serious in offering drug treatment to new minority groups in London then they must be active in taking every opportunity to reach out to and engage with those communities. Doing so offers potential for improving cultural competence overall and for harnessing as yet untapped resources of intelligence and drive.

Secondly; is that collaboration at all levels – between DATs, amongst statutory services and with the voluntary sector offers opportunities for a synergy that is inescapably sensible.

Thirdly; there was some sense among respondents that the issues contained in this report are short lived and that changing eligibility will resolve matters. However this is not the case. London is dynamic in terms of its demography. The opening of the EU in 2004 has permanently changed its composition. It is incumbent upon policy makers and agencies to respond creatively to that change. To do otherwise is to ignore the plight of London's vulnerable population while seeking to benefit from the tax payments which migration brings:

> *In Poland I have nothing…I am lost now*
>
> *Zachariasz, service user*

10. RECOMMENDATIONS

10.1. Recommendations for Practice

10.1.1 Recommendations for Action by Partnerships

1. To encourage collaboration with other partners in data collection and feed the information gathered back to the NTA for strategic action (police service, A&E, schools) [see page 46]
2. To promote the collection of 'softer' data by treatment services (e.g. changes in translation budgets, numbers accessing ESOL classes) which complements that collected from individuals and offers early indications of changing need [see pages 69, 84]
3. To continue and develop monitoring of unmet need and to feed this information back to the NTA for strategic action [see page 83-84]
4. To empower treatment services in the development of local responses to emerging need [see page 91]
5. To capitalise on expertise in minority communities by advertising for staff/volunteers in the Eastern European press [see page 88]
6. Services at all levels to use the opportunity afforded by the transitional eligibility criteria to extend and diversify the workforce prior to 2011 [see pages 88, 89]
7. To investigate mechanisms by which A8 nationals might be allowed access to DIP [see page 88]
8. To develop opportunities for collaboration at a local level in the development of services to meet migrants needs in relation to drug misuse as an aspect of social exclusion [see page 90]

10.1.2 Recommendations for Action at a Strategic Level

9. To develop a flexible monitoring tool enabling the gathering of data relating to both ethnicity and nationality by means of a 'tick box'/predetermined dataset combined with the opportunity for self definition (see appendix one) [see pages 44, 67]
10. To promote systems for information sharing in relation to needs assessments [see page 84]
11. To review prescribing via GP/shared care arrangements to enable A8 nationals to take up this service [see page 87]
12. To encourage collaboration at a local level in the development of services to meet migrants needs in relation to drug misuse as an aspect of social exclusion [see page 90]
13. To develop Harm Reduction leaflets and web based resources in Eastern European languages and to support these wherever possible by training and information sessions [see page 85]
14. To work at a strategic level with housing and employment services to meet the simple needs of A8 migrants before they become complex and entrenched [see page 86]
15. To take every opportunity to empower communities and the development of community

groups and to forge earlier contacts with those groups, enabling earlier engagement with statutory services [see page 83]

10.1.3 Recommendations for Actions at the Level of Government

16. To work towards the development of a Europe wide 'Reconnections' programme. Thereby engaging with migrants and encouraging the most vulnerable to return home to resolve problems in the area where they have greatest social capital [see page 90]
17. To consider opportunities for collaboration at a European level in the development of drug treatment in Eastern Europe [see page 90]

10.2. Recommendations for Further Research

1. To undertake further research into drug misuse trends among A8 migrants [see page 85]
2. To investigate circumstances under which A8 nationals are drawn into drug misuse [see page 85]
3. To investigate the extent of drug misuse among migrant women, and whether the issues explored within this report impact differentially upon women [see page 86]
4. To investigate drug misuse among migrant sex workers [see page 86]
5. To investigate perceptions of treatment systems among A8 nationals both to improve responses and to assess risks of health tourism [see page 50]
6. To investigate alcohol as a gateway drug in A8 nationals [see page 86]

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12. APPENDICES

12.1. APPENDIX ONE

Census 2001 and Self Classification Race and Ethnicity Monitoring

Category		Self Classification Entry
White: British		
White: Irish		
White: Other		
Mixed: White & Black Caribbean		
Mixed: White & Black African		
Mixed: White & Asian		
Mixed: Other		
Asian or Asian British: Indian		
Asian or Asian British: Pakistani		
Asian or Asian British: Bangladeshi		
Asian or Asian British: Other		

Black or Black British: Caribbean		
Black or Black British: African		
Black or Black British: Other		
Chinese		
Other Ethnic Group		
Refusal		

12.2. APPENDIX TWO – 3 Drug histories of A8 nationals

Case Study 1 - Dominik

Dominik is Polish and a member of a Polish speaking Narcotics Anonymous group.

He started drinking alcohol and smoking marijuana casually at the age of 15 while still living in Poland. This casual use progressed and had become daily by age 17, he then started using LSD, magic mushrooms and sniffing glue. At 18, Dominik was unable to break his addiction, so he accessed local drug support services where he received face-to-face counselling and then group therapy. Over the following six months he relapsed twice, both for short periods of approximately half a day. But, after six months he returned to daily using, which lasted for the next seven years, during which his longest time spent clean was three months. He said that he had found that Polish treatment systems were largely orientated to Heroin users and that there was less treatment available for people with marijuana and amphetamine addictions, like him.

In January 2005, Dominik migrated to Ireland with intentions of escaping his drug problems. This also fulfilled his intentions of hiding his use from his family. The lesser punishments (relative to Poland) incurred for drug use were also a factor contributing to his decision to migrate. While here, he has found that all classes of drugs are much easier to access and that the current drug classification system makes his own use less punishable.

Dominik spent a few months in Ireland before moving to London. By May 2006, he had been using drugs for 10 years. During the two years in which Dominik had been in the UK he had been using marijuana, ecstasy and hallucinogens like magic mushrooms (his preferred drug type). Dominik had never used Heroin or Crack and attributed this to the problems he had seen it cause other people, this was largely based on his experience of 'homemade' Heroin in Poland. However, he did always find himself lowering his expectations of himself as he progressed through to 'harder' drugs, "I'd always say at least I'm not doing puff, then it was amphetamines, then it was Brown." He joined an English speaking NA group in May 2006 and then moved to his current Polish speaking NA group when he was told out about it. He found it very difficult to express himself in English at his first NA group and says he would much prefer a Polish speaking worker to contact in services. Dominik expressed a strong desire to access drug services, particularly one-to-one counselling, however, he does not know what services are available, or how to find them.

Case Study 2 - Gabriel

Gabriel has been in the UK for 5 years. He started drinking from a very young age then started smoking marijuana when he got a bit older. Gabriel had an Esparel injection to stop his drinking in Poland

before coming to London. The doctor told him he would die if he drank within the next 12 months, so he smoked marijuana for the next seven months, he then starting to drink again.

Gabriel came to the UK to change his life and was trying to leave the addict behind, but he says he soon realised he wasn't able to do this. Gabriel stayed at hostels where there was a party on every floor, every night, and there were drugs everywhere. He was living in London for one month before trying ecstasy for the first time. A couple of weeks later he stopped paying his rent because he had spent all his money on drugs and was chucked out of the hostel.

Gabriel had lost a couple of 'proper' jobs due to his addiction problems. This took a cyclical nature, he would work for a period to pay his bills (normally two wage packets), then binge on drugs and alcohol till his money ran out, then work for another period and binge again. During this time Gabriel says he had no friends, just fellow users. Gabriel use was predominantly with Cocaine and Ecstasy, he tried LSD once, but he says he always used alcohol. While unemployed the next cycle in his life became one of using, followed by sleeping, and then borrowing, then he would use again, and the cycle would continue.

Even while working every day as a van driver, Gabriel would drink all day. He regularly drank all night all the way until 6am in the morning; he would start work at 8am. When he was fired from this job he says it was the "worst day of his life". He was feeling "desperate", he went to the church where the NA group is held and opened up to the Priest. He prayed for 2 hours on that day and continued to pray at the church everyday for the next three months, for this period he was able to stop drinking.

On another occasion he was able to abstain from alcohol for ten months but was still using drugs two or three times a week, usually when he went out to a snooker club.

For ten months he was able to maintain work as a building site supervisor, which he regarded as a good and well-paid job, but he was fired again for suspicion of drug and alcohol use. He attributes losing this job to the development of his Mental Health problems that were characterised by forgetfulness. He described this as his "hell" and was a period where he lost his friends, his money and his job. He was living in the flat which he had been able to keep for ten months, but when he started to drink everyday he got chucked out. Unable to get work for three months, he stayed with a friend who was also a drug user, but his friend eventually chucked him out too. He went back to a hostel, but he had no money or food for two days. The hostel chucked him out. He remembers lying in the hostel and staring at the ceiling for four hours, feeling like he had no future. He returned to the church, the Priest gave him the address of a Polish treatment centre, he made contact with his mum in Poland for the first time in over a year and she posted him money for a flight. He returned home for six weeks of alcohol treatment, he said the drug treatment was too long. With the help of the alcohol injections and religious support he was able to get clean. He preferred to go to Poland for

treatment, this enabled him to get away from drugs and he did perceived treatment services to be of equal quality Europe-wide. He returned to London to make apologies and fix the damage he had caused. He attended the NA group and says it was the first time and place he ever felt safe. He found a sponsor and has now spent 21 months clean. He places a large value on only needing to stay clean 24 hours at a time, because a promise of not drinking till the end of his life is too scary. "I now have a life, a job, pay bills, stay clean."

Case Study 3 - Petras

Petras says came to the UK searching for life. Petras drank alcohol heavily in Lithuania. When he arrived here he used marijuana, skunk, then progressed onto using pills, cocaine and by the end of his "career" he was using crack and heroin. His substance misuse started with intermittent, recreational using and he said he had initially managed to maintain his relationship with his girlfriend, which during this period became a marriage and he was also able to keep up with mortgage repayments during a five-year period of heavy weekend using.

> *"You have no friends when you are on Crack and Heroin, a Crack House is like a jungle. You can keep your friends, cars, girls with coke".*
>
> *"Then you reach the Crack House and suddenly you're a Junkie. "*

Petras says he eventually acquired "the gift of desperation", which was a feeling of being so desperate that he was ready to give it away all of his prejudices and beliefs (of wealth and understanding) and moved on from his blaming of everyone else to justify his behaviour.

> *"I was tired of abusing and being abused. The shame and guilt reaches a point where you can't even exist and I was tired of it all."*

Petras had been unhappy for a long time and the country he was in was irrelevant because he could find drink and drugs wherever he was, he had once told his mum:

> *"even in Siberia I would have been drinking vodka with the white bears".*

For Petras, drugs were a "medicine" for his depression and discontent, he could "not live with or without them".

> *"I was smoking crack alone in my room. I was scared of the Police, scared of gangsters, scared of myself. But if you were to come to me and try to help I would tell you to fuck off, I know of others like this too."*

Petras described his behaviours as attempts of escapism and said they were present from a young age when it started with television, before turning to drink and drugs. He described a feeling of not being

able to enjoy anything, of which he placed a certain amount of responsibility on the materialist expectations he was taught by society (the family, school etc). He felt he had been misled to believe that happiness would come from obtaining socially constructed goals such as qualifications, jobs, promotions, owning a house. He said purchasing a house made him happy for only one month and he always had a feeling of wanting a better car than anyone else and even himself.

Petras received a few drug assessments at the police station on different occasions and eventually decided to follow up with the offer of care. Before then he had always felt he was a strong man who did not need help from anyone else. A man from the service rang him and met with him a few times. Another user recommended the methadone program so he followed up with it. He described the services he encountered as more 'civilised' than those in Lithuania and said he believed they were more sophisticated in terms of understanding users.

"I had to lose it all before I was able to make a change."

Petras was barely able to keep his house, which had gone into serious financial arrears. After being clean for six months he started an access to higher education course, from which he hopes to be able to enter University this September. He was still doing community service at the time of the interview.

Appendix 1.3 Paper 3

Mills, K., Broome, K. and Green, R. (2008). ***Beyond Boundaries 2: A8 & A2 nationals in London: drug treatment needs and referral pathways*****. London: National Treatment Agency.**

Beyond Boundaries II

A8 & A2 nationals in London: drug treatment needs and referral pathways

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June 2008

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1. KEY FINDINGS

- The trend of migration into the UK appears to be slowing, and many migrants have returned or are planning to return to their countries of origin. Among the more vulnerable migrants, who are the subject of this research, planning of this kind was not in evidence.
- A8 and A2 migrants who are vulnerable in the UK may not have had drug or alcohol problems prior to migration. However social and emotional problems do seem to be common within this group. These difficulties were a precipitating factor in their decision to migrate.
- Women who have been trafficked into the sex industry are vulnerable in their country of origin. This includes poverty and experience of abuse and violence.
- Some migrants do travel to this country with an existing drug problem. Others have or develop a significant alcohol problem. All these migrants are vulnerable to developing problems with illegal drugs following their arrival - the nature of their situation, peer pressure and the prevalence of illegal drugs in a new context catalysing this risk.
- Women from A8 and A2 nations who are involved in the sex industry are not developing problematic drug use. During the time in which women are involved in the sex industry there appears to be some capacity to disassociate themselves from their situation. On leaving sex work drug problems do manifest themselves.
- Restricting the availability of drugs services does have a short term impact in encouraging individuals to move away from the borough.
- Those who remain present intractable problems in terms of drug use, crime and mental health.
- At present the numbers of individuals from A8 and A2 nations presenting to services are small.
- Once in treatment service users from A8 and A2 countries were described as not presenting complex, intractable needs.
- A8 and A2 nationals who seek drug treatment do have sufficient language skills to make use of the services available.
- Cultural issues were not seen by interviewees as presenting a barrier to the take up of services.
- A8 and A2 migrants are very keen to take control of their drug use in order to resume or continue employment.
- Lack of flexibility in service provision – specifically in titration and prescribing – undermines engagement and retention in treatment.
- Lack of access to residential rehabilitation undermines other treatment interventions.
- Staff in London boroughs where services are less freely available signpost individuals to other parts of London.
- Homeless services are beginning to offer health screening for HIV and TB.

2. BACKGROUND

In 2004 the European Union expanded to include ten new nations: Poland, Lithuania, Latvia, Hungary, Czech Republic, Slovenia, Slovakia, Estonia, Malta and Cyprus. Only two of these countries were offered full and unequivocal access to the benefits that membership of the EU brings in terms of travel and employment rights. The other eight nations (the Accession 8 or A8 countries) were offered only limited access. The UK, Ireland and Sweden were the only three countries who allowed travel for purposes of employment. In 2007 Europe further increased its borders to include Romania and Bulgaria. These two nations are described as the 'A2'. Taken together the accession states are sometimes described by the term 'A10'.

Initially migrants came to the UK in unexpectedly large numbers. Overwhelmingly their work proved beneficial to the economy. However some migrants were not able to make a successful transition into work in Britain. Drugs services in London observed that some had drug treatment needs and were uncertain how best to respond, since guidance about eligibility was not clear, and the numbers involved were uncertain. All Drug and Alcohol Action Teams (DAAT's – local partnerships established to fund and oversee substance misuse treatment systems throughout England) are required to conduct substance misuse needs assessments to inform their annual treatment plan. These needs assessments must identify changes to local substance misuse populations and indicate mechanisms to engage with those populations and provide effective treatment to address their (drug related) needs. Given the level of concern expressed about perceived changes in newly arriving populations in a number of partnerships, the London Region of the NTA commissioned the University of Hertfordshire to undertake research to contribute to substance misuse needs assessments. Initial findings are available as Beyond Boundaries (Mills et al, 2007).

This report follows up that research, providing an examination of the drug treatment needs of service users and investigating the impact of differential service provision on individual users and on communities. While the current report can be considered as information from a stand-alone project, it flows directly from the research undertaken for Beyond Boundaries I and there are areas where the initial research report offers greater depth of information. Where reference to that report offers specific further information, this is made clear within this document.

3. AIMS AND OBJECTIVES OF THE STUDY

This study aims to explore the drug treatment needs of A8 and A2 migrants. In addition the project explores the differences which policy decisions make to the treatment journeys of individual service users from A8 and A2 countries.

This report provides answers to the following:

- To what extent is drug use in this group a feature of individuals' lives prior to migration or does the experience of migration act as a causal factor?
- What is the interplay of drugs and alcohol for this group?
- What factors might encourage individuals to seek treatment?
- What factors inhibit individuals in approaching treatment and other services?
- What are the factors relating to service delivery which impede engagement by A8 & A2 migrants?
- Are there differences of culture which service providers must address in configuring treatment for the needs of this group?
- What are the other, situational stresses upon service users which should be addressed by wrap-around services in relation to this group?
- Are there specific issues for women from Eastern Europe?
- Are there wider implications – for example in relation to public health and crime?
- These questions link inevitably with cost and spending decisions. Are the needs of this new group such that resources should be freed to make provision for their treatment?

4. METHODOLOGY

The two London Boroughs involved in this study (Borough 'A' and Borough 'B') were selected in conjunction with the National Treatment Agency. Sufficient similarity was desired to allow a reasonable comparison in terms of demography and the challenges faced in responding to this new migrant group. Differences in approach were sought, not to castigate particular types of practice, but instead to explore the impact of differing policy decisions upon treatment journeys.

Initial contact was made with the DAAT in both boroughs and subsequently contacts were forged with local treatment services and other providers. Thereafter the study proceeded by means of 'snowball sampling'. In classic terms, snowball sampling proceeds by means of a number of stages. At each stage interviewees are asked to supply the names of a specific number of new potential interviewees who can be approached as research subjects (Goodman, 1961). In reality the process is slightly less simple to control: interviewees suggest varied numbers of contacts and as the research progresses a process of feedback begins to occur, where interested individuals hear of the research and contact the researcher independently (see Maruna et al, 2004). This proved to be the case in this instance, and the research team elected to follow up these contacts, provided they fulfilled the criteria of *both* working with A8 and A2 migrants *and* lying within the boroughs involved in the project.

Ultimately a total of 37 separate interviews were undertaken. Interviewees were drawn from a wide variety of services:

- Criminal Justice services;
- Drug Interventions Programme staff;
- Treatment staff in tiers 2 & 3;
- Needle exchange staff;
- Arrest Referral Workers;
- Police officers;
- Primary care staff;
- Women specific projects;
- Homeless services;
- Service users.

Among the group of interviewees were seven service users.

Four interviews involved more than one participant – being undertaken in a group or team setting for example. During the transcription process these different views were recorded separately. In this way a total of 47 views were gathered.

Two exceptions were made to the rule that services should be based and run within the boroughs studied. Firstly, in order to supply data concerning the needs of trafficked women, a project with this specific focus was visited. This project is not based within the target area, but does serve women across the capital. Secondly, it was viewed as important to provide information about creative ways of managing a process of reconnection for vulnerable migrants. For this reason – and independent of the rest of the study - information is provided about the work of Barka UK.

Interviews were transcribed. All data was then analysed thematically to provide aggregated and contrasting views across a range of subjects.

The research team approached the provision of statistical information with some caution. It is recognised that the numbers involved in this study are small and that small shifts can as a result appear amplified. Percentages of respondents have been supplied where the weight of numbers is sufficient to glean some information from their provision. The actual numbers of interviewees suggesting a particular view have also been included throughout. In this way the reader can sift for themselves the significance which should be given to any particular view. No percentages have been offered in relation to the needs of women migrants. Five interviewees held a specialist knowledge base in relation to women. To provide an alternative percentage figure in relation to these interviewees was viewed as potentially confusing. Here numbers of shared views alone have been offered.

Issues of confidentiality were of paramount importance in writing up this study. For this reason no identifying information has been included alongside quotations used. Where job role is particularly pertinent, this has been made clear in the text. Quotations from academic and other sources, which lie in the public domain, have been acknowledged as such and referenced in full.

5. FINDINGS

5.1 Prompts to Migration

Since the writing of Beyond Boundaries I (Mills et al, 2007), migration to the UK from Eastern Europe and the return of individuals to their home country has continued. The Border and Immigration Agency reports 50,000 initial applicants to the Worker Registration Scheme (WRS) in Quarter 2 of 2007(Border and Immigration Agency, 2007). This represents a reduction in registration numbers. (52,000 in quarter 1 of 2007, and 56,000 in Quarter 2 of 2006 (Border and Immigration Agency, 2007)). For more detail on these figures see Mills et al, 2007 p.27ff.

A8 and A2 migrants travel to the UK for a host of reasons – economic, cultural, and educational – contributing to the life of the economy in the process and ameliorating the problems of Britain's ageing population. A recent study by The Institute of Public Policy Research confirms that migrants travel to the UK to gain employment, learn English and broaden their horizons and to take advantage of the UK's 'enterprise culture' (Pollard et al, 2008). This is reflected in this piece of research:

> *The vibrancy of…London…has been really reflected in the minority groups that have opened new businesses, sustained other ones…property improvements, the rental market is booming…it's very positive.*

This search for a better life was seen to have prompted the migration of the respondents in this study. 57% of the service users interviewed for this project described themselves as having moved for work or what was more abstractly described as a "*better life*". However in the case of this group, self improvement is not the only factor in play.

The ease of travel was noted by respondents as well as the persistent illusion that life in London will offer a solution to all problems:

> *London has been attracting people since antiquity.*

In this, interviewees saw comparisons with other periods of mass migration to the capital – and six interviewees drew comparisons with other waves of migration within the UK and across the globe. However there was a strong sense among interviewees that for those without skills, and crucially language skills, the prospects can be bleak:

> *Missed out on a fundamental skill for doing proper work…people pay for skills…not hard work.*

> *[They] come looking for the pot of gold at the end of the rainbow and find that it's dust.*

Among this group of service users, however a sense emerged that the pull to a new country was matched by push factors which encouraged individuals to leave their home. Workers identified family difficulties (both in birth and marital families – with partners and children) as a significant feature. Of particular note and mentioned by two staff members specifically are the arrangements for maintenance payments in Poland:

> *In Poland it's a crime not to pay child support if you are divorced, you go to prison for it…So there's a certain percentage of men here who are fleeing the government because they don't want to pay their alimony, or they can't pay…*

Flight from the police for other crimes was also mentioned as was the fact (commented upon by three interviewees) that some individuals had been travelling across Europe for some time, London being the most recent stopping off point.

All these factors were mirrored among the group of service users interviewed. Of these, while three noted work as a reason for migration, one described the breakdown of his marriage as precipitating his decision:

> *Within two weeks I was here.*

And one described individuals as fleeing both a criminal record and potential criminal violence:

> *You may be on the run, but at least you are free.*

A hope of escaping drug problems was mentioned specifically by two interviewees.

These issues were reflected in the interviews undertaken with staff in services for women. For women, however there is additional vulnerability to trafficking. The UN Protocol to Prevent, Suppress and Punish Trafficking in Persons describes human trafficking as follows:

> *"Trafficking in persons" shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.*
>
> Home Office, 2006 (p5)

In this study, staff in women's projects characterised women as vulnerable both economically and socially. Attempts to escape violent backgrounds; poverty or lack of opportunity left women prey to coercion and deception from traffickers keen to lure them to the UK.

The 2004 report, 'Sex in the City', plotted women from all the A10 nations (Dickson, 2004) as being involved in the sex industry as a result of trafficking. Interviewees in this study reported Lithuania as among the 'top three' nations in terms of numbers of trafficked women.

In addition women were reported as been drawn into the sex industry following their arrival. Having travelled to the UK for other work or study, interviewees reported that they found Britain and London in particular, expensive and moved into sex work to earn more. One interviewee reported that following European expansion in 2004 the numbers of sex workers using their sexual health clinic rose by 62%.

5.2 Drug Use among A8 & A2 Migrants.

Among the respondents in this study, it was alcohol which was described as presenting the largest problem for A8 and A2 migrants. Ten interviewees including both staff and service users, described alcohol use as problematic (22%). Of these six said that their impression was that service users had come to the UK with an existing alcohol problem.

> *[We see] lots of alcohol use – people with entrenched problems from before they came*.

In homeless services, it was overwhelmingly alcohol which was reported to be problematic. One worker who had recently visited Poland commented upon the prevalence of alcohol in that country as a whole. A Polish worker commented that in Poland such alcohol use is not problematic, since it is contextualised both socially and culturally:

> *I think it's about socialising and belonging somewhere…when they drink they [share] the bottle they chat they sit around the table it's a kind of way of expressing [themselves]***.**

This difference in cultural mores was captured by a police officer who commented that migrants may have:

> *[An] alcohol problem in our opinion but not in theirs.*

Staff in drugs services, however perceived a rather different picture. Staff in these services made contact with migrants somewhat later in their journey, and saw people as being involved with a much wider range of drugs.

There was a mixture of opinions as to whether service users had drug problems prior to migration (see also Mills et al, 2007 p19). This mix of views was independent of job role and is perhaps indicative of the genuine range of individuals' experiences. Three service user respondents within this study reported pre-existing illegal drug habits (see also Mills et al, 2007 p92ff). Some interviewees observed that the levels of apparent entrenchment in drug use led them to the conclusion that these must be long standing issues. Others drew attention to the vulnerability and fear of a homeless life which catalyses both drug and alcohol use:

> *Hardly any homeless clients who aren't using drugs – a lot of them will say they use drugs to help them sleep at night because they are scared and they are cold.*

> *Sleeping out on the streets – in squats – in dangerous places [it's] unsafe and vulnerable. Need something to relax you, make you sleep at night. Cheapest thing is 'White Star' cider.*

One interviewee observed the gradual transition from alcohol use to drug use in a particular client:

> *One specific client who came through DIP…his engagement was irregular, he had to work. He was getting sucked into the drug life. And his [case] was particularly sad because he had been to London before, and had a good time…but when he came back a second time… his friends that were here had all slid into heroin and crack use and he ended up joining them.*

This last point is particularly interesting when set against the observation by a substance misuse worker in a homeless day centre that she had never referred a client for drug 'detox', only alcohol. Three interviewees observed the demarcation between drug and alcohol services in the UK – for these interviewees this reflected a cultural perspective which is not shared in Poland, where both were described as being '*equal concerns'*.

Experimentation with drugs in a new, freer context was mentioned by two interviewees:

> *One female client comments that she is freer here free from family…freedom leads to drug use.*

And the extent to which the social context of migration intensifies any vulnerability was mentioned by 10 respondents, including 2 service users (22%).

> *My life is crazy … the people I live with are crazy.*

The drug users in contact with treatment and DIP services were described as being both heroin and crack-cocaine users – a fact that was mentioned by 7 respondents (15%). Staff at all levels – from beat police to clinical and probation staff saw clear similarities between the nature and the level of drug use among this group and other local service users.

Heroin and crack use… the people I'm talking about it's like love and marriage now…the two go hand in hand…everybody now is heroin and crack.

Interviewees in this study did not report the dangerous injecting practices among these users that were identified in Beyond Boundaries I (Mills et al, 2007). Drug use was perceived as being influenced by the immediate context and associates rather than being culturally dependent. One interviewee ascribed these similarities to the process of enjoying and engaging with a new culture:

[They are] here because they like being here...they like being in London; they like the culture and the life…so I don't know how much of what they present is their original home culture and how much is what they have adopted because they like it.

5.3 Responding to the Substance Misuse needs of A8 & A2 Migrants

5.3.1 Numbers in Treatment

As with Beyond Boundaries I (Mills et al, 2007), although the overall number of migrants is relatively large, the numbers of individuals identified as being in drug treatment in the boroughs studied in this project proved to be quite small. Although one service for homeless men and women identified that 70% of its 110 regular service users are Eastern European, within drug treatment services there is a much lower level of demand.

Borough 'A' has, since the arrival of A8 migrants in the UK, taken the decision to apply the guidance concerning eligibility stringently. In this borough only primary care and harm minimisation services are available. As a consequence, no individuals from A8 or A2 nations are in treatment in Borough 'A'. Some Polish men were reported to the research team as having been accepted for treatment; however it emerged that these individuals had been living in the UK for some time and had full eligibility for services.

In Borough 'B', while services were made available to migrants, the numbers presenting for treatment remain relatively small and have not placed an undue strain on service delivery. The DIP team in this borough reported having held 4 clients on the caseload in the past 12 months. The Probation Service locally reported:

Of [the] entire caseload at present…8…and that is out of 224 cases that are on treatment…on ATR or DRR. [Including 2 ATR]

5.3.2 Access to and Exclusion from Services

Because Borough 'A' offers no services, workers within the borough face a dilemma when intervening with clients. Three interviewees described the tension between the desire to provide a service and the knowledge that capacity within organisations is limited:

> *You start getting problems when it becomes focused on one area.*

Other respondents described the practical difficulties of providing services to individuals who are extremely transient.

Another expressed strong reservations about the morality of offering services to migrants in the context of limited resources:

> *I don't agree with helping everyone…I think there's a lot of people who have been born and bred here and have families and pay taxes…who don't get funding for residential rehab…and those people need to be [served] first.*

A variety of mechanisms appear to be at work to reduce the scale of the issue which migrants present in Borough 'A'. One interviewee noted the changing criteria in 'street counts' of the homeless to exclude the counting of homeless A8 and A2 migrants; another mentioned a 'rumour' that GPs had been instructed by the PCT not to take these individuals as patients. Two further respondents commented that these restrictions formed part of a suite of interventions designed to protect residents and legitimate visitors to the area:

> *There's only so long you can be on the streets and around here you get moved on pretty quickly. If you're begging they do begging ops every week… [It's] about moving people on…*

The end result of the policy is a reduction in overall numbers of migrants remaining within Borough 'A' and staff here reported that the numbers approaching them had reduced significantly in the past 12 months:

> *We certainly don't have people banging on the door looking for 'scripts.*

However not all A8 and A2 migrants have left Borough 'A'. DAAT staff reported that those who are now arrested within the borough are:

> *Becoming more chaotic, as their drug and alcohol use spirals out of control.*

Treatment services echoed this, stating that:

The people left are the ones who are the most complex…mental health is the big one.

Faced with this, when complex and chaotic people are arrested, the only recourse of staff is to direct individuals to tier 2 services locally or to signpost them to resources elsewhere in the city.

This residual problem affects other parts of the Criminal Justice System. Without the capacity to offer structured treatment/DIP as a sentencing option the probation service saw its options as limited:

> *That affects us as a service [and] it affects the courts because they don't know what to do with these people, because we are saying 'they are not suitable, we can't get them assessed'…so they end up in prison. So they are being up tariffed*.

This interviewee highlighted implications for the service's reputation and credibility:

> *Most of the time it's unpaid work and that is not addressing the issues or the problems.*

In Borough 'B', clients have access to treatment in tiers 2 and 3, via referral processes which are the same as all other clients in the borough. In the case of voluntary treatment drug users were described as approaching tier 2 services for needle exchange, advice and harm minimisation; in relation to coerced treatment first contact is with an arrest referral worker, then with DIP staff, treatment providers and criminal justice staff.

Four interviewees in Borough 'B' and one in Borough 'A' commented upon the similarity between members of this migrant group and local service users, in terms of needs, patterns of offending and attitudes.

> *The Polish people I have seen here…are no better off and no worse off than the majority of clients that come through this door anyway…I wouldn't say that their presenting's been overly different from the rest of the drug using population.*

In discussing the needs of Eastern European service users, interviewees commented on the relatively straightforward nature of the issues they present. This was encapsulated by one respondent thus:

> *[Eastern European Migrants] don't have the same sort of complex issues…it's really straightforward, [they] came here, I'm working I've got money and friends and people I work with. I've developed a drug habit I want to get off it. I want to be scripted and then I would like detox because I would like to go home for a couple of months, but I can't do that while I'm still using methadone…and I can't go back with a heroin habit – I can't get it there.*

Similarities were observed in relation to both presenting problems and patterns of offending. In managing these issues, interviewees were asked about communication. Within drugs services, language and communication were not described as problematic. Arrest referral and needle exchange staff commented upon the difficulties in providing high quality interpreting services within the exigencies of service delivery, and some loss of quality in engagement was noted even when interpreters are available:

> *When I'm speaking to a client…sometimes a client is very apprehensive …you get them into treatment by gaining their trust and it's very difficult to do that through an interpreter.*

The majority of interviewees within drug treatment services and criminal justice agencies stated that in relation to this group, language did not present a significant barrier to the take up of services. This was mentioned explicitly by 6 of interviewees:

> *Surprisingly easy. Most of them are young and speak pretty good English*

This facility with English was ascribed by two interviewees to the recent development of English teaching in Eastern Europe:

> *Especially the young people – they're all a product of Solidarity 25 years ago. So they all switched from being Russian to learn English. They've had 20 years of English lessons*

This stood in stark contrast to services for homeless migrants, where lack of language skills was perceived as a massive barrier to access to services (mentioned by 7 interviewees – 15%):

> *That makes a huge barrier to accessing all kinds of services" "and getting work of course too.*

> *Language creates a ghetto*

Three interviewees mentioned the fact that leaflets and advertising for local drugs services are mainly presented in English, and that advertising is undertaken in GP practices. One extrapolated from this to comment:

> *People that come here…probably the people that come here…are the people with the best grasp of language.*

Another interviewee, working specifically with Eastern European migrants did comment on the importance of using a native language in facilitating change:

> *It is important for therapy for addiction to take place in mother tongue.*

Another, offering interventions in a group setting, highlighted the difficulty of managing diverse language needs within a group:

> *it would be difficult to expect someone to manage in a group situation…with loads of people speaking at different rates…it would be setting someone up to fail.*

Over and above issues of communication, interviewees had differing views on levels of engagement. Some described the efforts which staff members make to engage with service users and develop a rapport. Others, however, described this client group as disinclined to form a strong connection with providers:

> *For this group they don't want to hang around, they want to get their works and go.*

This perception resonated with respondents from other parts of the treatment network who also commented upon the relative independence of A8 and A2 clients:

> *[They are] keen to access voluntary treatment on an 'as needed' basis…dragged kicking and screaming into …structured [treatment] you must do this … because it doesn't fit in to the lifestyle.*

This detachment from services, the possible reasons for it and its impact on engagement and retention is worthy of separate consideration, and the findings in this area are presented below.

5.3.3 Service Provision: engagement and retention

As has been mentioned above, policy decisions within Borough 'B' do not act explicitly to exclude A8 & A2 migrants from services. Other factors were identified by interviewees as impeding engagement.

While referral was available to all services within the borough, these were not necessarily ideally configured to meet the needs of service users who are compelled to work in order to support themselves. (For more information concerning employment and eligibility for benefits among A8/A2 nationals see Mills et al, 2007 p.38 ff). A number of respondents described referral to the local prescribing service as laborious:

> *Because all our A8 nationals work, or are trying to work…builders, labourers, scaffolders, they can't just pop in/pop out, turn up late. [The prescribing service] initially until people are stabilised want people to go in every morning, and [undergo] titration, and they want to make it a very long, drawn out process… [They need to] take a week off work and they just can't afford to do it.*

One service user described his experience of the system extremely forcefully:

> *Treatment is a joke there. I went there and they gave me 20 mls of methadone, they said it was for a trial … they treat me like a fucking rat...they said come back the next day. Maybe it is not enough but we have to try it out… it was not enough. So I did not go back…I do heroin now at home, back on heroin.*

Criminal Justice staff also mentioned the importance of early engagement in the processes of intervention, commenting that it is when the chaos of an individual's situation combines with a slow treatment response that breach of a court order is most likely:

> *Sometimes it's not fast enough and that's when they fall out.*

Several respondents expressed the concern that the consequence of this lack of engagement is ultimately a prison sentence for drug related offending, and that contributes to a damaging spiral:

> *Getting very short sentences anyway and they are coming back out and their drug use hasn't been addressed or their problems haven't been addressed*

Equally problematic within the treatment system is the lack of access to rehabilitation. Residential services of all kinds are not available to A8 and A2 migrants. These require types of funding from which migrants are excluded throughout the country. Interviewees commented upon the undermining and demoralising effect which this ruling has upon those seeking treatment.

> *Xxxx was the first to go though detox. But [he had] no entitlement to any rehab, so no follow up. He didn't last a week, though he did find a little bit of work afterwards.*

In the case of alcohol detox the physical strain which repeated detox places on the body was pointed out:

> *Repeated detox used to be thought of as a way of controlling use, but recent research shows that detox takes a toll on the body and that repeated detox is bad.*

This lack of secure follow up was seen as being compounded by the social context in which rehabilitation is forced to take place. Respondents commented that the established Polish community want little to do with a new migrant group. The lifestyle desired by these new migrants is different, and the countries themselves have changed between these waves of migration:

> *Come from a completely different place…they don't have a common experience of Poland*

This, combined with the process of establishing oneself in a new country, means that A8 and A2 migrants are thrown together for housing, work and recreation. 12 interviewees (26%) noted the close groups formed by migrants in the local area, with two commenting upon the fact that this extends back to an individual's country of origin (with stories developing about how to become established and how to get work) and a further three mentioning that exploitation occurs within these groups. Given the vulnerability mentioned above and the tendency to draw individuals back into drug use, this situation was described as bleak:

> *Even if they want the help…it's so difficult for them to come off…because [of] the social factors behind it.*

> *All the Polish people we had coming in here were all using and all living together. So if one of them wants to clean up they can't, they are condemned.*

Despite these difficulties, respondents spoke warmly of the resourcefulness and acumen of migrants – emphasis was placed upon their autonomy and self reliance. Fourteen interviewees (30%) mentioned the interplay between homelessness or unstable housing and drug/alcohol use. Four described individuals 'squatting', and two contrasted these service users' attitudes with other homeless clients:

> *It's a very different mindset from the rest of the clients…Came here with the expectation that they would have to sort everything out…*

Sixteen interviewees (35%), within all roles and areas consulted, described employment as being these service users' aspiration. This is perhaps unsurprising as economic advancement was also seen as the motivation of migration and this desire is undiminished by a negative experience:

> *The driving force is because they can't get benefits, but the majority of people came over to work…and not just to work to …send money home, but to enjoy the lifestyle.*

Seven respondents commented that despite substantial drug habits service users were able to maintain themselves in work:

> *Most of the clients that come in that are using from A8 countries… you see them 7-8 times in the space of a few months they are arrested this week and next week again, then there might be a little lull and then it starts again the cycle…perhaps that window that break is when they…got some money coming in…that dries up and they start offending again.*

> *I have to work to get money because of the drugs.*

Despite the strength of this work ethic, several respondents expressed the view that it was unlikely that the majority of these more vulnerable migrants would register via the Worker's Registration Scheme and thereby achieve a degree of stability in the UK. This was attributed variously to the expense of registration, a lack of knowledge and to the transience inherent in their situation:

> *We have had 585 people go through our work centre in the last 12 months. 2 of them were registered. 583 didn't know what it was and were not registered. A lot of people are not interested in it because they are not interested in staying in the UK to get benefits…people don't come here to get benefits…they come here to get a job and to send money back to their family.*

5.4 Issues for Women Migrants

As with Beyond Boundaries I (see Mills et al, 2007 p49), in all services approached, the numbers of women service users were very small in comparison to men. In one homeless service visited, of the 40% of service users who were Eastern European migrants only 2 women were observed. In treatment services staff spoke of having had only 'one or two' female service users from A8 or A2 nations over a period of years.

In Borough 'B', women's drug use and offending was described in similar terms to that of men. Only one interviewee drew attention to the sexual vulnerability of women:

> *Women are vulnerable – they have the same issues – no money no skills no English…so they hang around with Polish guys.*

By contrast in Borough 'A,' attention was drawn to the large increase in the numbers of women in the sex industry. Here, a 40% increase in the number of sex workers was reported, and a local sexual health service reported that 85 – 90% of current service users are migrant women (though it must be noted that this figure is one of global migrants, not solely A8/A2 migrants).

All three services for sex workers which were approached for this study reported that A8 and A2 nationals are not, in the main, engaged in street sex work where drug use is endemic (Home Office, 2008a). These women are far more frequently engaged in sex work in flats, saunas and massage parlours. Women in this situation were not identified as using illegal drugs in a problematic way. Alcohol, 'skunk' cannabis and what were described in interview as *'disco pills'* were highlighted as drugs of choice used to relax and to ameliorate the boredom of the work. A minimal amount of crack-cocaine use was observed by interviewees and only a couple of women were identified by interviewees as having heroin problems. These women were described as having had problems prior

to migration which had been exacerbated by their current circumstances. These findings resonate with those of Dibb et al (2006).

Powder cocaine was discussed as being used for two purposes. For those women engaged in long 'shifts' cocaine was described as a drug used to stay awake and responsive. In addition the fantasy of a party was described as being a characteristic of sex in these situations. In these circumstances cocaine is used by women and their clients:

> *Lots of clients want to party. They'll do a booking with a girl who can either get them some coke…or do coke [with them].*

Flat owners were described as being opposed to drug use by women generally – as it was felt that this would draw unwelcome attention to their business, however this use by women in conjunction with clients was *"overlooked"*.

In relation to trafficked women the situation is somewhat different. 10 -15% of trafficked women were reported by one interviewee as coming from A8 or A2 nations. These women were described as having their lives and consequently their drug use very heavily controlled. Drug use here was described as not commonplace, and any drugs administered were those likely to increase the passivity of women – principally alcohol. However, where women leave or escape a situation of debt bondage or trafficking and are subsequently without resources, they were described as being in a worse situation than non-European women. In the latter case women can be granted asylum, and as refugees have full access to benefits.

For A8 and A2 nationals, the lack of resources combines with very blurred sexual boundaries to drive women back into situations of sexual exploitation and into street prostitution, where they are much more vulnerable to drug misuse. One interviewee reported that in recent months three Romanian women had approached their service in exactly these circumstances.

> *We usually find that when women leave the trafficking situation, that's when you start to…take on board what's been happening to you. So in terms of the emotional trauma, it starts then. Previously you're in survival mode.*

Return home was described by three interviewees as less likely for these women. In some cases outstanding debts owed to traffickers mean that return is not safe and the likelihood of families finding out about the degradation women have suffered is a significant threat.

In terms of contacting her family back home, she would never do that because he would say 'I'm going to tell your family what you are doing…I've got your family address, I've got your children's picture.'

5.5 Wider Issues: health and public health

Nine respondents (20%) mentioned health concerns – in terms of public health or personal health – during the course of the interview.

Within homeless services, systems of health screening and harm minimisation are in place. One respondent mentioned the provision of cheap meals as a simple harm minimisation practice. Elsewhere homeless clients were screened every six months for TB.

In terms of sexual health, homeless services described the paucity of knowledge of HIV/AIDS among migrants:

[There's] no acknowledgement of HIV in Poland …because Polish men aren't gay.

This service has begun a project on sexual health in conjunction with the Terence Higgins Trust.

Two interviewees mentioned hepatitis B&C as being issues of concern. Where migrants are not routinely engaged with health services and access is primarily through day centres, there was some anxiety that these conditions would not be noticed. One respondent, for a sexual health service, commented that large numbers of migrant women involved in the sex industry are hepatitis B or C positive on their arrival.

In addition the increase in numbers of sex workers was reported as having health implications. Several respondents commented that with a larger number of women offering sexual services, women are being called upon to offer a broader range of services, with lower levels of protection. Migrant women were mentioned as being especially vulnerable in this regard. Women arrive in the UK with less grasp of the *"discreet guidelines"* governing sex work and a poorer grasp of English, which makes refusal more difficult.

When they first come they are very discriminated against.

In addition the numbers of women available for sex means that there is significant pressure from pimps and employers:

Any sex worker is now expected to provide a massive range of services to keep a place and offer services without condoms. Otherwise she can't keep a job.

With unprotected oral sex being most likely, clinics reported that they are observing a consequent rise in Chlamydia in the throat, but not a big increase in female sex workers who are HIV positive. Among male sex workers the rate of HIV is higher, and among transgender workers the rate was described as *"disproportionately high."*

In relation to Mental Health, the response from interviewees was mixed. Two substance misuse workers described mental health/dual diagnosis issues as rare among A8 and A2 users of drug services generally, saying that mental health problems exhibited themselves only as low level depression. Other interviewees however, did describe significant mental health problems.

> *Many come with an existing mental health condition that gets further exacerbated by the move/homelessness, producing a vicious cycle of need and dependency.*

For sex working women from Eastern Europe the corrosive nature of the work was described as having an impact on long term mental health. The blurring of sexual boundaries has been described above. In addition the element of role play and artifice was described by one interviewee as leaving women vulnerable in the long term:

> *A lot of women lose themselves and lose their sexuality – they have got no idea of who they are or what they want as a sexual person and relationships can be compromised…especially after people have left.*

This interviewee posited that this vulnerability might precipitate drug use, but said that little was known what happens *"later down the line."*

5.6 Diversity issues

> ***How might we best characterise...differences without being essentialist in the process? That is, without assuming that certain beliefs about different groups of people are fundamental differences."***
>
> ***(Gelsthorpe, 2002 <u>in</u> Bottoms et al, 2002 p152)***

In responding to issues of diversity, staff from drugs services did not characterise the differences between clients from A8 and A2 nations and those from the UK as being fundamental.

> *Just that it's hard to get their needs dealt with; they stand outside because of the whole benefits issue… [But they are] not specifically presenting us with very different attitudes than we get from our general offending population.*

This echoes comments from Beyond Boundaries I (Mills et al, 2007) where an interviewee proposed the idea that the bonds which unite individuals across Europe are fundamental and the aspects of culture which are different are superficial.

Issues from all cultures that are different…that's just how it is.

Some aspects of cultural difference were more clearly seen in the context of homeless services. Here five interviewees commented that diversity of culture was evident in the dynamics of the service and at times this caused friction between service users.

They think it's OK to touch and hug people – much closer than is acceptable.

This was in part ascribed to the advances which the UK has made in relation to equality in recent years:

a lot of the cultural changes in this country in the past 30 years…feminism, anti racism…didn't happen in eastern Europe…if feels like a time warp sometimes…the attitudes are frozen in time…towards women and towards non-white people.

However one interviewee did comment that an appearance of greater sexism may in fact simply be misinterpretation of culturally specific body language.

Three interviewees did sound a note of caution in relation to diversity. Two - as mentioned above - saying that as language is translated there is an important loss of nuance and a third commenting that with a lack of proper background information the possibility of making inadequate risk assessments rises.

5.7 Going Home

The ease of travel between Eastern Europe and the UK was mentioned as a factor in migration by one interviewee. This reiterates the notion expressed by The Institute of Public Policy Research that in many cases patterns of migration are circular, with individuals travelling seasonally between countries (Pollard et al, 2008). However, The Institute of Public Policy Research reports that there is a strong element of planning in migration of this kind:

A significant proportion of migrants that have returned home say that the time they chose to go home was pre-planned, with 16 per cent saying they always intended to return once they had earned a certain amount of money, 15 per cent stating they intended to return after a certain amount of time and 18 per cent after their temporary or seasonal work had come to an end.

Pollard et al, 2008 p 45

No such plans were evident in the group of A8 migrants interviewed for this study and none planned to return home or leave the UK. This lack of planning was commented upon by two other interviewees as being characteristic of clients:

The sad thing is there doesn't seem to be a plan.

In the case of migrants engaged in prostitution one interviewee reported that while women did foresee leaving the industry and returning home this proved difficult:

They don't really have exit [strategies]. A lot of girls have a dream of what they are going to achieve… [For] a lot of them it never really materialises.

Many of the factors which acted as an impetus for migration for this group – family breakdown and flight from the police/courts - continue to act as factors which prevent return. In addition six respondents commented upon the humiliation which would follow from an ignominious return:

What's a real issue is if it is a young man who has older parents – single and he's come here and he wants to prove himself.

If you leave your country, your family and children…and are living on the street would you go back? Humiliation…stigma…pride…can't admit to it.

In addition some interviewees commented upon the extent to which migrants build for themselves a mythology of imminent success, and of the horror of return which becomes impossible to overturn:

Very proud people – I hear them on the phone 'I'll send some money next week', but they are homeless...there is no money.

Men need to feel that they can return to their families in Poland with something…success. They develop a "perhaps tomorrow" attitude, hoping they may gain success the next day, cheating themselves into believing things will improve, thus perpetuating situation/problems.

But how bad would it be to face up to the problems? …how much of this is a rehearsed story people have told themselves and come to believe.

In overcoming this apprehension both Boroughs 'A' & 'B' had systems in place to transport individuals home. Interviewees described this as a scheme whereby those individuals in the direst circumstances are offered an escort to the coach station and the price of a ticket home.

When they get so chaotic they become homeless [the] police step in and they get diverted…Have special buses and escort to get them to coach and pay for them to go home …A lot do take it when they get into that terrible position.

This interviewee did comment that:

They come back pretty quickly but they have often cleaned up their act a bit.

Elsewhere in London, The Barka Foundation – in conjunction with the Simon Community and Housing Justice UNLEASH, established an arm of its "Foundation for Mutual Help" to support A8 & A2 nationals in the UK.

> *The project is aimed at providing assistance to "work migrants" who fail to find employment, end up on the streets and are subject to quick degradation processes.*
>
> Barka website, 03.05.2008

In Poland, Barka offers support to recovering alcohol and drug misusers through a model of social enterprise. Having undertaken detox and rehabilitation, individuals are offered places within a variety of work projects led, run and staffed by Barka 'graduates'. In London, representatives from Barka undertake street outreach to make connections with destitute migrants and, on a fortnightly basis, support them in travelling back to Poland and on their arrival through the process of extensive wraparound support.

Working in partnership with the local borough council, Barka is committed to supporting 3 returning migrants each month. The Barka website reports that approximately 12 migrants travel home each month (Zagrodniczek, 2008).

5.8 Solutions

Interviewees highlighted a variety of improvements which would enhance service delivery. One interviewee commented that more restrictive migration practices should be applied, but that with the systems currently in place, more open access to services ought to be allowed. Improving the availability of accommodation was mentioned by four respondents and allowing access to benefits was assessed as important by two interviewees. One interviewee described current restrictions very forcefully as:

> *Ideology of starvation…bound to failure.*

The majority however placed their suggestions in the context of current provision and six interviewees mentioned either the possibility that widening availability might attract more people to the location or that improving access – particularly to housing – is not feasible in the context of reduced social housing stock.

> *But the vast majority of English people aren't getting these things now…that's the harsh reality really – even if you got them these services [eligibility for housing/benefits] they still could be waiting years because housing is in such crisis there's no sort of magic fix.*

For eight respondents (17%) the key to success in delivering services was via improved language services. Improving access to interpreters was desired by three respondents while 5 expressed the desire for improved access to English for Speakers of Other Languages (ESOL)/English language classes. The probation service described this as embedded within existing provision, since basic skills assessment is an integral part of probation induction and in one borough, the basic skills worker is also an ESOL teacher.

In relation specifically to substance misuse, seven respondents (15%) felt there was a need to open up access to services and improve signposting into available provision. Two commented upon the need for greater flexibility in styles of provision – opening hours and titration to improve engagement:

> *Extended, flexible services do not just benefit A8 nationals but everyone else.*

For some respondents the whole process of migration for this group was seen as requiring attention. Improved integration into British systems and services was mentioned by eight respondents (17%). Two spoke specifically of a system of greeting and orientating migrants on arrival – offering a counterbalance to the illegal gang masters who facilitate travel to work sites around the country and can be exploitative in their nature.

Linked to this was the need for the better dissemination of knowledge between providers and between services and communities. One service described a strategic thrust to overcome this by developing a web presence, gathering and distributing information.

Three interviewees commented upon the lack of a system of transferable qualifications between nations, which discriminates against sometimes highly qualified migrants:

> *Many well-educated people from Poland, Lithuania etc. work doing low skilled jobs. That's the waste of skills, knowledge and talents. You can meet the doctors who work as security, or even worse. Many of my friends who are psychologists, sociologists, teachers can not work according to their occupation.*

One interviewee pointed out that voluntary agencies and charitable organisations are, to some extent, meeting the needs of migrants who approach them in destitution and that these services do present a cost to the public purse. This cost however is not quantified overall, and is therefore more easily lost when assessing how to respond to need.

6. DISCUSSION

This is a blip, this is not going to last forever…it's probably peaked. Sometimes people compromise their principles.

It was the view of this interviewee that services which have restricted access to A8 migrants for fear of overwhelming demand have made unnecessary concessions in their fundamental values. It does seem to be the case that the trend of migration has slowed, and that some migrants have already returned the Eastern Europe, to take advantage of those nations' rising economies. Many more plan to do so in the medium to long term. Also, as other European countries open up their borders to the A10 nations during the next few years, patterns of migration will change once again. As was highlighted in Beyond Boundaries I, in 2011 provision across Europe will be equalised and completely free movement allowed for all (Mills et al, 2007 p64). However the individuals approached during this study do not seem to conform to these trends. Nor do staff in the services interviewed see this developing circular pattern of planned migration and return. For some in this study the impetus to migrate is stronger than lure of return; for others the loss of pride involved in returning unsuccessfully make travel home unlikely.

Levels of Need

If this is the case service providers will continue to be faced with the challenge of meeting the needs of migrants whose aspirations have outstripped their current capacity. Several situational issues seem to make the collapse into drug use a risk among this group. The social and emotional problems which led some people to migrate continue to present problems and the physical stresses and fears caused by homelessness accelerate drug and alcohol problems. While it would seem that alcohol is the drug of choice among many new migrants from Eastern Europe – a feature explained in part by price and in part by cultural mores – there is some risk of drug problems developing. This last factor is intensified by the inter-dependence of new migrants; all of whom face the same difficulties and who – as a consequence of benefit restrictions – are thrown together in squats and crowded rented rooms.

Meeting this need presents commissioners with an ethical dilemma. Any expansion in demand for services must be met from within existing resource allocation. Can a response to this new need be met, or will services for UK nationals be compromised?

The response of Borough 'A' has shown a degree of short term success. Active policing and the application of Anti Social Behaviour Orders have served to meet the needs of established residents in many respects. Those migrants who remain however are the most chaotic: offending regularly;

exhibiting mental health problems and having little capacity remaining to enable them to take up the advice which is available. Short prison sentences offer the borough no significant respite and the lack of services available mean that Borough 'A' now has no mechanism for managing this problem actively.

Staff in Borough 'A' faced with a significant human need at an individual level, make potential service users aware of provision in other areas. In doing so, they exploit an aspect of treatment provision that exists only in large conurbations. The opposite issue was described by Borough 'B', that in providing services there was a risk of developing a 'honey pot' which would increase demand for services within the borough.

The insularity of boroughs in terms of funding is not matched by a static population – drug using, offending and treatment can exist across boroughs, though treatment spend is confined within borough boundaries. Only London-wide protocols – and collaboration in spending - for the treatment of very transient groups can overcome this and enable London boroughs to quantify their spending against health and crime savings across London as a whole.

In Borough 'B' a range of facilities are available to address presenting problems. Here however poor access to long term rehabilitation undermines the help given and treatment systems are not always configured around the particular needs of A8 and A2 migrants in relation to housing, employment and social factors. As a result long term social functioning is not best supported.

Improving Service Responses

This study does not suggest that at the moment, opening up drug service provision across London would be problematic or create an unsustainable demand for services. In services where provision is currently available, numbers remain in single figures. Even in a context of budget restraint, these numbers could be absorbed into current treatment systems without adversely affecting quality. Allowing complete access would not drain partnerships' capacity to offer high quality provision across the board. Indeed, any attention to diverse needs required may have benefits for other service users. In managing this small increase in numbers Beyond Boundaries I highlights the importance of collaborating with other agencies so as to create synergy within existing provision (Mills et al, 2007 p 90).

In the process of addressing the drug problems of A8 and A2 nationals it is of interest that so many individuals present at homeless services, while so few engage in drug treatment. In improving levels of engagement, cognisance should be given to the use of alcohol within the group of A8 and A2 migrants. Staff from migrant services saw drug and alcohol use as existing upon a continuum. This

was also observed by treatment staff who saw alcohol users making a transition into drug use. A more joined up strategy in relation to alcohol and drug use might allow for an earlier identification of problems, tackling these before they become entrenched. Once again developments of this type would have benefits across all groups of homeless service users, who experience similar risk factors in relation to making a transition from alcohol into drug use.

Language and Communication

The transition from alcohol use to drug use is not the only factor affecting engagement and retention among A8 and A2 migrants. Drug treatment staff did not consider differences in language to be a barrier to offering services to A8 and A2 migrants, since virtually all service users speak reasonable working English. However in day centres language issues were perceived as being one of the main barriers to the ability to access services. Two possible hypotheses resolve these opposites. It is possible that a certain amount of time elapses before users of day centres develop drug habits and that during this time sufficient language skills are acquired to allow these individuals to take up services. Perhaps more likely however is the possibility that there are numbers of drug users who are not able to take up services either because they don't know of their existence or because a service in a foreign language is of no use to them.

If this latter is the case, then improved leafleting, advertising and outreach could significantly improve penetration rates. Additionally enhancing language skills as an integral part of treatment could increase individuals' likelihood of success. A model whereby service users were offered ESOL and basic skills training as an integral part of a Drug Rehabilitation Requirement was observed within this study. The fact that in this case the worker held both skills may not be repeatable, however offering ESOL alongside education and training is entirely feasible and worthy of development.

Employment

In contrast with many other service users, A8 and A2 migrants are keen to use work as an engine of change in their drug use. In part this is out of necessity because of the lack of recourse to benefits. Work however was also described as a part of this group's sense of self and as part of the arrangements they have made for themselves as migrants. McKeganey (2000) speaks of employment as a key feature in restoring drug users' identities and re-establishing social functioning. The provision of NHS prescribing services observed in one borough in this study was an active stumbling block to maintaining work for these clients. It is surprising that treatment services are not sufficiently flexible to accommodate employed clients, and this should be addressed as a matter of urgency. Reshaping service delivery to allow for this would benefit all working service users, not only A8 migrants. The

strength of comments within this report is indicative of the importance of this issue for new migrants. Since these clients must work (or offend) in order to survive failing to support employment places services in the position of being part of the problem in relation to drug use rather than a solution. Falling out of treatment as a result of the pressure to work gives clients a further experience of failure and, for those within DIP services risks the breach of a court order and the consequences which flow from this.

Diversity and Culture

In other respects the needs of service users from A8 and A2 nations were described as being unremarkable – straightforward and simple. This assertion should be treated with some caution however. It is perhaps axiomatic to say that workers can only perceive difference insofar as it lies within their sphere of understanding. Cultural and social differences which lie outside this field are lost. As a result clients must conform themselves to the majority culture if they wish to receive a service. It is clear from the interviews contained in this report that a service can be provided on these terms, provided drug users approach services initially. However there is a risk that workers may miss important cultural factors in drug misuse and thereby undermine the progress, or the long term effectiveness of treatment. This is particularly the case in relation to this client group since evidence in this report suggests that unless actively engaged, A8 and A2 migrants tend to participate in treatment at a superficial level. It is incumbent upon providers to find out about and respond to minority cultural needs and doing so presents a constant training need for services. (Sangster et al, 2002). The rapidity of this change in London undoubtedly presents real challenges to services at every level and this may be compounded by the fact that drugs staff are not afforded a coherent framework of diversity training of the type available to Social Workers and Probation Staff. Enhancing the provision and consistency of training would reap dividends in relation to diversity generally and A8 nationals in particular. For Partnerships, engaging with issues of diversity offers an opportunity to demonstrate robust protocols and creative responses within both needs assessments and service delivery (Adams, 2005).

Accommodation

On the evidence of this research it is in the arena of accommodation that the long term success of drug treatment is most likely to be compromised. Here again the self sufficiency of A8 and A2 migrants is evident. However the lack of provision of proper housing support for migrants places them in an invidious position. It is in the nature of new migrant communities to congregate together. As can be seen throughout London, A8 and A2 migrants have travelled to areas where similar, established

communities have formed. (Though this research project shows that this is not always a successful stratagem, particularly for more vulnerable migrants with whom the established community may not want to be associated). In addition housing and employment opportunities are often passed by word of mouth, adding to the cohesive nature of this migrant group. However where there is a risk of drug use, this very cohesiveness presents a threat. Polish workers interviewed for this project highlighted the communal aspects of alcohol use for Eastern European migrants and service users drew attention to the part which their social groups played in the development of illegal drug habits. Particularly intractable are the housing problems which force clients to 'detox' alongside user groups, and live with them once drug free. In other circumstances, a period of residential rehabilitation might allow an individual to become more secure in a non-using identity prior to being thrust back into inauspicious circumstances. In the case of A8 and A2 nationals this is not possible.

Improving the housing situation of even UK nationals is not in the gift of drug treatment or wrap around services. Still less is this a possibility for new migrant groups. More than any other aspect of their situation, routes into social housing have been closed off by court judgements (Housing Rights Service, 2006). There is some very limited access, though this relates to those migrants who can show a 'right to reside' and this in turn is dependent upon registration as a worker. This study has shown the lack of knowledge and the reluctance of some A8 and A2 nationals to register and as a consequence some individuals never achieve this status. Findings also showed that housing workers in drugs services have not briefed themselves and that other staff do not refer clients to them. For a pressed workforce developing this knowledge base when so few clients have any eligibility may seem a redundant exercise. At present however this is the only recourse of individual services. This situation is clearly at odds with the thrust of the new Drug Strategy (Home Office, 2008b) which states explicitly that it offers "a radical new focus on services to help drug misusers to re-establish their lives" (p30) and focuses upon poor housing as an impediment to inclusion. In view of this mandate from central government, it is for the NTA nationally to work with strategic partners in relation to social housing and to lobby for any change in relation to the availability of accommodation and residential rehabilitation.

Women Service Users

In relation to women, the situation would seem to be somewhat different. At present women are not presenting to drugs services in great numbers. This study indicates that where recourse to other employment has been unsuccessful women are moving into the sex industry, but that the part of the industry which they generally choose is 'indoor' sex work, not specifically associated with problematic drug use. It would seem that while engaged in sex work within flats and massage parlours, women

separate themselves from their situation. However this study does highlight the possibility of a future concern in relation to these women. As with the male participants in this study, these women were reported as having no concrete plans to return home. Indeed some aspects of their situation make return difficult. On making the decision to leave sex work – or in the case of trafficked women, following any escape – the corrosive aspects of prostitution come to the fore. Women were described as experiencing a type of post traumatic stress which increased their vulnerability to drug misuse. This study shows that women are already presenting with problems – including drug problems – which stem from this. At a strategic level organisations would do well to prepare for the presentation of what is likely to be a small, but significant need. For these clients, women only services are crucially important and cover not only drug rehabilitation, but also Mental Health services, child care provision and safe housing. The argument that provision of a service to these women would act as a drain on the public purse is unconvincing when the market served by the sex industry has been based in the UK.

Wider Considerations

In making decisions relating to treatment provision, commissioners must act wisely to stretch restricted budgets. This study shows that not providing services does have significant implications for wider public health and crime as well as the health and wellbeing of the individual drug user. This study – in contrast with Beyond Boundaries I - did not find evidence of dangerous injecting practices as routine, however a number of other risk factors were evident and these have implications for both A8 and A2 nationals and for the health of the wider community. In closing off services, boroughs fail to take advantage of the work undertaken within communities and voluntary organisations with whom partnerships might be forged. Doing so could yield considerable economies of scale which would significantly benefit all parties.

A spectrum of interventions is required in relation to A8 and A2 migrants, and undoubtedly encouraging some migrants to return to their country of origin is the best way forward. Boroughs have been active in paying for tickets home for some migrants. This study shows that the emotional factors which inhibit return may mean that this is not the best course of action. Firstly this may not appeal to all those who would benefit from returning, nor is there any guarantee that having arrived home individuals will be able to reconnect with social structures, develop their resources and make good judgements as to whether re-migration is in their best interests. The Barka model shows that, as with other areas of intervention, investing in a more thoroughgoing programme of measures may reap dividends.

7. CONCLUSION

This report provides a snapshot of treatment need within two London boroughs. Its findings suggest that while closing services to A8 and A2 migrants may have short term benefits, there are negative long term consequences both for potential service users and for the communities in which they live. The report suggests that it would be beneficial to increase access.

However offering wider access to drug treatment services does present some practical difficulties. At the moment provision of services of all kinds is fraught with the fear that A8 and A2 migrants will travel across London to take these up. If the issue is to be handled equitably, it would be fruitful to begin developing mechanisms for merging resources within the Pooled Treatment Budget (PTB) in order to cope with a new section of the population who may remain mobile for some time to come.

If these logistical matters can be overcome there is much to gain from developing treatment provision. Day centres and services for homeless clients are developing a considerable knowledge base about the needs of this group. Accessing this knowledge and collaborating in service delivery may yield a synergy which can only be of benefit to the wider community.

8. ACTION POINTS

Strategic Action

- **To make drug treatment services available to A8 and A2 nationals across London.**
- **To investigate the extent to which the provision of prescribing services across London is restricted to core hours and to enhance the flexibility of provision within London as a whole.**
- **To lobby for the provision of rehabilitation services for A8 and A2 migrants.**
- **To move towards the treatment of alcohol and drug problems as a continuum in relation to this group and to begin to develop strategies for intervention which will address the risks of individuals moving from one drug to another.**
- **To develop pan-London mechanisms for managing new migrant groups, mapping the numbers in treatment and allocating resources accordingly.**
- **To support commissioners and providers in their delivery of diversity training to staff.**
- **To collaborate with Sexual Health Services in estimating the need for provision for women who face trauma on leaving the sex industry or trafficking.**
- **To participate in the development of women-only services (drugs services, mental health services and housing provision) to respond to this demand.**
- **To investigate and support the roll out of the Barka Foundation's service more widely across London.**

Local Action

- **To make drug treatment services available to A8 and A2 nationals within the local partnership.**
- **To explore mechanisms for delivering drugs services flexibly to all clients beyond core hours.**
- **To consider mechanisms for enhancing the provision of ESOL training within treatment and allied services – collaborating with probation services in the provision of basic skills and with ESOL providers in local boroughs.**
- **To develop promotional materials in languages other than English.**
- **To broaden the scope of advertising to target services used by A8 and A2 nationals**
- **To develop outreach services aimed at engaging A8 and A2 nationals who are developing drug problems.**
- **To explore avenues for the employment – either as paid staff or as volunteers – of workers from A8 and A2 nations.**

- **To support the training of housing and welfare benefits workers in undertaking training concerning the eligibility of A8 and A2 migrants.**
- **To encourage the referral of A8 and A2 migrants for housing and benefits advice.**
- **To enhance the level and consistency of training for drug workers in relation to diversity.**
- **To take up every opportunity for collaboration with other service providers – where necessary moving beyond formal partnerships – in order to work creatively and efficiently in developing service provision for this group.**
- **To collaborate with providers of services for women in developing services for women leaving the sex industry or who have escaped from sex trafficking.**
- **To collaborate with day centres and services for homeless clients in developing screening programmes for HIV and TB.**
- **To consider mechanisms for assisting migrants to return to their country of origin in a structured and supported way.**

Further Research

- **To examine the application of these findings within other London partnerships and across the UK**
- **To consider the implications of migration from A10 nations for the delivery of health promotion – particularly HIV hepatitis B/C and TB – and health services in London**

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Appendix 1.4 Paper 4

Mills, K. and Knight, T. (2009). Offering substance misuse services to Accession Eight Migrants in London: findings from a qualitative study, *Drugs: education, prevention and policy,* 2009; 17, 6. 1–17. doi: 10.3109/09687630903200777

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Offering substance misuse services to Accession Eight migrants in London: Findings from a qualitative study

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Abstract
This article reports findings from a study undertaken in two parts between November 2006 and May 2008, investigating the drug treatment needs of new migrants to the UK. The study explored the eligibility and treatment needs of new communities in London. This article reports findings in relation to EU Accession Eight (A8) nationals' entitlement and access to drug treatment. For this part of the study 20, in depth interviews were conducted with staff of Drug and Alcohol Action Teams and treatment services in seven London boroughs to identify levels of service provision, along with practitioners' interpretations of entitlement to services, perceptions of local need and gaps in treatment. Additionally, 19 interviews were conducted with related service providers. Six service users were interviewed. Findings show professionals are eager to address the needs of A8 migrants but services are providing limited treatment to A8 nationals. However, entitlements vary between boroughs and decisions are pragmatic, based upon assessments of clinical necessity but also financial constraints. Decisions made on this footing can lead to services being denied despite intense need and resulting in reduced opportunities for planning. The article concludes with observations as to how provision might develop to meet a changing context.

Introduction and background to the study

On 1 May 2004, ten countries – Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia – joined the European Union (EU). While nationals of Malta and Cyprus had full free movement rights and rights to work throughout the EU, existing EU member states had the right to regulate access to their labour markets by nationals of the other eight

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countries – the 'Accession 8' or 'A8'. Following this expansion the UK Government made the decision, along with Ireland and Sweden, to allow migration from the A8 nations. However, transitional measures to regulate A8 nationals' access to the UK labour market (via the Worker Registration Scheme) and to restrict access to social security benefits were put in place (Home Office, 2007, p. 1). These restrictions meant A8 nationals arriving in the UK after accession were not entitled to the housing or unemployment support available to UK nationals until they had completed one full year of registered work.

Recent studies (Pollard, Latorre, & Sriskandarajah, 2008) have shown that for the vast majority of Eastern European migrants, travel to and work in the UK forms part of an ordered life plan and is, for all concerned, a useful and beneficial experience. However, there are indications that a number of A8 migrants, as yet unquantifiable, have had difficulties with finding housing and employment upon arrival in the UK (Drinkwater, Eade, & Garapich, 2006; Homeless Link, 2006; Morris, 2004), and some London boroughs drug services are beginning to be approached by individuals seeking treatment (or being channelled via the Drug Interventions Programme (DIP) process). As a consequence of restrictions placed upon access to income related benefits (such as Income Support, Jobseekers Allowance, Pension Credit, Housing Benefit and Council Tax Benefit) and healthcare access limited to visitor's rights only (discussed further below), some drugs services have been unwilling or unable to respond to these approaches.

Furthermore, the nature of their need is not by any means properly understood. While the past 5 years have seen some coalescence of research into the substance misuse needs of minority populations (Becker & Duffy, 2002; Sangster, Shiner, Patel, & Sheikh, 2002; Fountain, Bashford, & Winters, 2003; Mills, 2008), research projects have focussed in large part upon established populations – women, Black British and British Asian communities. The literature relating to newer populations is sparse. Hard data as to the numbers of migrants is not available (Hansard, 2006a) and without this as a starting point, understanding the levels and type of need is mere estimation and guesswork.

The current literature (Audit Commission, 2007; Homeless Link, 2006) identifies homelessness, language barriers, alcohol misuse and public service entitlement to health and social care as key issues for newly arrived populations, particularly those from the European Union accession countries. Recent research into A8 nationals in the UK is largely focussed on labour trends and public service provision (Anderson, Ruhs, Rogaly, & Spencer, 2006; Audit Commission, 2007; Gilpin, Henty, Lemos, Portes, & Bullen, 2006; Sriskandarajah, Cooley, & Reed, 2005). Findings from this work have limited direct application to drug service provision. Little is known about substance misuse among A8 nationals in the UK. There are many unclear areas, including: the prevalence and nature of substance misuse within newly arrived populations; how migration is affecting substance misuse in these populations and whether migrants are bringing domestic substance misuse patterns with them or adopting those found in the UK.

New migrants often exhibit high patterns of residential mobility early after their arrival (Cole et al., 2006; Robinson & Reeve, 2005; Travers, Tunstall,

Whitehead, & Pruvot, 2007) and this has been highlighted as presenting difficulties for services trying to engage with them. The UK popular press reports (Hetherington, 2007 among many others) that among newer populations there is an increasing need for significant public service support and many Local Government Authorities make associations between increased costs and the arrival of new populations in their boroughs (DCLG, 2008). It is important to make sure local authorities minimize local tensions by dispelling myths surrounding the costs of migrant workers (Audit Commission, 2007) and supporting community cohesion (DCLG, 2008). In reality, A8 migrant groups place fewer demands on public services (Hansard, 2006b; Travers et al., 2007), perhaps because these groups also tend to be young (83% aged between 18 and 34) with no dependent children (Sriskandarajah et al., 2005; DCLG, 2008). So, although local authorities encounter highly visible costs to account for concerns associated with particular households (such as translation services and specialist support for the homeless) (Travers et al., 2007) with rapid population change amplifying these pressures (DCLG, 2008), many recent migrants are making relatively large contributions to the public purse (DCLG, 2008, 2009; Sriskandarajah et al., 2005).

The Audit Commission (2007) makes suggestions as to how the UK Government and regional bodies can help local areas to respond to the challenges of emerging populations by developing regional strategies, and coordinating their own activities to support local areas with data and information so they can prepare for future increases in migration. However, it suggests that local authorities (which include substance misuse services) are responsible for maintaining an understanding of how their local areas are changing by monitoring data and intelligence. The Department for Communities and Local Government Paper 'Managing the impacts of migration: a cross government approach' (DCLG, 2008), underlines the fact that local mechanisms are most effective in managing local need but notes the need for national, government led support for these initiatives. The Audit Commission (2007) suggests local authorities address language, advice and information needs and that they need to be active in modifying services to meet the needs of their changing populations. This is especially important for treatment services because drug and alcohol knowledge and awareness has been found to be low in BME communities (Banton, Dhillon, Johnson, & Subhra, 2006; Mills, Brooks, Sender, & Green, 2006).

Concerns about homelessness, rough sleeping and alcohol consumption among A8 migrants are increasing (Homeless Link, 2006; McLaughlin, 2006; Morris, 2004; St Mungo's, 2005; Travers et al., 2007). The Department of Communities and Local Government's (DCLG, 2006) Statutory Homelessness Statistical Releases do not publish the nationalities of those they define as both homeless and entitled to local authority assistance, an omission shared by the National Drug Treatment Monitoring System (NDTMS) at the time of this research. Even where entitlement is established, homeless people with substance misuse problems often live extremely chaotic lives and find it particularly difficult to recognize their own support needs or seek help and tackle their

situation (Randall, 1998). Exclusionary bureaucracy and the fact that unregistered A8 nationals have no access to welfare benefits compounds this vulnerability to rough sleeping and exclusion, conflicting with the Government's Community Cohesion Agenda (Home Office, 2005a). It is axiomatic to say that the voices of newly arrived populations are rarely heard and that gathering their opinions is not a straightforward process, but findings from research in other UK cities reveal that where individuals from new communities are not integrated into social networks there appears to be an increased risk of substance misuse (Mills et al., 2006).

The Department of Health (2006) suggests A8 nationals should receive free primary medical care (i.e. that which is deemed 'clinically necessary') as with other 'visitors' to the UK and place emphasis on lawful residence, tax and national insurance contributions as the main qualifying criterion for receiving free GP care (Homeless Link website, 01/02/2007).

However, entitlement to income-related benefit is linked to a person's ability to prove their 'right to reside' and 'habitual residence' in the UK, both of which are based on proof of nationality and economic activity. Although economic activity may be part time it must be judged by the Department of Work and Pensions to be 'genuine and effective' and not of such a small scale as to be 'marginal and ancillary' (Kennedy & Wilson, 2004).

Those who have been in the UK for more than 2 years are not required to demonstrate a right to reside or be subject to the habitual residence test (Kennedy & Wilson, 2004). As such, it appears that current 'workers' and those who have completed 12 months work on the Workers Registration Scheme (WRS) or been in the UK for more than 2 years should be able to fully access health services and those who are not 'workers' should be treated according to visitors rights as the European Commission (website, 30/04/2004) says:

> *These restrictions only apply to access to the labour market, and not to access to social security benefits or entitlement to social advantages.*
>
> *European Commission* (*website*, 30/04/2004)

Moreover, these restrictions will end in 2011 and should be utilized to accommodate the *transition* to *'complete freedom of movement for workers from new Member States'* (European Commission website, 30/04/2004).

These interpretations are based on parliamentary documents and discussions. Such guidelines are difficult to source from the Department of Health and National Health Service, and though the Department of Health has updated and clarified guidance (Department of Health, 2007) the issue remains a subject of contention amongst clinicians (Cassidy, 2008). As a consequence drug services lack information when trying to provide for A8 migrants.

From these observations it can be seen that there is a pressing need to clarify the minutiae of eligibility, draw together and follow up economy-based research studies and to provide accurate information about the needs of new populations (Audit Commission, 2007) in order to enable Drug and Alcohol Action Teams (DAATs) to make informed decisions concerning service delivery. This research

project, based upon work undertaken in London in 2007, describes the problems which the current lack of knowledge and clarity is creating in the field and offers some observations about levels of need and solutions.

Methodology

In pursuing this piece of research, data were collected from semi-structured interviews with 'key informants', including representatives of drug agencies, community groups and organizations supporting newly arrived groups. All interviews were audio recorded and subsequently transcribed.

A sample of London boroughs was generated by identifying those with existing challenges in working with new populations.

A research project steering group advised, directed and commented on the research throughout. The group was composed of representatives from the project's funders, the research team and key service commissioners and providers. The group were consulted about the boroughs which might be useful partners. Key features in the selection were

- a geographical spread
- need identified or an interest expressed in the research by the DAAT
- diverse populations with known groups of new migrants.

In total, 45 interviews were undertaken as follows: DAAT Joint Commissioning Managers (4), DAAT Information/Data Managers (6), DAAT Managers (2), DIP Managers (2), DAAT Communities Coordinator (2), Drug Treatment Service Managers (2) and Staff (2), Voluntary sector Staff (13), Local Authority Staff (2), Police (1), Rough Sleepers Services (2), Prison Teams (1), Service Users (6).

Interview schedules were prepared by the research team and agreed with the steering group. These schedules were reconfigured to meet the knowledge of five broad groups in the sample: DAAT joint commissioning managers, DAAT information managers, DAAT/Local Authority diversity officers and members of community and service users from newly arrived populations. Initial interviews were undertaken with key personnel within the DAAT in order to collect data about current practice and levels of information. Further interviews were undertaken with DAAT and local authority staff holding particular responsibility for diversity and community engagement to learn about the communities in the borough. These initial interviews triggered the involvement of treatment services which led in turn to interviews with wider community groups – some specific to new populations and others meeting broader support needs of vulnerable individuals. Similarly some interviews were undertaken with key London-wide services (prison staff, second tier agencies) as part of the investigation into the types and needs of newly arrived populations. Finally, interviews were conducted with service users in a variety of settings – self-help groups, day centres and 'drop ins' – to gather some information on their experiences. The majority of these

interviews were undertaken 'face-to-face'; however, circumstances demanded that eight interviews were conducted by telephone

The majority of interviewees supported the project as an aspect of their working role. Nonetheless confidentiality remains an ethical priority. In order to preserve the anonymity of respondents, interview tapes and transcripts were held exclusively by the research team and not shared with any other parties.

Data was analysed by means of a Framework Analysis (Ritchie & Lewis, 2003). This method of qualitative analysis was selected because it allowed the pre-set aims and objectives of the research to be investigated, while maintaining the integrity of the accounts and observations of the interviewees (ibid). The *a priori* focus meant that data were extracted for analysis on the basis of a pre-defined thematic analysis matrix. The themes making up the matrix were: numbers and levels of newly arrived populations in services; information recording, sharing and use; substance misuse among A8 nationals; eligibility, primary care team[1] (PCT) response and the impact on service delivery; related needs of eastern European migrants; towards solutions.

All analysis was undertaken by both authors. The short time allocated to the research by its funders and ethical considerations required that analyses were not distributed for comment to research participants but to go some way towards their verification, aggregated analyses were presented to the project steering group for comment and discussion.

Findings

This section does not present all information arising from the research project. Some items – concerning information gathering and recording, for example, are of greatest interest to service commissioners and providers. In order to open discussion, this article concentrates upon perceptions of numbers seeking treatment, service responses to this apparent influx and the needs of migrants discovered thus far.

Levels of demand and service restrictions

The authors are acutely aware of the importance of avoiding caricature in describing groups of people. Nevertheless this research did appear to identify three very broad groups of post-2004 A8 migrants. The first have developed networks within the UK and make a significant contribution within the economy. A second group appears to be less well prepared for transition to a new country and with poor skills in English and little financial backup, its members are vulnerable to exploitation. Unless housing and employment are obtained, these individuals can fall into complete destitution as they have no resort whatsoever to public funds. The needs of this group fell outside the scope of this research project. However, other research (HM Treasury, 2006) would indicate that the

input of initial employment and language support enables members of this group to make a proper transition into the life of the nation.

This research did observe a third group: while much smaller in number, its members did appear to have much more entrenched problems. Staff in homelessness services perceived the difficulties they present as being analogous to those of other rough sleepers: health and mental health problems or drug and alcohol use. It would seem to be members of this group who are presenting at drug services. The extent to which drug misuse was a pre-existing problem could not be ascertained firmly, but one drugs worker observed:

> *You don't come here looking for work and just end up on heroin.*
>
> *Drug Treatment Worker*

Some sense of growing numbers of European migrants was reflected in all boroughs visited. Seventeen respondents (40%) commented that the number of migrants from Eastern Europe was increasing. The opinions of workers in arrest referral provided a sense of a growing trend where numbers were described as 'quite a few'. This is borne out by respondent's reports that at one central London police station 10% of its arrests were of A8 nationals. This sense of an impending increase in demand for services resonated with information from frontline homeless services. When asked, staff within homeless services estimated the numbers of service users from A8 countries as approximately one third of the whole. However when counted, the numbers concerned were discovered to be in the order of 15% – concordant with other research findings (Homeless Link, 2006).

It was, however, clear from the findings of this research that current information systems are unequal to assisting services in gathering proper information in managing and developing services in relation to new migrant groups. The current NDTMS offer no data at all in relation to migrants from Eastern Europe. Information Managers reported their efforts to gather information as to changing trends, but these relied upon informal systems and were not reliable.

Access to drug services varies between the London boroughs studied. While some successful work is being done with A8 nationals within existing resources, other A8 nationals are denied access to the treatment systems based on resource constraints.

Some boroughs described services offered to all with no restrictions, while in others there was evidence that treatment was abruptly terminated following the issuing of guidance on eligibility. Within most boroughs decision-making was undertaken on a pragmatic basis and clients were able to access not only harm reduction advice and needle exchange, but also prescribing services and open access counselling:

> *We may refer them for GP prescribing as it is primary care and tier two[2] like needle exchanges. So open access services, plus anything from a GP. We wouldn't refer them onto anything structured, like a day programme.*
>
> *Joint Commissioning Manager*

Interviewees described the difficulty of making good clinical decisions in the context of these restrictions

> *We can't sanction that you use NHS money . . . on treating A8 nationals . . . but . . . Do whatever you think is clinically appropriate for that individual.*
>
> *Joint Commissioning Manager*

> *The open access fits into tier 1, 2 . . . where there isn't any hard and fast money being handed over. You can come for groupwork; you're not really taking someone else's place because they have got some spare capacity . . . in the spirit of trying to help the individual.*
>
> *Police Officer*

However, decisions were also based on concerns that typical weekday programmes restrict people's ability to work, a key factor for a group unable to access financial support:

> *They aren't able to claim any benefits so if we were to put them on a treatment programme for 15 hours a week they wouldn't be able to work.*
>
> *Joint Commissioning Manager*

Another DAAT manager perceived the guidance as being further obscured by pressures to fulfil targets for overall numbers in treatment.

Residential rehabilitation was not available to residents of any borough owing to restrictions on Community Care funding, but in one borough inpatient detox was available, provided this was not funded by the local authority.

Overall a picture emerged of services attempting to make provision for individuals in abject need, according to targets set for mainstream service users, but amid a general impression that any provision was contrary to central guidance. Equally, providers were aware that by doing so they might compound existing problems.

Service restrictions and criminal justice provision

Differences in practice are perhaps most clearly seen when refracted through the lens of the DIP process. The explicit purpose of DIP is to tackle drug-related crime by influencing drug misusing offenders to engage in treatment. A mix of persuasion and coercion is brought to bear at every stage of the criminal justice process with a view to reducing crime and improving the health and life chances of drug users (Home Office, 2008). In five of the boroughs involved in the research project, access to DIP was open to A8 migrants (and a joint commissioner described referrals as flowing at the rate of two per week). However in two boroughs, migrants are denied access to provision, albeit reluctantly:

> *Resources are so tight – what does the DIP manager do. Let those clients into treatment and then a* [*local borough*] *client doesn't get in? That is a conundrum.*
>
> *Information Officer*

However, the consequences for individuals emerged as significant. Denied access to 'restrictions on bail' (bail on the condition of treatment) can lead to remands in custody. Interviewees perceived this as counter to the intentions of

the programme:

> *'You've come to me . . . you're interested in treatment. I can't offer you treatment'. It seems to be going . . . against the ethos of the programme.*
>
> *DIP Operations Manager*

In one borough, negotiations were in train to devise alternative local bail arrangements for such cases. However, in another, information about low levels of service provision had led to a reduction in referrals to arrest referral workers.

Other than in specific areas where A8 nationals appear to be settling in larger numbers, there was not a sense among respondents that this demand for services could not be met. In those boroughs, which are experiencing the largest inward migration, it was evident that some individuals perceived themselves as managing a scarce resource. One interviewee felt that at the outset hypothecating money is crucial:

> *There is a need for ring fenced money if any is going to be spent on this group.*
>
> *Council Policy Officer*

However, four interviewees viewed any spending as revenue neutral, with savings being made in other areas (Accident and Emergency presentations and Police service being specifically mentioned). In developing services, interviewees commented on the risk of creating a 'magnet' drawing new need into an area. Four interviewees mentioned this specifically, with one noting the undesired consequences for all concerned:

> *The consequence would be an influx of individuals who are struggling in their own country and want to travel for services. They would inevitably be cut off and then people would be coming for services which no longer exist.*
>
> *Homeless Day Centre Worker*

In spite of these fears, there was no indication in this research that individuals crossed Europe to seek treatment in a cynical manipulation of the system, with one service user revealing that he returned home for treatment.

Two interviewees commented upon the fact that the regulations on eligibility for services will change in 2011 as the restrictions on access to health care fall away:

> *One of the strange things about this is that . . . in* 2011 *the rules around benefits have to be regulated across the European Union anyway. So you won't be able to have these barriers.*
>
> *Homeless Link*

In some respects this change in eligibility was seen as a resolution of the problem:

> *This is an interim arrangement from a policy point of view. It will resolve itself in* 2011.
>
> *Homeless Day Centre Worker*

Treatment need and service responses

> *This policy* (*i.e. EU expansion*) *has been hugely successful for* 99% . . . . *It's just a small proportion . . . that are in a really bad way.*
>
> *Deputy Rough Sleepers Manager*

Although the numbers experiencing problems were noted by respondents as being a small section of inward migrants from the EU, concerns were raised about the housing difficulties and language barriers experienced by the more vulnerable individuals. These were viewed as leading to difficulties with gaining satisfactory employment and problems negotiating British systems.

Interviews across London indicate that migrants from Eastern Europe are attempting to access treatment at all levels (needle exchange, arrest referral, prescribing, group counselling, DIP and prison-based schemes). In responding to that need some interviewees did comment upon the differences between British culture and that of Eastern Europe. This was perceived particularly by organizations with a Christian or Catholic ethos, who stated that migrants were likely to seek support from church organizations because of the importance of the church in their home countries.

However, it was the lack of access to public funds which was seen by respondents as most prohibitive in developing creative and culturally competent services:

> *No recourse to public funds is the biggest problem for A8 nationals trying to access treatment. For example, the DAAT wanted to provide a holistic response to trafficked sex workers. However, no help could be provided.*
>
> *DAAT Data Manager*

A further impediment was the informal nature of the tier 2 services for which migrants are universally eligible. One Drug Treatment Worker observed that many migrants have travelled to the UK specifically to seek building work. For these individuals the presence of visible 'track marks' on the upper body may create difficulties when trying to conceal drug use from employers and is therefore a strong disincentive against injecting in the arm. It was noted that in this case injecting users had moved immediately to injecting into the groin. However, the nature of needle exchanges where harm minimization advice might be provided is such that native speakers and interpreters are rarely available and harm reduction messages become harder to transmit.

Despite these difficulties some respondents reported success in penetrating and engaging migrant communities through GP[3] prescribing or via local 'walk in' centres which are able to offer a:

> *Prescribing service, no appointment, quick prescription for methadone . . . has attracted many new communities we were not aware of . . . We had one Eastern European guy come in, then he brought a small group of friends the next day.*
>
> *Joint Commissioning Manager*

Similarly there was some evidence to indicate that services were attempting to make good use of expertise at their disposal, these included secondments of Polish workers and the translation of leaflets into new languages in order to identify and engage with treatment naïve communities.

One interviewee commented forcefully on the benefits of engaging new migrants in existing services:

> *I know personally . . . two A8 people . . . really chaotic drug users who were probably in and out of* [*the*] *custody suite* 4 *or* 5 *times a month . . . and were stabilised on methadone. Stopped committing the*

> *burglaries they were committing to feed their habit. They were given B&B*[4] *accommodation just to stabilise them, both of them ended up working . . . money coming in. B&B packed up . . . and they ended up in a squat . . . but they go to work . . . and are receiving a script. As far as I'm concerned they might be . . . working illegally and living in a squat . . . the fact that they are getting scripted [means] they are not committing burglaries . . . From what was . . . 4 or 5 times a month in our custody suite in the last 6 months nothing at all.*
>
> *Police Officer*

Overall, however, frontline staff expressed the view that, presented with drug users expressing a desire for change, there was nothing they could do:

> *We would love to offer some of these guys detox who genuinely are sick of feeling sick every day.*
>
> *Deputy Rough Sleepers Manager*

To some extent service users endorsed this with one describing himself as having been given 'the gift of desperation' while another said

> *I was tired of abusing and being abused. The shame and guilt reaches a point where you can't even exist and I was tired of it all.*
>
> *Narcotics Anonymous Member*

For both of these men it was Narcotics Anonymous rather than formal treatment which was available.

Discussion

In undertaking this research the team met, at every stage of the process, individuals who were keen to offer a sound and responsive service to new communities. Frustration was expressed at structural, policy and practice impediments which can prevent this. It is these impediments that this discussion seeks to address.

Restricting services on the basis of overwhelming need

The Audit Commission (2007) suggests that both national and local authorities have responsibilities to plan for new communities. A failure to meet these needs with employment and housing services, resulting in A8 migrants being left homeless and descending into substance misuse might be seen as a failure in this regard. Whether the responsibility for such failure lies at local or national level is a moot point.

Although the numbers of vulnerable migrants were described as extremely small in proportion to the whole, without firm data there remains a risk of escalating the extent of the need. This can be seen in the fact that homeless services, when interviewed, overestimated the numbers of service users as almost twice that indicated by this and other research (Homeless Link, 2006). This appears compounded by a lack of hard data – for example from NDTMS. Taken together these two may have consequences for service delivery; with a lack of proper information combining with perceived high levels of need to increase the likelihood of an overreaction in clamping down on new need. This fear about swamping of services can be seen in the response of some boroughs to the influx

of migrants. Overestimation of the numbers of vulnerable A8 migrants suggests the possibility that the restriction of services is a panicked response, informed not by actual numbers but by a fear of overwhelming demand were the door opened.

In these circumstances, lack of proper information might increase the likelihood of an overreaction resulting in a clamping down on new need. In addressing this problem, DAATs might do well to tap the information base of frontline services. By encouraging the gathering of softer data (spending on translation services, for example) indications of potential need might be flagged earlier and more accurately.

Furthermore, it may be that this inflation of numbers is influenced by the sheer destitution and desperation observed by workers in these agencies. Staff repeatedly expressed frustration at their inability to make any inroads into the needs of individuals who approach them and it is possible that a consequence is a conflation of individual extreme need with levels of need overall.

It is possible that changes in the economic climate will see a reduction in the numbers of potential service users. However this cannot be guaranteed: while registrations on the WRS have reduced in recent months (DCLG, 2009), Mills, Broome, and Green (2008a) posit that different impulses drive travel amongst this more vulnerable group and that therefore while economic changes may reduce the pull to the UK, factors of abuse, rurality and social exclusion continue to act as drivers of migration.

Restricting criminal justice interventions

Restricting access to services by definition results in the restriction of access to the DIP. The findings of this research project show that access to treatment through Criminal Justice routes is restricted in two ways. Firstly because of perceptions about eligibility and cost and secondly because of the impact which attendance would have upon an individual's capacity to work. The premise of the DIP is that expense of treatment is recouped nine-fold by savings in other areas (Home Office, 2005b). Of course any such savings occur at a national or at least pan-London level, while DIP funding remains a local expense. This creates a tension for local authorities. Nevertheless, savings are not based on nationality and closing DIP to A8 migrants would seem to be economically foolhardy and against natural justice. Furthermore, these findings indicate that as a consequence of lack of DIP provision, in some areas of London drug misusing A8 nationals are remanded in custody, or receive custodial sentences. Not only does this disturb working patterns, with the elevation in risk which is concomitant with unemployment, custodial disposals carry with them significant avoidable expense. The fact that once in a custodial setting, individuals are eligible for treatment but on release this ends as funding returns to local government would seem to compound the issue.

Developing responsive services

In responding to the needs of drug users from the European Union's Accession 8 nations, boroughs had widely differing policies. While all offered emergency care

and harm reduction advice, access to other services was very limited in some boroughs. As seen from the 'findings' section, guidance on eligibility is open to interpretation, but the research team did not find guidance which suggested that A8 migrants should be debarred from services automatically, nor was there firm evidence that drug services are overwhelmed by new service users.

Some boroughs were able to offer prescribing via GP/shared care arrangements and this together with open access and low threshold prescribing services appeared to be successful for this group. Interventions of this type are relatively inexpensive. The same could be said of harm reduction information in Eastern European languages. Since dangerous injecting practices are being observed and native speakers are not available in needle exchanges, the need for the development of this material is pressing.

However, the treatment needs of a Polish person who arrived in the UK prior to 2004 cannot be assumed to be the same as those of migrants arriving more recently. Wanigaratne, Dar, Abdulrahim, and Strang (2003) offer a definition of ethnicity which is composed of shared 'language, customs and recent common ancestry' (ibid p. 40), However, also mentioned is the notion of a common 'sense of belonging' (ibid p. 40). Since the Second World War, the countries of Eastern Europe have changed fundamentally on more than one occasion. It is open to question whether an individual who fled the Communist regimes of the post-war period experiences the same 'sense of belonging' as a post-expansion migrant. More research into these communities' needs is required in developing and rolling out treatment services.

In responding creatively to the needs of new communities as they are currently understood, interviewees offered a range of solutions. There was considerable debate, however, about the extent to which drugs services are central to those solutions or whether in fact drug misuse in new migrant communities is a product of the experience of migration and a symptom of the social exclusion that migrants face. It was questioned whether drugs services orientated increasingly around local Crime and Disorder Partnerships can offer appropriate services to communities where need is not expressed through crime.

On this point too, further investigation is needed, and the new Drug Strategy (Home Office, 2008) suggests that discussion of this issue would be welcome.

Towards solutions

In a context of eligibility restrictions and finite resources, collaboration between DAATs, community groups and amongst partner agencies offers the greatest synergy in service provision. Such collaboration might allow the recruitment of peripatetic workers or volunteers from minority communities by boroughs where the nucleus of that community is not of sufficient size to allow DAATs to take such steps alone. The workforce pool of staff with these composite skills and attributes is inevitably small. Moreover, cross-borough working might support clients who feel most comfortable seeking treatment outside their own area.

In fact DAATs, having already embraced a multi-agency partnership model, are well placed to participate with other sectors in developing culturally competent services orientated around social need, of which drug misuse is a component. Engaging in discussion might allow DAATs to offer services to those communities whose drugs of choice are not highlighted in the Drug Strategy (Home Office, 2002), which currently has a primary focus upon heroin and crack cocaine.

In the longer term it might be possible to act collaboratively across Europe. Treatment expertise developed in the UK can be used to expand provision in Eastern Europe; the result could be not simply repatriating rootless migrants, but reconnecting people with links at home, developing human and social capital at source (DCLG, 2006).

Many of the solutions proposed above involve, to a greater or lesser extent the devolution of power and money to a more local level. The pursuance of these solutions was seen as on occasion cutting across the targets and performance indicators of centralized monitoring agencies. This creates a tension – the requirement for evidence being offset against the desire for timely action. Commissioners identified themselves as being steeped in governmental priorities and perceived themselves as gatekeepers of services: to be trusted with flexibility in this regard. However, this flow cannot be only one way. Services and DAATs themselves must think actively about the changing demography they observe and use existing mechanisms (for example treatment planning) to feed the information gathered back to the centre in order to highlight need and galvanize change. Only when this double loop (Morgan, 1997) has been achieved can organizations properly respond to the changing needs of a dynamic community.

Conclusion

The origins of this research project lie in the appearance, borne on drug service commissioners and providers, that the influx of new migrants from Eastern Europe to the United Kingdom may precipitate a significant increase in demand for drug services. The findings of this research would indicate that this is not the case. While some individuals are approaching services for treatment, it would seem that these numbers are not large enough to compromise wider service delivery. Nor does it seem that there is a need to impose stringent eligibility criteria in order to stifle this demand. Indeed the imposition of such restrictions may have the negative consequence of increasing prison remands and sentences for this group.

This research project does offer some insights into the treatment needs of this group of service users. Low threshold prescribing showed promise here in attracting individuals into treatment, and as with other groups the need for harm reduction materials is important. Further research and the broadening out of service provision will undoubtedly add to the depth of this understanding. However, if services are to respond to the challenges of a dynamic population

services, providers and policy makers must be willing to cut across service types and budget headings to find new responses to the needs of new groups.

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Notes

[1] This is the title given to a local health organization responsible for managing local health services.
[2] UK drug service commissioning is coordinated under the 'Models of care' framework (NTA, 2002, 2006). Interventions are tiered according to service users' needs and organizational assessment.
[3] General Practitioner: Community-based Medical Doctors.
[4] Bed & Breakfast.

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Appendix 1.5 Paper 5

Mills, K. (2009). Racism, Ethnicity and Drug Misuse: a brief introduction. In Bhui, H.S. (Ed.). *Race and Criminal Justice*. London: Sage.

TWELVE

Racism, Ethnicity, and Drug Misuse: A Brief Introduction

Karen Mills

Introduction

In recent years there has been a growing body of research into the drug treatment needs of black and minority ethnic groups in the UK, although the same is not true across Europe (EMCDDA, 2000; Fountain *et al.*, 2004). This research shows that the social and treatment needs of black and minority ethnic drug users are as varied as those of any other set of individuals. Drugs of choice and mode of administration vary between communities – drugs of greatest prevalence are different in the black Caribbean and Asian communities for example, and are affected by both geography and life experience (Sangster *et al.*, 2002; Mills *et al.*, 2007). A balance must be struck between developing broad provision and meeting individual need. With a new drug strategy in place (Home Office, 2008), the time is now ripe to review drug service provision as it relates to black and minority ethnic communities and consider how well-judged changes might serve to translate research evidence into best practice.

This chapter explores the prevalence and nature of drug use in black and minority ethnic communities, as well as the treatment needs of black and minority ethnic drug users and the extent to which they are being addressed. This discussion is complemented by research evidence into good practice in the area. The chapter concludes with an examination of the ways in which drug treatment services might need to develop to respond to Britain's constantly changing demography.

Black and Minority Ethnic Communities and the Prevalence of Drug Misuse

The history of drug use in Britain abounds with stereotypes. In the broad context of endemic and institutional racism (MacPherson, 1999) it is unsurprising

that many of these centre on the prevalence and perceived dangerousness of black drug users. Thompson (2001) has created a seminal model for the understanding of racism in the British context. His description of racism as operating at the *personal*, *cultural*, and *structural* levels can be seen in operation in wider British society and in relation to the assumptions concerning race and drug misuse. For example, at a cultural level racism attaches the negative stereotypes of drug misuse to particular cultures. Though they mutate over time, these cultural stereotypes are remarkably persistent, whether it be in the form of the evil drug-wielding 'oriental' menace of Dr. Fu Manchu (Rohmer, 1913), the association between African-American jazz music and a supposed drugs 'epidemic' (Yates, 2002), or the violent threat posed by Jamaican 'Yardy' drug dealers (Thompson, 2003). The reality of the situation is rather more complex, and as a result, very difficult to map accurately. Baker (1997) describes the paucity of knowledge about drug use, particularly in minority communities, as inviting 'wishful thinking, anecdotal assertions, propaganda, rumour, exaggeration, and potentially wildly inaccurate guesswork' (Baker, 1997, quoted in Wanigaratne *et al.*, 2003: 40).

One study developed a model for extrapolating drug use overall from the numbers of drug-related deaths (De Angelis, 2004), but this was restricted to opiate use and offered only limited evidence of the much wider range of drugs used by minority ethnic communities. Furthermore, since problem drug users form only a small proportion of the population[1], and since minority ethnic groups form only a small sub-section of that group, even very large minority population samples can yield imprecise results as to the prevalence of drug use and problem drug use (Ramsey *et al.*, 2001). In an attempt to overcome this problem, the 2000 British Crime Survey incorporated 'booster samples' of larger minority groups (Ramsey *et al.*, 2001), a notable finding being the relatively higher use of illicit drugs amongst people of dual heritage (Aust and Smith, 2003).

Sangster *et al.* (2002) were able to provide a clearer view of the nature and extent of drug use in minority populations. Focusing on the issue directly and combining literature search with targeted interviews to examine specific needs, they highlighted the pattern of crack cocaine and cannabis use among black Caribbean people and the preference for smoking (rather than injecting) heroin in South Asian communities. They also point out the subtle geographical differences and difficulties in categorizing cultural difference. Among new communities (Mills *et al.*, 2006, 2007), drug use can be seen to be influenced both by the trends they experience in the UK (e.g., Polish migrants being influenced by *khat* use among the London Somali community) and by the patterns of use brought from a country of origin (e.g., opium as a drug of choice among Peterborough's Iranian community). However, as Fountain *et al.* (2003)

[1]Hough (2002: 987) estimates that while some two million individuals use illegal drugs each month, the 'number of problem drug users is unlikely to exceed 200,000'.

point out, some trends are judged by the numbers presenting to services and are therefore possibly skewed by the services available, rather than being a reliable measure of actual need (see also Shaw *et al.*, 2007).

Drug Misuse, Social Inequality, and Race

A large body of research, dating back to the 1980s, highlights the fact that drug misuse is concentrated in areas of greatest deprivation (Fountain *et al.*, 2003). Seddon (2006) elaborates upon the social context of the drugs–crime nexus, and Buchanan (2006) stresses the extent to which disadvantage acts to limit and fracture the lives of drug users. McIntosh *et al.* (2000) offer a powerful description of the ways in which drug users must repair these 'spoiled identities' (p. 181) if they are to protect themselves from relapse into drug misuse in the long term. Housing, employment, and social structures – the hallmarks of full inclusion within society – are key to this process of restoration.

The 2001–02 British Crime Survey draws out a connection between poverty and heroin use, just as there is an association between affluence and the use of powder cocaine (Aust & Condon, 2003). However, the link between ethnicity, social exclusion, and drug use is by no means clear. The Social Exclusion Unit (1998) commented that the majority of England's black and minority ethnic communities are concentrated in some of the most deprived inner city areas. Furthermore, many of these communities are young and growing, with large numbers of under-25s. As drug use is more likely amongst younger age groups, higher usage would therefore be expected amongst black and minority ethnic communities. However, the evidence indicates that, nationally, the prevalence of illegal use is actually less among minority ethnic communities than white communities (GLADA 2003, 2007). This is particularly the case among South Asians, who report much lower drug use than white people. (Fountain *et al.*, 2003). Theories about the reasons for this lower reported prevalence among minority groups include protective factors afforded by strong family supports and cultural taboos against admitting to drug use (Sangster *et al.*, 2002)[2]. Sangster *et al.* (2002) point to the fact that drug seekers of all races and ethnicities visit areas of 'known' drug prevalence in order to purchase drugs to consume elsewhere. Since the drugs market operates strictly within the laws of market forces, open and closed drugs markets – street sales and crack houses – develop to provide for this 'need'. In the process these neighbourhoods become places of high crime, noise, and nuisance and crack houses develop in the homes of the most vulnerable (GLADA, 2003). This developing of markets in response to a myth of availability reconciles the apparent opposites that levels of drug use are

[2] As noted earlier, the only substantial difference from this trend is higher use among individuals of dual heritage than would seem to be the case among other minority groups (Aust & Smith, 2003). However, this needs to be replicated in other studies before it can be seen as a conclusive difference.

actually higher among white users than black and minority ethnic users but that, nevertheless, drug misuse tears minority communities apart (Sangster *et al.*, 2002).

Community Stigmas and Strengths

Social exclusion is not the only factor which influences the lives of black and minority ethnic drug users. Low levels of drug awareness are discernible in all minority communities (Bashford *et al.*, 2003; Mills *et al.*, 2007). These levels of ignorance can cause problems in themselves – for example, in some Asian communities young people with addictions might be sent back to Pakistan in the belief that this will offer some respite, while in fact heroin is nearer its source and cheaper for the user (Bashford *et al.*, 2003). Furthermore, a lack of parental knowledge can intensify pressures upon Asian young people who are conversant with and under pressure to use drugs but have an important avenue for advice and discussion closed to them (Mills *et al.*, 2007).

In newer communities, and among established communities where older members remain non-English-speaking, there may quite literally be no shared language to discuss drugs problems. Some languages (e.g., Farsi) simply have no pejorative words that equate to 'illegal drugs' and must rely on more generic terms (medicines). Some minority groups display a strong element of denial, wanting to see drug problems as affecting the host community and not their own lives (Mills *et al.*, 2006). Such attitudes risk feeding stereotypes that some minority communities – particularly those from South Asia – are a low-risk group with no need for services (Bashford *et al.*, 2003). This sense of the betrayal of fundamental cultural mores, sometimes described as the 'stigma' attached to drugs, is often associated with Asian or Muslim communities. It is linked to issues of cultural and religious doctrine and is a significant feature affecting the openness with which drugs issues can be discussed in some black and minority ethnic groups (Pearson & Patel, 1998). Stigma applies both to the use of drugs and to talking about drug-related issues – with a sense that such discussion serves to normalize and offer encouragement towards drug use. In breaching these rules, individuals risk exclusion from family, and families risk exclusion from the wider community. Evidence of stigma can be seen both in established minority communities and among newly arrived populations. Mills *et al.* (2007) comment that this reticence can extend to community members denying the impact of drugs upon their lives even though, in their experience of migration and displacement, they have witnessed or faced the use of drugs as a weapon of war. In these newer community groups, stigma is made more acute by the fact that networks are limited and communities are sometimes vanishingly small – ostracism in these circumstances is total and potentially lifelong (Mills *et al.*, 2007).

Patel *et al.* (2004) explore the vulnerability to drug misuse of unaccompanied minors arriving in the UK. These young people, without the points of reference

provided by family, are subject to influences from new friends and street culture. Patel *et al.* (2004) point out that young refugees are not a homogenous and easily defined group. Mills *et al.'s* (2007) research found that some of these young people had been sent abroad by their parents to escape the repercussions of a regime change, and that a previously privileged background had left them unfit for their new life. In seeking acceptance amongst new peers they turned to the credibility they felt was offered by drugs.

However, these vulnerabilities are only part of the picture and great strength lies at the heart of minority communities. Most asylum seekers travel only as far as the borders of the next country (Refugee Action, 2005). Only the richest, most powerful, and most capable are likely to journey as far as Europe and to the UK (Mills *et al.*, 2007). Studies in Lambeth, London (see Mills *et al.*, 2007), show that 48 per cent of the borough's Somali community are educated to degree level or above. Harnessing this untapped potential (and a similar percentage of that community are unemployed) might be the key to overcoming social exclusion in these communities and consequently to helping address and prevent drug misuse.

Delivering Services to Black and Minority Ethnic Groups

Widespread drug misuse in the UK is a relatively recent phenomenon. Prior to the 1980s addiction was limited to a small number of white, middle-class users dependent upon heroin (Strang & Gossop, 2005; Pearson & Patel, 2007). During the 1980s, however, the availability of heroin in UK cities mushroomed (Yates, 2002). At this time the issue was refracted through the lens of public health and the main problem was seen as the transmission of HIV/AIDS (Robertson, 2005). The response from the UK press was fierce and triggered the public health responses of mass HIV-awareness advertising and a rapid growth in treatment services (ACMD, 1982; Edwards, 1989). At this stage, however, heroin use was seen as a white, male issue. Treatment services concentrated their efforts on this section of the population, and treatment grew up around these needs (Pearson & Patel, 2007). The focus of treatment since has been upon substitute prescribing, and since no comparable treatment option exists in relation to crack cocaine, these services were slow to grow (Bottomley, 1999), with negative consequences for black crack users. Similarly, the fact that services for opiate users grew up in response to HIV/AIDS meant that stress was laid on the dangers of injection as a mode of administration, and the substitution of heroin smoking as a less dangerous form of use. For South Asian users, however, where the chosen mode of administration is smoking (Cottew and Oyefeso, 2005), such advice can lead to needs being marginalized and underestimated (Sangster *et al.*, 2002).

This history casts a long shadow. While services might have changed dramatically, black and minority ethnic service users remain estranged from

services that are perceived as unwelcoming and inappropriate (Home Office, 2002; South, 2002). Interestingly, in some areas, evidence is emerging that where young black men are engaged by services, their retention is as good as it is for white service users[3]. If this is confirmed to be the case, then there are learning points to make good practice more widespread and issues for services in advertising their presence.

More recently the focus – and the funding – of drug treatment has been upon those drugs that cause greatest harm in terms of crime. While this has led to a growth in the development of crack services – many offering cognitive behavioural therapies – this does cause a further set of tensions. Firstly, minority communities have tended to have negative experiences of the criminal justice system (Bowling and Philips 2002; see also Smith's Chapter 2 in this volume). Unless actively overturned, the misgivings stemming from a history of negative experiences can have a similarly negative impact upon an individual's engagement with the treatment process. If such treatment is quasi-compulsory via a drug rehabilitation requirement (McSweeney *et al.*, 2006), this has implications for equal access to justice. If retention is compromised by previous negative experiences, then the consequent breaching of an order will serve to accelerate an individual's journey through the criminal justice system.

Furthermore, there is a neglect of those drugs and, consequently, of the communities more associated with particular drugs and are not strongly connected to crime and disorder. *Khat* is a particular case in point here. Used extensively by the Somali and Yemeni communities and strongly associated with deprivation, unemployment, and exclusion (which would not appear to be the case in Somalia and Yemen itself), this drug has until recently received only low priority in strategy documents as it is not a Class 'A' drug (Havell, 2004), and its use not a cause of crime. Indeed it can be argued that within the current framework – focusing as it does upon crime and disorder – to include *khat* use would be inappropriate (Mills *et al.*, 2007) and serve to criminalize a whole new section of the public. While *khat* use does create problems for the families and individuals who use it the solution lies not in judicial measures, but in inclusive, community solutions to what is in fact a symptom of social exclusion (Havell, 2004; Buchanan, 2004). Buchanan (2006) goes so far as to argue that if the problems of drug misuse stem from social exclusion, then drug treatment cannot act to resolve them (McKeganey, 2008). It is heartening to observe that the latest drug strategy makes specific mention of wider problems (Home Office, 2008), possibly heralding a broadening of strategy to include the much more intractable problem of social inclusion.

[3]This is a finding of an unpublished study commissioned by the National Treatment Agency. Source: personal communication with senior NTA official.

Service Responses

Responding to the drug treatment needs of black and minority ethnic groups requires effort at all levels. Fundamental requirements are enshrined in law (Drug Strategy Directorate, 2003), and the Race Relations (Amendment) Act 2000 speaks of the need to eradicate discrimination and develop action plans for race equality. In practical terms the starting point for developing services is a local needs assessment, and increasingly needs assessments accentuate the needs of black and minority ethnic service users within local crime reduction partnerships. From this starting point, however, clear guidance is required to support commissioners and providers in promoting good practice. Sangster *et al.* (2002) emphasize the importance of 'cultural competence'. This concept, underlining the need for provision to be sensitive, specific, and appropriate (Sangster *et al.*, 2002), is active and incremental, with services striving to build upon existing good practice. The Race and Drugs Project (2005) offers explicit action points to services at every stage of development in order to support them in making race equality explicit.

Good practice, then, begins with policy development. Here it is crucial that policies are developed and reviewed in conjunction with local minority communities, and with key partners to ensure that all participants in service delivery are committed to processes of equality (Race and Drugs Project, 2005). In implementation, there is a need to embed race equality at all levels and to ring-fence funding for its delivery. This includes the representation at all levels of black and minority ethnic staff (Havell, 2004). Sangster *et al.* (2002) stress the dangers of interpreting this last point as crude 'ethnic matching'. It cannot be assumed that clients will wish to see a worker from their own ethnic background. Indeed, concerns about confidentiality may mean that staff from outside the community are preferred (Mills *et al.*, 2006, 2007), though a balance must be struck in each case between the requirement to demonstrate privacy actively and the possibility of offering services in an individual's own language (Fountain *et al.*, 2003). Clearly at its best, a process of training and cross-fertilization can occur within staff groups to a point where all frontline staff are meshed into community needs and are able to offer an appropriate and responsive service (Bashford *et al.*, 2003).

When delivering services there is a need to target publicity appropriately, including giving specific thought to the needs of women from minority ethnic groups (Race and Drugs Project, 2005), and to ensuring that service users can recognize that services are not threatening. This might include the presentation of a waiting room with provision of culturally specific pictures and newspapers to show to new service users that the diverse needs of local minority groups are considered from the first (Sangster *et al.*, 2002). Alone, however, these symbols are tokenistic and alienating. They must be backed up with a familiarity with the needs of communities (Home Office, 2006), proper staff training, and adequate resources.

For some communities, services need to be reconfigured entirely. Differences of opinion are evident about the extent to which it is the goal of services to be delivered via mainstream mechanisms (Mills *et al.*, 2007). These have the advantage of greater stability via core funding (Sangster *et al.*, 2002; Havell, 2004), but not all service users are at a point where access to these is possible. While Sangster *et al.* (2002) envisage a process whereby over time specialist services might be integrated into mainstream provision, it must be remembered that the demography of the UK is fluid and that new groups might always require some degree of separate provision. In developing new models for services, a balance must on occasion be struck between the need to maintain the privacy of individual service users and the capacity to draw upon the strength that family networks can provide (Mills *et al.*, 2006). In Mills *et al.*'s (2006) research, service users from Asian communities expressed a strong desire to enter into discussion with parents and family but needed mediation and education to facilitate this. Overall there is a need for the democratization of services, that is a sharing of power and the cross fertilization of ideas and knowledge so that the voices of minority communities can be heard more clearly and responded to more actively (Race and Drugs Project, 2005; Fountain *et al.*, 2003).

Conclusion: Translating Knowledge into Action

While it is not possible to draw general conclusions that apply to all places at all times, existing research shows that, in general terms, drug use is lower in black communities than in white. The relatively higher level of crack cocaine and cannabis use amongst black Caribbean people should be seen in this context. Heroin use is highest among white service users and there is relatively low usage of any drug amongst South Asians. In terms of any drug treatment needs, historically, members of black and minority ethnic communities have been described as 'hard to reach'. However, it might be more accurate to say that the nature of the treatment need among these groups is different and that it is service provision that has neglected to conform itself effectively to their needs. The impact of poverty and exclusion, together with individuals' own experience of migration trauma and of racism, combine to catalyse vulnerability. While research into good practice has advanced, there is considerable delay in the implementation of findings. New research indicates the persistence of issues of shame and stigma, continued fears of a lack of confidentiality, and a lack of cultural and religious competence (LDAN, 2007). In part, problems persist because the challenges are diffuse and the landscape apparently shifting. But the guidance offered centrally also lacks specificity. For example, in advising best practice in relation to asylum seekers, the Home Office diversity manual states 'Service providers need to be able to address the differing needs of all these groups' (Home Office, 2006: 35). While at the same

time, demands in relation to waiting times, overall numbers in treatment, and attrition are extremely specific, couched as targets and increasingly cash-linked (NTA, 2007). Behn's aphorism about performance management: 'what gets measured is what gets done' (Behn, 2003: 599), is clearly relevant here.

In the meantime, the demography of the UK changes with new minority groups arriving – for example, from an expanding European Union and asylum seekers from the world's most troubled nations. The new Drug Strategy, set to direct policy until 2018 (Home Office, 2008), does emphasize the need for attention to the needs of black and minority ethnic communities. Drugs like *khat*, which have not previously been given attention, are now noted and responses to local needs assessment in relation to minority communities are stressed. It remains to be seen whether and when strategy becomes action.

Summary

This chapter examines the racist stereotypes that underpin many of the assumptions about drug use by members of minority groups, before exploring the rather more complex reality of drug use within minority ethnic communities. While the evidence does not lend itself to many firm conclusions, it does show that overall drug use is actually less prevalent among minority ethnic groups. The specific risk factors that apply to minority ethnic communities are investigated, with a particular focus on the part played by social exclusion. The chapter assesses how these risks are counterbalanced by protective forces in play for some communities – these include community, family, and faith – although these forces can also alienate and exclude individual drug users.

A brief history of the development of drug treatment services shows how minority groups have often been excluded from provision. The treatment needs of service users from minority groups are outlined, together with an assessment of the efforts which providers have made to meet these needs. While research is providing a fuller picture of what is required, progress by treatment providers remains slow. The chapter concludes with some thoughts about recent policy developments – it remains to be seen if the expressed aspirations can improve the quality of service delivery.

Key Texts

Fountain, J., Bashford, J. and Winters, M. (2003) Black and Minority Ethnic Communities in England: A review of the Literature on Drug Use and Related Service Provision. National Treatment Agency for Substance Misuse and the Centre for Ethnicity and Health, London: NTA.

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Appendix 1.6 Paper 6

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Under the radar: Impact of policies of localism on substance misuse services for refugee and asylum seeking communities

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Abstract
Drug services struggle to respond to the UK's minority communities. Despite some success, suspicion persists. The UK government has advanced localism as a mechanism for supporting communities in developing systems which will meet their needs. Drawing upon three research projects, this article examines the needs of asylum seekers and refugees, the formation of communities and the barriers which leave individuals unnoticed. It explores the potential of localism to engage and support drug users in new communities.

Keywords
asylum, Big Society, drug treatment, drugs, localism, refugee, substance misuse

Notions of 'localism' are widespread in the discourses of politics, economics, globalization and sustainability, at a European level and internationally. The notion of 'subsidiarity' is a guiding organizational principle of the European Union, and Mohan and Stokke (2000) describe the confluence of

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interests which results in the 'paradoxical consensus' (p. 263) of widely opposing political forces hailing the benefit of localism for communities. This impetus towards localism can be observed in UK political activity over the course of the past 15 years (Taylor, 2003).

Localism appeals to those who want to hear the voices of communities who are 'hard to reach'. Refugee communities fall squarely into that category in terms of both research and practice, and this article discusses whether the pursuit of local drug treatment can offer new approaches or whether barriers to service delivery remain insuperable.

What is localism?

Concepts of localism were embedded in the policy agenda of the recent Labour administration. Lodge and Muir (2010) trace Labour's interest in pluralist politics to their exclusion from power during the 1980s and 1990s and the corresponding investment in constitutional reform as a brake on executive power.

Taylor (2003) observes politicians as perceiving the potential of localism to answer problems of democratic participation and social inclusion at local, regional and national levels. All these can be seen in the New Labour administration. Examples of national restructuring are the Acts of devolution which passed administrative, judicial and fiscal powers to Assemblies in Wales (Government of Wales Act 1998) and Northern Ireland (Northern Ireland Act 1998) and to the Scottish Parliament (Scotland Act 1998). At a regional level powers were devolved to local mayors (Labour Party, 1997); the 1997 manifesto envisaged further powers passing to local councils (Labour Party, 1997). Locally, community development operated as a tool for public policy development (Taylor, 2003). In truth, however, this rhetoric was not fulfilled. The Labour Party in government held political power to itself with a complex framework of centrally set targets, oversight and governance (Bache, 2003; Smith, 2010).

Drug treatment demonstrates the central control and targets-based supervision of the delivery of local services. 'Tackling Drugs Together' (Home Office, 1995) established procedures for local needs assessment and commissioning under the aegis of local joint commissioners. While budget streams have changed, this framework remains in place some 15 years later. Under Labour, the control exerted by national targets was super-imposed upon this model. Key indicators of impact and quality were rolled out from the centre with adherence to targets overseen by the National Treatment Agency for Substance Misuse. With objective evidence of treatment efficacy (Gossop et al., 1998, 1999) and a perceived financial saving seen to flow from drug treatment (Home Office, 2008), money was pumped into the

system; numbers in treatment doubled and new initiatives for drug misusing offenders flourished. Entry into treatment has become much easier for the majority of drug users with shorter waiting times, lower thresholds for service delivery and improved outcomes. However, a concentration on the link between drugs and crime has meant that provision has focused upon Class 'A' drugs (heroin and crack cocaine) with central government, maintaining a clear line of sight between national policy and local implementation. This restricts services in delivering treatment to communities who, as will be seen below, have different patterns of use or balance of social and criminal needs.

Localism and the Big Society

The economic downturn in 2008 created conditions where the two main UK political parties could establish a clear demarcation of policy. Faced with the imperative to reduce the economic deficit, Labour's intended response was to increase taxation and bolster growth, while the Conservatives proposed the reduction in the size of the state, with welfare capacity maintained through the development of the 'Big Society' (Smith, 2010).

Elected in May 2010 the UK Coalition Government stated an intention to shift power from Westminster to local areas, the goal being to reduce the state, increase democratic engagement and empower communities (Goodwin, 2011). Localism under the coalition has been expressed in the Localism Act (2010) (DCLG, 2011) devolving power for housing and planning to local government (DCLG, 2010). In addition, in his leadership of the Conservative Party, the Prime Minister has popularized the term the 'Big Society' as a banner under which the key themes of modern Conservative/Coalition decentralization can muster. It is envisaged that every part of government will employ six key drivers to transfer power from Whitehall to the citizenry. The mechanisms which exemplify this process are: reducing bureaucracy; empowering community decision-making; increasing local control of public finance; diversifying the supply of public services; increasing transparency in government and strengthening accountability (DCLG, 2010). At its most effective the 'Big Society' has the scope to achieve a genuine relinquishing of power by Westminster government (Goodwin, 2011).

Localism and drug treatment

Drug treatment in England and Wales demonstrates several of the hallmarks of localism, particularly local control of finance and diversifying supply of services. Treatment is nested within, and affected by, broader trends within health provision. The 2010 White Paper 'Equity and Excellence' proposed

significant organizational change to 'strengthen the local democratic legitimacy of the NHS' (HM Government, 2010: 34). The architecture of these changes is yet to be finalized – political manoeuvring, public opposition and the voices of health service professionals having acted as a brake on the legislative process. However, the consequence for drug treatment is to move funding for drug and alcohol treatment from central control to local government, with responsibility for health priorities and spending decisions vested in local 'Health and Wellbeing Boards' (Department of Health, 2011). Furthermore, the Drug Strategy (Home Office, 2010) emphasized recovery from dependency, with that recovery being supported by treatment agencies and the wider community (Home Office, 2010). These features of local control and recovery combine within a new outcome-based commissioning system. This shift in NHS procurement will allow 'any willing provider' to bid to offer services to drug users and be judged (and paid) on the basis of the successful outcome of their intervention, rather than upon the process.

Simultaneously, the sector has seen the development of ideas of asset-based recovery. Drawing on recovery and strengths-based approaches seen in the fields of justice and mental health (Carpenter, 2002; Farrell, 2004), treatment services work to stimulate the capacity within individuals in order to reduce drug use and concomitant crime and promote long-term recovery.

Localism in new communities

In examining the extent to which the trends of localism and asset-based approaches support the needs of the UK's emerging communities, this article draws on three recent studies focusing on asylum seeking and refugee communities in the UK. These drew on the voices of different interest groups to examine the drivers and the barriers to seeking support from drug treatment services.

The first study, undertaken in the east of England (Mills et al., 2006), explored attitudes to drugs and treatment services. The area studied is a dispersal area within the UK (Sales, 2002) and the 29 respondents (of a wider sample of 96 interviewees) were refugees and asylum seekers from Middle Eastern countries.[1] Interviews were undertaken by speakers of the respondents' mother tongue then transcribed into English. The identity of the respondents was not known at any stage to the research team, a factor crucial to promoting free discussion in this group. Equally, respondents were not asked to identify their asylum status, the limitation this imposed being balanced with enhanced freedom of expression. The majority of respondents were male ($n = 27$) and the sample was relatively young with 20 interviewees being under 30; none were over 45. The refugee community

in the area is composed generally of young men who fled the Iraq war and who are being joined by other family only insofar as their status has been resolved.

The second sample (Mills et al., 2007) was drawn from service providers within a London-based study. Here semi-structured interviews were undertaken with specialist staff in 40 drug and refugee support services within seven London boroughs.

The third study (Sikora et al., 2010) also took place within a UK dispersal area. It drew on a sample of eight refugees (from a wider sample of 58 interviewees) and 44 providers to explore need and service provision for emerging communities in the southeast of England.

The commissioning of the studies and the responses of the group of service providers in the London study show that there is some awareness of the problems faced by individuals seeking refuge in the UK; however, mainstream providers were not alert to the nature or extent of local populations. As an example, information provided to the London study by drugs agencies stated that recent needs assessment had revealed that the largest local minority community was of Somali refugees. Local refugee organizations refuted this, saying that it was in fact only the third largest but that the Somali community had begun to coalesce and consequently be noticed:

> It takes five, six, seven years maybe from when the conflict is at its height to when communities are settled enough to set up community organizations . . . it then takes four or five years for those community organizations to develop enough for anybody to know what they're doing. It takes maybe 10 years before local authority start to recognize that they have got a big community. There are about 15 Somali organizations in [the borough], and it's only really in the last two or three years that they . . . have started being heard. (Refugee Worker, London)

Griffiths et al. (2005) highlight the role of Refugee Community Organizations in supporting new communities both in meeting basic needs early in this process and in negotiating the contested ground of settlement and integration as communities coalesce. However, in relation to drug treatment this process has additional complications. Problematic drug users in refugee communities may wish to remain concealed. In part this can be ascribed to a fear of deportation. Forty-five percent of individuals in the east of England study commented upon the importance of securing refugee status and not acting to undermine the process. Respondents were wary of acknowledging the extent of their own drug use and only one described himself as a drug addict.

Equally persistent is the stigma of drug use. Documented in the literature (Fountain, 2010; Fountain et al., 2003; Mills, 2009; Sangster et al., 2002),

this was prevalent in all three of these studies – mentioned by 93 percent of the east of England respondents. Furthermore, communities forming in England are small and do not see themselves as 'local', but as national or even European in their orientation. As a result, the ostracism which may result from acknowledging a drug problem may be total, lifelong and global.

> Because [the] only people they have to turn to for all their needs . . . are members of their own community and those members – just as in any community – tend to be . . . critical about drug use . . . [it's a] handful of people, but they are very excluded people . . . excluded from their own community as well as excluded – simply because of being asylum seekers or refugees – from the community at large and on top of that the exclusion any drug user would face. (Refugee Worker, London)

This factor accentuates the reality of individuals' fear of a loss of confidentiality in approaching services: that information will leak back to family, friends and community with devastating consequences.

Vulnerability to drug use associated with the stress of acculturation is noted by Johnson (1996). The east of England study noted young men as being vulnerable to a mix of dynamic risk factors: rootlessness; disengagement from services and lack of family support. The London study echoed this challenge of acculturation for unaccompanied minors who have fled from privileged backgrounds, are emotionally unprepared for UK life and experience a great deal of pressure to conform to new and unfamiliar norms (Patel et al., 2004).

Interviewees in the London study made particular mention of drug use as an aspect of modern war, a factor which has resonances with Keller et al. (2003) and Pumariega et al. (2005). Traumatic experiences characterize the expulsion, journey and arrival of a great many asylum seekers with consequent elevation in post-traumatic stress and drug use (Sowey, 2005).

The drugs which respondents perceived as problematic were much broader than those contained within the current UK Drug Strategy. Twenty-one percent of respondents in the east of England group mentioned opium/heroin as problematic within their communities. Cocaine and crack were hardly mentioned, while cannabis was mentioned by 31 percent and cigarettes or naswar (a tobacco-like drug) (Merchant et al., 2000) by 51 percent. Alcohol was viewed as problematic by 48 percent of interviewees and tea was viewed as overused by 10 percent of interviewees. The method of administration of drugs was different from that common in the UK and reminiscent of drug use in interviewees' home nations. For example, respondents mentioned the use of opium smoked using a hot wire plunged into an opium pot.

In the London context the use of khat was described as problematic – and contrasted with the social use of khat in the local Somali context. The social impact of khat use was identified by several respondents. The impact of trauma and of the process of migration as well as acculturation was noted by respondents as having an impact upon the drug use and the consequent need for services. However, this created tensions in service delivery:

> It's been put to us that we should be doing something about khat . . . I don't doubt that there is a need there . . . providing structured drug treatment for people who are chewing khat in response to feelings of isolation and being a minority within our community . . . having post-traumatic stress disorder, having mental health issues. I can see the need. The issue then is when you are told that the only solution to that need is providing drug treatment . . . and making those people come off that drug . . . instead of going right back to the beginning and thinking systematically about how we support any emerging community, any settling community in our borough. (Joint Commissioning Manager)

The strong link under the Labour administration between treatment provision and crime prevention undermines the provision of services to meet social needs. One Joint Commissioning Manager in the London study put it thus:

> Crime and disorder partnership is the wrong focus because this is nothing to do with crime or disorder. It's about wider social care. (Joint Commissioning Manager)

Seventy-two percent of respondents in the east of England study described carrying with them the myths and perceptions of justice and treatment at home and ascribing them to the UK context. It is interesting to note that these findings, and also those contained in Fountain (2010), show the same persistent mythology about the inadequacy of treatment services despite advances in treatment provision and research to suggest that the retention of people from minority ethnic communities who enter treatment is as good as that of their white counterparts (NDTMS, undated).

The London study noted the assets held by refugee communities in terms of human capital. The education and resource of individuals in flight from governmental upheaval was evident in the responses of staff and in the needs assessments carried out by treatment services – one of which revealed that 48 percent of the local Somali population is educated to degree level or above.

Discussion: Localism in action

These findings suggest an unmet need for drug treatment in refugee communities and prompt the question of whether refugee and asylum seeking communities hold the wherewithal to enlist in the UK's Big Society, or whether the impulse of localism will exclude these new communities from treatment pressing them into the ranks of the socially dispossessed.

These findings would suggest that there are significant factors which inhibit refugee and asylum seeking communities from seeking support from drugs services. Newly arrived populations carry with them residual fears of the power of governmental institutions and a persistent mythology about drug treatment. Fear of deportation back to a situation of war or oppression, certainty that admitting a problem will count against any asylum application and an abiding sense that drug treatment offers only punishment and degradation combine to form a barrier to seeking help. Moreover, these findings show the isolation of minority groups within the wider community, and the isolation of drug users within communities themselves. Shame and stigma lead drug users to remain silent about the issues they face, rather than risk exposure. Moreover, the nature of drug use in the minority communities studied would appear to be different from what is broadly anticipated within recent strategy. A wider conception of what constitutes problematic use and drugs of abuse, and the social disintegration which follows, is such that current policy – predicated on criminal behaviour – meets the needs of refugee communities in only the most partial of ways.

The vision of localism is predicated upon the notion that services will follow the clamour of local activism, but the slow formation of new communities within areas militates against their voices being heard. McCabe (2010) describes local communities which exist beyond the sight of local partnerships as 'below the radar'. Refugee communities lie still further out of sight, well under the radar of current mainstream drug service delivery. Small communities form glacially slowly and develop as national, European and global diasporas – not local in their perspective. These individuals remain truly 'hard to reach'.

With these features as a constant background, can a local agenda break through barriers and support inclusion? The commissioning and delivery of treatment services will fall to local 'Health and Wellbeing Boards' (Department of Health, 2011). If these are well constituted (and the planning for their formation remains in its infancy) they hold potential to craft services which will balance the conflicting needs and tensions inherent in the provision of services to minority groups. If boards are not well framed, however, the potential for ideologies to grow up and services to develop along lines which are partisan and exclusive is significant (Alcock, 2010).

Kisby (2010) and Parvin (2009) both suggest that a shift towards localism in politics will actively disadvantage ethnic minority communities. Existing services for refugee groups might, under a Big Society, develop a collective voice, loud enough to penetrate the walls of the establishment. This would be no guarantee that such organizations could overcome fears about confidentiality that were a feature of these studies. Nor does it address the fact that refugee communities are by definition global in their composition, outward facing in their perspective. However, the present situation affords no voice at all to new communities, there is little scope for refugee groups to join in creative partnership with statutory agencies and their knowledge of drug use in these communities is lost. Shifting the balance of power would fit the rhetoric of the Big Society. But local refugee groups have very limited funding and little extra capacity for development and campaigning. The proposals for funding small community groups within a new political framework are rather under-developed. The Prime Minister has floated the notion of a Big Society bank (Alcock, 2010), utilizing the untapped resources in dormant bank accounts, but it remains debatable whether the £400m released would be sufficient to grow third sector organizations to fulfil this new function. The issue of continued funding lies at the heart of the matter. Voluntarism cannot meet the case; political will and local action must be matched by consistent funding if any shift is to be made.

Such funding is not available to the UK Coalition Government. Recession presents a threat to the rollout of local agendas with profitability declining, social impact bonds (see e.g. Social Finance, 2011) potentially appearing less fertile, and charitable giving reducing alongside income (Goodwin, 2011). Taylor-Goobey and Stoker (2011) posit that UK fiscal cuts exceed those observed in other EU nations, with the Department of Communities and Local Government being significantly affected. Cuts of this intensity may reduce capacity within a third sector which remains heavily dependent upon grants and subsidies from central sources. This is especially so as funds as well as power will be devolved to local institutions. Localism without any hypothecation of resources has in the past led to reduced services overall and especially for minority groups. Ring-fencing is not envisaged for the implementation of the Big Society (Evans, 2011). This in turn raises the intensely political question of whether the 'Big Society' is a genuine attempt to restructure power relations in the UK or an old-fashioned attempt to reduce services for the poor while facilitating tax cuts for the wealthy (Kisby, 2010; Smith, 2010).

And if funding were available to new communities, what other services must wither instead? Racist and nationalist attitudes harden in a context of financial uncertainty (Sibbitt, 1997). Unemployment and perceived inequities

in service provision act as catalysts in fomenting race hate. The popular media and the political discourse are seeded with notions of new communities being invasive, malingering and threatening. Were drugs services for these new groups to be developed at the apparent 'expense' of the indigenous population, the outcry would be significant and the possible consequences for individuals might be grave. If a spirit of inequity and exclusion lies at the heart of localism it will quash unheard voices and provoke bigotry.

But localism does offer the promise of a greater prize for new communities. These findings show that the asylum seekers whose destination is Europe have just the personal resources to benefit from asset-based treatment and ultimately contribute to the Big Society. Strength and acumen are the hallmarks of their history and of their journey. Their experiences have taken a toll in terms of trauma, mental strain and consequent drug problems, and a pressing need for services exists. Mainstream drugs services have not had success to date in overcoming barriers to drug use early in the drug using careers of these individuals. What is needed is truly responsive provision.

Conclusion

The traditions of Conservative administration have strong roots in social responsibility and the commitment to 'do good' (ACEVO, 2011; Disraeli, 1845). Those roots have become attenuated as a result of ideologies which state that 'there is no such thing as society' (Thatcher, 1987) and policy which places a focus on individualism. The Big Society may represent an attempt to return to those roots. If this is the case, it has not occurred at the most auspicious time and the initiative must attempt to establish itself in the context of drastic cuts.

These findings do demonstrate a significant gap in treatment provision which it might be possible for an initiative such as the Big Society to fill. If this were to be realized, then refugees and community agencies might find a mechanism to identify authentic needs and develop drugs services in response. But without active effort to bring new communities up from under the radar, coupled with considerable creativity and consistent funding on the part of the architects of localism, progress will not be achieved and the situation for refugees may in fact worsen. The unfolding of this process will reveal whether inclusion or budget restraint is the true driver of policy.

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Note

1. A further section of the wider sample was composed of interviewees from African countries. These are not included in this article as their reasons for migration cannot be confidently inferred from the interview responses or from the background information provided by the research commissioner.

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Author biography

Karen Mills is Senior Lecturer in Social Work/Flexible Learning Coordinator, University of Hertfordshire, UK.

Appendix 2 – letters from joint authors

May 13th 2016

To whom it may concern

RE: Karen Mills: PhD submission – inclusion of jointly authored papers

I am writing to confirm that between October 2005 and June 2008 the Centre for Community Research (CCR) was commissioned (by Peterborough Drug and Alcohol Action Team and the National Treatment Agency) to undertake three research projects relating to the drug treatment needs of new minority communities in the UK. As Centre Director of the CCR I oversaw these projects.

At an operational level the Peterborough project was jointly led by Karen Mills and Susan Brooks. The projects commissioned by the National Treatment Agency were led by Ms Mills.

It was the practice of the Centre to incorporate the views and guidance of research partners in the research process and all methods were selected collaboratively by Ms Mills and the research teams, taking into account the views of the research commissioners and guided by me.

The research culminated in the presentation of research reports. Responsibility for the preparation of these reports was shared as follows:

Mills, K., Brooks, S., Sender, H. & Green, R (2006) *Accessing Drug Services in Peterborough: a study of black and minority communities.* Centre for Community Research University of Hertfordshire.

- Literature review authored by Helen Sender
- Analysis and discussion of the interviews by Karen Mills
- Analysis and discussion of the Life Stories by Susan Brookes

Mills, K., Knight, T. & Green, R. (2007) *Beyond Boundaries: offering substance misuse services to new migrants in London.* Centre for Community Research: University of Hertfordshire.

- Literature review authored by Terry Knight
- Analysis and discussion of the interviews by Karen Mills
- Analysis and discussion of the life stories by Terry Knight

Mills, K., Broome, K. & Green, R. (2008) Beyond Boundaries II. A8 & A2 nationals in London: drug treatment needs and referral pathways. Centre for Community Research: University of Hertfordshire.

- Report authored entirely by Karen Mills

In all cases Ms Mills took responsibility for final full findings and recommendations.

I understand that Ms Mills wishes to make use of these papers as part of the submission of her doctoral thesis.

Yours faithfully

Dr Roger Green

Director/Senior Research Fellow Community Studies
Centre for Community Engagement Research
Department of Social, Therapeutic and Community Studies
Goldsmiths
University of London
31, St James
New Cross
London SE 14 6NW

r.green@gold.ac.uk
020 7717 2591

8th April 2016

To whom it may concern

RE: Karen Mills: PhD submission – inclusion of jointly authored papers

I am writing to confirm that between October 2005 and January 2006 Ms Mills and I undertook a research project on behalf of the University of Hertfordshire. The project was conducted by the Centre for Community Research and overseen by the Centre Director, Dr Roger Green. The project was commissioned by Peterborough Drug and Alcohol Action Team and led to the production of a report entitled:

Mills, K., Brooks, S., Sender, H. & Green, R (2006) ***Accessing Drug Services in Peterborough: a study of black and minority communities.*** **Centre for Community Research University of Hertfordshire.**

The project was jointly planned and executed by myself and Karen Mills, taking an equal part in its development. Methods were selected collaboratively by Ms Mills and myself, taking into account the views of the research commissioners and were guided by Dr Green. The training programme for co-researchers was jointly developed and delivered.

Responsibility for the final report was divided between myself and Ms Mills as follows:

- Literature review authored by Helen Sender
- Analysis and discussion of the interviews by Karen Mills
- Analysis and discussion of the Life Stories by Susan Brooks

Construction of the final full findings and recommendations was undertaken by Ms Mills.

I understand that Ms Mills wishes to make use of this report as part of the submission of her doctoral thesis and can confirm that the work submitted was undertaken by her.

Yours faithfully

S. D. M. Brooks

S.D.M. Brooks

UCL Institute of Education
Department of Social Science
55-59 Gordon Square
London
WC1H 0NU

8th April 2016

To whom it may concern

RE: Karen Mills: PhD submission – inclusion of jointly authored papers

I am writing to confirm that from Dec 2006 - March 2007 I undertook a research project on behalf of the University of Hertfordshire. This project was conducted by the Centre for Community Research and overseen by the Centre Director, Dr Roger Green. The project was commissioned by the National Treatment Agency and led to the production of a report entitled:

Mills, K., Knight, T. & Green, R. (2007) *Beyond Boundaries: offering substance misuse services to new migrants in London*. Centre for Community Research: University of Hertfordshire.

The project was led at an operational level by Karen Mills.

Methods were selected collaboratively by Ms Mills and myself, taking into account the views of the research commissioners and were guided by Dr Green.

Responsibility for the final report was divided between myself and Ms Mills as follows:

- Project managed by Karen Mills
- Literature review authored by Terry Knight
- Analysis and discussion of the interviews by Karen Mills
- Analysis and discussion of the life stories by Terry Knight

Construction of the final full findings and recommendations was undertaken by Ms Mills.

Following the completion of the project Ms Mills and I jointly authored a peer reviewed article entitled:

Mills, K. and Knight, T. (2009) Offering substance misuse services to Accession Eight Migrants in London: findings from a qualitative study, Drugs: education, prevention and policy, 2009; 1–17, Early Online.

This paper was jointly prepared and authored.

I understand that Ms Mills wishes to make use of these papers as part of the submission of her doctoral thesis.

Yours faithfully

T. Knight.

T Knight

Appendix 3 – ethical approval

Prof Anwar Baydoun
Associate Dean, Research
School of Life and Medical Sciences
University of Hertfordshire
HATFIELD
AL10 9AB

14th November 2013

Dear Anwar

Re: Karen Mills Ethics

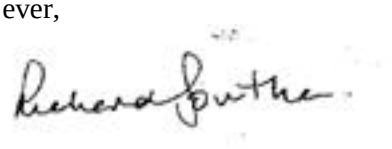
I have been given extensive documentation by Brian Littlechild concerning Karen's project and the procedures she went through to obtain ethical clearance. I am entirely satisfied that her entire work has been carried out in accordance with the Ethical Procedures, Policies and Regulations of the University of Hertfordshire at the time of her application.

In particular, ethical clearance for Karen's work was obtain from the external organisations she worked with whilst undertaking her research, namely Peterborough DAT and the National Treatment Agency. This process was overseen by Dr Roger Green at the time and conformed to the then ethics committee with delegated authority that the Centre for Community Research was subject to. Furthermore, the ethical aspects of the research were also overseen by a research steering group comprised of representatives from commissioning organisations, the CCR and community representatives. It was quite common in the past for students working with external organisations who have their own ethical procedures to follow them.

Whereas I can be totally satisfied that ethical procedures were in place, and I have evidence for ethical clearance being granted, the way in which she obtain ethical clearance could not be condoned today for new research undertaken. Today all research students would be expected to gain an ethical protocol number from the relevant ethics committee with delegated authority, save those researchers who would gain clearance through the NHS. Karen did not have a UH ethics protocol number as far as I can tell. It would have been good practice for her ECDA to have given her a protocol number on ascertaining that she'd received external clearance.

I hope this is of help. Please don't hesitate to contact me should you require further information.

Yours ever,



Dr Richard Southern FRGS
Chair, Health and Human Sciences Ethics Committee with Delegated Authority
University of Hertfordshire
HATFIELD
AL10 9AB

Tel. 01707 286491
Fax. 01707 285258
r.l.v.southern@herts.ac.uk

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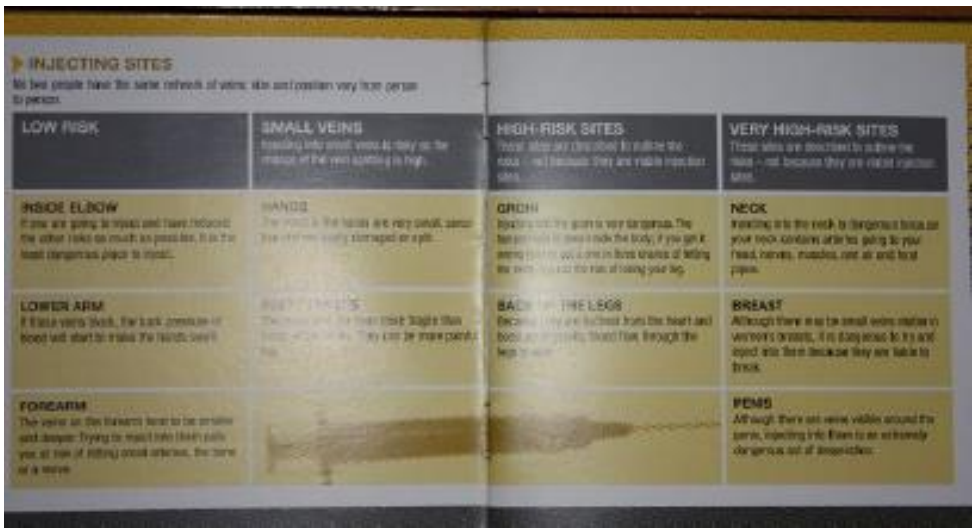
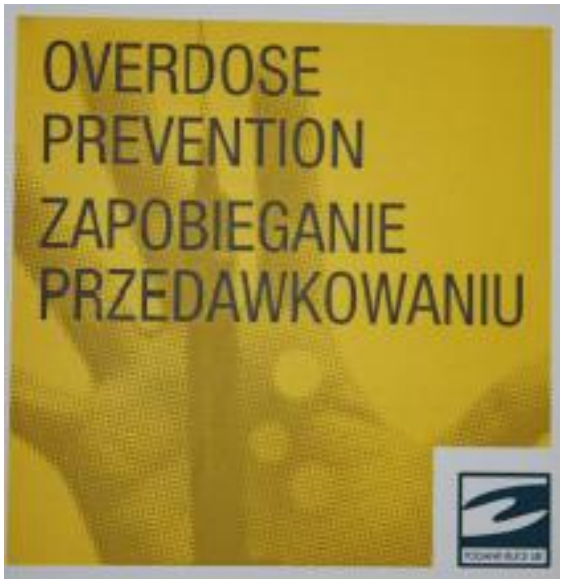
Appendix 4 – evidence of impact




OVERDOSE
PREVENTION
ZAPOBIEGANIE
PRZEDAWKOWANIU


You don't have to take a lethal dose of drugs to die of an overdose; it only takes a tablespoonful of fluid to kill you if you are on your back, unconscious and unable to swallow! This has been the cause of many overdose deaths.
OVERDOSE CAUSES
The main things that cause overdose are:
- Injecting drugs: Heroin injectors are about 14 times more likely to die than non-injectors. People who inject heroin are much more likely to overdose than people who smoke it.
- Mixing drugs and alcohol: Most overdoses happen when people have alcohol or downers – like valium and temazepam – in their system at the same time as injected heroin. The combined effect of sedative drugs is to depress the central nervous system and the breathing. People can literally stop breathing.
- Using opiates when tolerance is low: It only takes a few days for tolerance of opiates to drop. After a week or so without opiates, a dose that at one time wouldn't have affected you, can kill you. People who die have often overdosed before and survived. It isn't normally 'new users' who overdose. It is usually people who've been injecting for years.
Sometimes overdoses aren't accidental. Feeling depressed, hopeless or not caring whether you live/die can all make overdose more likely. Talking about feelings is important and can help reduce the risk of non-accidental overdose.
- WYSTRZEGAJ SIĘ MIESZANIA RÓŻNYCH NARKOTYKÓW I LEKÓW
- PAMIĘTAJ O OBNIŻONYM ZNOSZENIU PO OKRESIE ABSTYNOWANIA
OBNIŻANIE RYZYK
OZNAKI PRZEDAWKOWANIA

Appendix 5 – Karen Mills' complete list of publications

Karen Mills' Publications

Mills, K. (2004). Reducing Drug Related Deaths: the responsibility of NOMS? *Probation Journal.* Vol. 51 No. 4 December 2004.

Mills, K. (2009). Racism, Ethnicity and Drug Misuse: a brief introduction in Bhui, H.S. (ed.) (2009). Race and Criminal Justice. London: Sage.

Mills, K. (2012). Under the radar: Impact of policies of localism on substance misuse services for refugee and asylum seeking communities. International Social Work, 55(5), 662-674. doi: 10.1177/0020872812447637

Mills, K., Davies, K. & Brooks, S. (2007). Experiences of DTTO: the person in the process. *British Journal of Community Justice.* Volume 5, Issue 3. November 2007.

Mills, K. and Knight, T. (2009). Offering substance misuse services to Accession Eight Migrants in London: findings from a qualitative study, Drugs: education, prevention and policy, 2009; 1–17. doi: 10.3109/09687630903200777

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Heather, J., Mills, K. & Green, R. (2008). *Public perception of drug use in Hatfield.* Hatfield: Herts Constabulary and Centre for Community Research, University of Hertfordshire.

Green, R., Diosi, M., Broome, K. & Mills, K. (2006). *Local Solutions to Local Needs: A Community Needs Survey of the Kingsmead Estate, Hackney*. Hatfield: Centre for Community Research, University of Hertfordshire.

Mills, K. & Brooks, S. (2005). *In Working with Offenders Subject to Drug Treatment and Testing Orders, what Best Supports Compliance?* London: London Probation Area.

Mills, K., Brooks, S., Sender, H. & Green, R. (2006). Accessing Drug Services in Peterborough: a study of black and minority communities. Hatfield: Centre for Community Research University of Hertfordshire. Retrieved February, 2nd, 2009 from http://drugs.homeoffice.gov.uk/publication-search/dip/Peterborough_BME_report?view=Standard&pubID=456186

Mills, K., Broome, K. and Green, R. (2008). Beyond Boundaries 2: A8 & A2 nationals in London: drug treatment needs and referral pathways. London: National Treatment Agency.

Mills, K., Curran, B., Broome, K. & Green, R. (2008). Evaluation *of the Contact NR5 Substance Misuse Treatment Service.* Norwich*:* NELM Development Trust *&* Centre for Community Research, University of Hertfordshire.

Mills, K., Knight, T. & Green, R. (2007). Beyond Boundaries: offering substance misuse services to new migrants in London. London: National Treatment Agency.

Conferences and Presentations

06 – 09.07.2004. British Society of Criminology Conference. University of Portsmouth. Parallel Session Speaker: *Drug Related Death: the probation response.*

05 – 07.07.2006. British Society of Criminology Conference. University of Glasgow. Parallel Session Speaker: *Refugees and Asylum Seekers and Drug Service Provision.*

05 – 07.07.2006. British Society of Criminology Conference. London School of Economics. Parallel Session Speaker: *Providing Drugs Services for New Migrants: opportunities and challenges.*

07.11. 2007. London Drug and Alcohol Network (LDAN) – Plenary Speaker: *A8 Migrants & Treatment Need.*

April 2009. European Research in Social Work (ERIS) Spring Conference, Ostrava, Czech Republic. Plenary Speaker: *New European Migrants in London: vulnerability to drug use and treatment needs.*

11 – 14.07.2010. British Society of Criminology Conference. University of Leicester. Parallel Session Speaker.

21 – 24.09.2011. 11th Annual Conference of the European Society of Criminology, Vilnius, Lithuania
Parallel Session Speaker: *Under the Radar: substance misuse services for refugee and asylum seeking communities.*

Book Reviews

Stevens, S.J. & Morral, A.R. (eds.) (2003) *Adolescent Substance Misuse Treatment in the United States*. Binghamton, NY: The Haworth Press, Inc Criminal Justice Review. Vol. 31 Number 2 December 2006.

Tracy, S, & Acker, C.J. (2004) *Altering American Consciousness: the history of alcohol and drug use in the United States, 1800 – 2000.* Amherst & Boston: University of Massachusetts Press. Criminal Justice Review. Vol. 32 Number 4 December 2007.

Whitehead, P. & Thompson, J. (2004) *Knowledge and the Probation Service. Raising Standards for trainees, Assessors and Practitioners* (2004) London: John Eilley & Sons. Vista Vol 11 No1. 2006.

Boekhout van Solinge, T. (2004) *Dealing with drugs in Europe. An investigation of European drug control Experiences: France, The Netherlands and Sweden*. The Hague: BJu Legal Publishers. European Journal of Probation.