Drug prevention for asylum seekers, refugees and undocumented migrants*

Roland Lutz, Eberhard Schatz

* Findings of the European Project 'SEARCH' by the 'LWL Landschaftsverband Westfalen Lippe', Münster, Germany.

Colophon

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Editors:
Dagmar Domenig
Jane Fountain
Eberhard Schatz
Georg Bröring

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Foundation RegenboogAMOC
Correlation Network
Postbus 10887
1001 EW Amsterdam
Netherlands
Tel. +31 20 5317600
Fax. +31 20 4203528
http://www.correlation-net.org
e-mail:info@correlation-net.org

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1 Introduction

In different Member States of the European Union (EU), local, regional and national (health) authorities are faced with the a growing number of refugees, asylum seekers and undocumented migrants (i.e. immigrants without legal residence permits from various countries and ethnic backgrounds). Their stay in a particular Member State is sometimes limited to a few months, but a substantial number remain for years or permanently.

UNHCR (United Nations High Commission for Refugees) estimates that one in every 250 of those who leave their home country do so to find a safer existence elsewhere. It appears that many of these suffer from various health problems, including problematic substance use. However, apart from some explorative studies (e.g. Braam et. al 1999), there are few reliable data about the nature and extent of these problems. What little information there is rarely consists of more than hearsay - often based on dubious political interests - and some anecdotal evidence from health and social agencies.

Various European and national projects on the topic of migration and substance use have focused on different aspects of this issue, such as the mobility of substance users among EU Member States, and infectious diseases and substance use among migrant communities who are well-established in a country. New refugees, asylum seekers and undocumented migrants, however, differ substantially from the groups covered by these projects. Major differences are their diversity (different nationalities, languages, ethnic, religious and cultural backgrounds) and, in the case of asylum seekers and undocumented migrants, their legal immigration status. From the little we know, we can conclude that some were using substances before they came to Europe, while others became involved in substance use during their stay in refugee camps. Different factors contribute to making these groups especially vulnerable to substance use, including traumatic experiences in their home countries, psychosocial problems connected to difficulties adapting to their new environment (language problems, different norms and values, etc.), a lack of social and family contacts, their often uncertain future, and boredom due to forced unemployment and lack of other activities.

In different EU Member States, drug agencies have developed ad hoc approaches and information material in the fields of drug prevention and demand reduction. However, data are generally lacking on the extent and nature of substance use among asylum seekers, refugees and undocumented migrants, and their specific prevention and demand reduction needs.

2 Initial situation

The subject of addiction has been comprehensively and scientifically researched. This applies not only to substance and use risks, but also to care systems. However, very little reliable research data have been produced on the risk of addiction among migrants, and the data available on the health risks of refugees, asylum seekers and undocumented migrants are very poor. In many European regions, it has been observed, however, that there are major addiction problems within these groups. The experience of practitioners in drug prevention has shown that it is precisely in this area that there is a considerable need for research. The Coordination Office for Drug-related Issues at the LWL (Landschaftsverband Westfalen-Lippe) in Münster, Germany, has also consistently received reports that existing drug prevention programmes have proved to be unsuitable for refugees, asylum seekers and undocumented migrants. Preventive approaches have failed owing to a lack of knowledge about the target groups, the inability of drug workers to contact them and, last but not least, communication difficulties because of language.

The SEARCH project developed out of the motivation to produce basic findings on this problem area. Those taking part in the project were not pursuing any political objectives. Nevertheless, a correlation was seen between the individual behaviour of those affected and the conditions under which they live. Therefore, drug prevention can only be successful if it takes into account not just the individual requirements of those migrants in need of help, but also their living conditions. The conditions under which refugees, asylum seekers and undocumented migrants live can reduce the risk of addiction if targeted protection mechanisms are fostered. By promoting awareness, tolerance, communication and intercultural encounters, the intention was to influence these conditions. Efforts to change environmental conditions have a particular relevance for the health and social systems in almost all European countries, because refugees, asylum seekers and undocumented migrants are excluded from these systems. It therefore seemed necessary to address this issue at European level.

How many asylum seekers are actually accepted by an EU Member State varies considerably. Whereas Spain and Italy, for example, hardly accept any, the number of undocumented migrants there from North Africa appears very high, although their living situation is comparable with those of documented migrants in other countries.

3 The rationale for the SEARCH projects

The results of the SEARCH (2000 – 2002) and SEARCH II (2002 – 2004) projects were targeted at practitioners in drug prevention who deal with refugees, asylum seekers and undocumented migrants. At the European level, SEARCH and SEARCH II were concerned with raising awareness about problems and methods relating to this subject. The results of the projects were intended to have a promotional effect and through earlier and better recognition of health risks in the social groups concerned, the intention was to improve the planning of suitable measures. It was also intended to obtain information on good practice.

SEARCH was initially concerned with securing basic data on the prevalence of addiction in the target groups, and it was intended to develop methods for drug prevention based on the concept of intercultural competence. The purpose here was to equip refugees, asylum seekers and undocumented migrants with the necessary competence to be able to deal with the risks and dangers in what for them are alien cultures. In the final analysis, this means better protection from health risks.

Drug prevention work as envisaged by SEARCH and SEARCH II has practical consequences for local communities and local authorities, where most practitioners work. If suitable living conditions for the refugees, asylum seekers and undocumented migrants can be achieved successfully at the local level, then it might be possible to reduce the risk of addiction. The prerequisite for this, however, is that the local public institutions support drug prevention work.

4 The SEARCH projects

To address the issues outlined above, the SEARCH project, 'Drug Prevention for Refugees and Asylum Seekers', was funded by the drug prevention programme of DG Public Health and Consumer Protection in Luxembourg and co-ordinated by the LWL in Münster, Germany. The project's aim was to contribute to the development of instruments in the field of drug prevention that can be used in other regions and Member States. The objectives were:

- To obtain a picture of the drug problem among refugees, asylum seekers and undocumented migrants in a number of EU Member States.

- To identify the drug information needs of these groups.
- To identify existing good practice.
- To initiate and support the development of new approaches and information material.
- To initiate and support the exchange of expertise.

The first phase of the project (SEARCH) focused on developing and piloting a method for the rapid collection of valid information on drug problems among the target population that can be used directly for drug prevention activities. The Rapid Assessment and Response (RAR) method, as developed by Stimson, Fitch and Rhodes (Stimson et al., 1998a) was used. Stimson et al. used this approach with success, notably in the prevention of infectious diseases among injecting drug users.

This phase of the project included the following activities:

- An inventory of existing interventions and information material in the regions of the partner projects in six European Member States.
- Developing an RAR model for refugees and substance use.
- Training and support in RAR methods.
- Realising RARs in the six Member States to cover topics such as the (legal and illegal) substances used, the routes of administration, use and problematic use, the context of substance use, the specific needs of refugees in terms of drug prevention, etc.
- Producing a manual on how to conduct an RAR on the issue of drug use among refugees, asylum seekers and undocumented migrants, to allow other organisations to use this approach.

The second phase, SEARCH II, consisted of the development of interventions in the six member States, based on the results of the surveys conducted in phase one. The results of this work were presented in a guide to drug prevention interventions for refugees and asylum seekers (Lutz, 2004a).

SEARCH II provided a smooth transition from SEARCH and supplemented the basic tasks with the following aspects:

- With the help of the RAR Monitoring Module, the changes in the target groups were recorded and interpreted (research aspect).
- The projects that had been started were further developed, consolidated and firmly established at a regional level on a sustainable basis (practice development).

- Six new European regions (countries) were added to further disseminate SEARCH throughout Europe (European dimension).
- The results of the projects in terms of procedural recommendations were published (guidelines) (Lutz, 2004b).

5 A selection of results from SEARCH and SEARCH II

When researching the health problems of migrants, a series of stress and risk factors lie behind general health risks, including that of addiction: intercultural communication, linguistic problems, living conditions, working conditions, lack of knowledge of care structures, family structures, the trauma of migration, and the prevalence of addiction.

5.1 Intercultural communication

Owing to the often short period of time in which they have been living in the country, their specific living situation and the reasons for their migration, our target groups in particular clearly have more communication difficulties with the people of the host country than, for example, the second or third generation of migrants who live there. In turn, the people from the host country have more difficulties in developing contact and in overcoming their reservations with the new arrivals. This situation, which must be overcome by both sides in order to achieve intercultural communication, requires the acquisition of intercultural competence. The experiences of both project phases concerning this central area are described in the 'Guidelines' (Lutz, 2004b).

5.2 Linguistic problems

Not being able to express oneself in the language of the host country means to be cut off from lively everyday communication and opportunities for contact, except with others who speak the same language. This encourages isolation and segregation, and even when the host country's language has been learned, considerable cultural differences are expressed in the content of the language (i.e. at semantic level), which can make it very difficult for migrants to understand health and medical issues. This understanding is, however, of essential importance for prevention activities. All our respondents confirmed that the inability to speak the language of the host country contributes to the isolation (and even to the 'ghettoisation') of asylum seekers, refugees and undocumented migrants. If addiction

prevention is to be successful, then it is essential that the risks and means of avoiding them are explained to them in their language and in terms of their cultural background.

5.3 Living conditions

Across Europe, many first generation immigrants (and frequently subsequent generations) live in disadvantaged areas in poor housing conditions. Often, their place of residence does not conform to the norms of the country of origin[1]. This is particularly the case for asylum seekers, many of whom, in all European countries, live in restrictive and oppressive conditions such as prison-like immigration centres, and for undocumented migrants, many of whom are homeless. It was an extremely depressing experience for the SEARCH team to realise how unfit for human habitation much of their accommodation is.

5.4 Working conditions

Several studies in German-speaking countries (and we assume that this also applies to other European countries) indicate that immigrants generally have not just poorer working conditions than the rest of the population, but fewer possibilities of receiving training in the host country. Furthermore, the high technological demands of the host countries does not match their work experience in their home land, and places them at a disadvantage in terms of obtaining employment.

Other employment-related issues also affect the asylum seekers investigated by the SEARCH projects: state legislation dictates that most of them are not allowed to work, or only to a very limited extent, and many are therefore doomed to idleness and degraded to 'charity cases'. This promotes isolation, 'ghettoisation' and – according to our studies – has considerable impact on their self-esteem and motivation to deal actively and positively with their lives and health. Many never escape from this situation, not least because the financial means available to them are generally and structurally very restricted. This leads to the risk that they will commit acquisitive crimes, including selling drugs.

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

5.5 Lack of knowledge of care structures

Migrants frequently live in considerable ignorance of the care structures within the social and health sectors of the host countries. When problems arise, they do not seek help, but discuss solutions within the family, who are often, however, overtaxed and react with helplessness. Whilst in the case of working migrants, this situation tends to improve over time, it applies to the SEARCH target groups to a considerable extent: they very often do not know how and where to receive help and sometimes access to this help is blocked by state legislation (there is no financing of certain health services for asylum seekers and refugees through the Asylum Seekers Benefits Act in Germany, for example[2]). A further important issue was identified in the various project locations: often, the people in our target groups come from areas of the world where violence, lack of rights, state despotism and political and religious persecution prevail. They do not understand the care systems in the western democratic world and mistrust institutions and their intentions. It is therefore important to identify culturally sensitive solutions to encourage access that take this into account.

5.6 Family structures

There is a tendency of migrants' (traditional) family structures to disintegrate and this plays a considerable role in their psychosocial stress. This disintegration can occur during migration itself, but also through the gradual adoption of the host country's cultural norms by some family members (generally the second generation), which can lead to internal family conflicts, increasing 'cultural antagonism' and the associated mental health problems[3].

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2 Compare critically with PRO ASYL (Hg.): G. CLASSEN, Menschenwürde mit Rabatt. Kommentar mit Dokumentation zum Asylbewerberleistungsgesetz (AsylbLG) und zum Flüchtlingssozialrecht, Berlin 2002.

3 'Imitating' the lifestyles of people in the host countries also plays a role: the habitual lifestyle and behaviour patterns in the culture of the country of origin may contrast considerably with those of the host country. For those who 'give up' their cultural identity, which may assist in protecting them from drug use, for a long time only have the possibility of 'simulating' a 'new' cultural identity. The use of alcohol, for example, becomes more risky the less this use was culturally acceptable in the country of origin.

These observations apply to immigrants in general but are even more dramatically experienced by the target groups we investigated as a result of further stress factors: often, family members were separated in the course of migration and, due to state restrictions in the reception countries, were unable to meet up again, or only to a limited extent. In such cases, the family cannot operate as a 'protective factor' - a shield against the dangers of the host country which are largely unknown, particularly to new migrants. The loss of the family leads to a loss of relationships and opportunities in life, and this is a risk factor not only for general health but also for substance use[4].

5.7 The trauma of migration

The loss of the home, familiar surroundings, family, cultural certainty and confidence play a considerable role within every migration process. Foreign cultures can be experienced as something extremely incomprehensible, even threatening, while the loss of all that is familiar is mourned. The general process of 'uprooting' has begun to be taken seriously in all European countries, and no longer just responded to with the knee-jerk call for 'integration'. Integration presupposes openness, trust, confidence and respect on both sides. This must be first earned and the demand for integration must not be linked to the 'demand for cultural identity' or it will have the effect of creating fear and segregation, which in turn can lead to mental stress and other ill health.

This applies even more to the groups investigated by us. The reasons for leaving the home country are often dramatic and traumatising: persecution, fear, humiliation, torture and the threat of death play a role, but also squalor, poverty, impoverishment and hopelessness in the homeland. Such severe wounds heal slowly, and the insecure status as an asylum seeker or undocumented migrant, characterised by many new stresses and fear of the future, hinders the healing process. Our RAR found that trauma (and the associated post-traumatic stress syndrome) is a highly significant factor contributing to vulnerability to substance use and problematic use.

Overall, with the help of the RAR, we have acquired an impressive dataset on substance use and the associated risk factors among refugees, asylum seekers and undocumented

4 In some of our studies, we were able to establish a clearly higher vulnerability to the use of addictive substances for single men.

migrants, as well as appropriate means and methods for addiction prevention. Many of our initial assumptions had to be revised, but some were confirmed.

5.8 Prevalence of addiction

The actual prevalence of problematic substance use among the groups the SEARCH projects investigated is, in quantitative terms, very small. However, where addiction problems do occur, they tend to have a more detrimental effect when compared to a country's native population. In many countries, it was also noticeable that due to the national policies, it is almost impossible for asylum seekers and undocumented migrants to receive therapeutic treatment for addiction, because finance is not provided for it. However, this deficiency was not pursued any further in the project, especially since we had to restrict ourselves to looking at preventive activities. Nevertheless, we are mentioning this here to illustrate the effect of the health and social policies of the various European countries.

6 Recommendations for practical addiction care

Preventive care for refugees, asylum seekers and undocumented migrants at risk of addiction should focus on intercultural competence. Initiatives will be effective only if there is mutual understanding between those needing help from the one culture and the helpers from the other culture. That is one of the central findings of the SEARCH projects.

Initiatives should begin as soon as possible after migrants' arrival in the reception countries and be designed on a long-term basis. This particularly applies to behaviour-based approaches (addiction care distinguishes between behaviour and relation-based approaches). In SEARCH and SEARCH II, it became clear that approaches aimed purely at changing the behaviour of addicts or those at risk of addiction will remain largely ineffective.

There are six levels of action for practical addiction care work with refugees, asylum seekers and undocumented migrants: knowledge, access, action, sustainability, monitoring, and policy. These levels can only be seen as sequential to a limited extent.

6.1 Knowledge

Cultural knowledge is the first stage in effective addiction care. Not only is precise knowledge required of the culture from which clients and potential clients come, but also of the culture of the host country. Information must be collected on the ethnicity, religious views and values of the migrants, bearing in mind that their country of origin may not provide a reliable indication of their cultural roots. The results may identify behaviour patterns, viewpoints, norms and values that operate as protective factors and can be used as a basis for risk protection initiatives, including addiction, and they should be respected, promoted and shared with other service providers. The RAR method is very suitable for securing such information as well as for developing, implementing and evaluating suitable methods and approaches. A useful aid here are the grids that were used for the projects in SEARCH and SEARCH II (Verbraeck and Trautmann, 2002).

6.2 Access

Key informants (or key persons) are those who are in a position to gain the trust of the people being helped, and facilitate access to refugees, asylum seekers and undocumented migrants. Acting as cultural mediators, they imply a “we” feeling, whilst providing a connection to the culture of the host country. Ideally, the key persons should have shared some of the experiences of those needing care, such as ex-asylum seekers who have been granted refugee status. In addition to key informants, access to migrants could be via individuals working at health and social care facilities, but all key informants, cultural mediators and interpreters must acquire intercultural competence.

6.3 Action

The prevention methods used must take a sensitive and respectful approach based on the cultural background of the people requiring care: the cultural values and standard drug prevention initiatives in the reception countries should not be the only considerations. For example, with some migrant groups, it is possible to make effective use of drug risk- or fear-oriented education techniques that are deemed to be no longer valid in prevention initiatives aimed at native Europeans. Special attention needs to be paid to the double taboo associated with addiction problems: in many migrants’ countries of origin, addiction

is not discussed, and in the host countries they fear that revealing they have an addiction problem could adversely affect their residential status. Refugees, asylum seekers and undocumented migrants should be involved in planning and conducting drug prevention programmes that address these issues.

Key persons who instil trust can be effective at persuading the target groups to make use of care programmes. It is much more likely that migrants will access these programmes if they are discussed on the personal rather than the professional level.

Specific drug prevention approaches for migrants must be firmly established in schools. This is dependent, of course, on migrants' children being allowed to attend school. Parents need drug and drug service education, too, particularly in terms of young people's vulnerability.

Drug prevention means integration work. Existing local community programmes should be involved. These could, for example, include computer and language courses or youth programmes. Integration does not mean forcing the migrants to adopt the host country's cultural norms: rather, it means encouraging participation.

6.4 Sustainability

Drug prevention projects should be incorporated into existing networks of organisations and institutions that work in the migration and health sectors. Assigning clearly defined institutional responsibility ensures the long-term establishment of addiction care activities. The knowledge and competence of the key persons should be linked in a 'competence pool', to facilitate future work via the care networks.

6.5 Monitoring

SEARCH's intention was to continuously control and evaluate the organisation, methods and impacts of drug prevention and addiction care activities. Changes in the number and composition of migrant populations must be continuously observed and care activities targeted accordingly. The RAR method proved appropriate for this task.

6.6 Policy

A political mandate is a desirable prerequisite for intercultural prevention and addiction care work. It ensures that the relevant projects and programmes are invested with the necessary personnel, expertise and materials.

The area of drug prevention particularly requires that governments make it possible and/or easier for refugees, asylum seekers and undocumented migrants to gain access to other health and care services. Discussion of these issues, however, was beyond the scope of the activities of SEARCH and SEARCH II. Nevertheless, effective drug prevention for refugees, asylum seekers and undocumented migrants should also strive to change the environmental conditions that can increase the risk of addiction. This can also only be ensured through political support.

6.7 The correct combination of methods

Every method chosen to address drug prevention for asylum seekers, refugees and undocumented migrants should be based on a comprehensive cultural analysis, including clarification of the cultural roots of the host country and of the migrants. As discussed above, for instance, seemingly 'outdated' methods can prove to be very useful, and many methods are particularly successful if they are taught by people who instil trust. The mixture of methods must include peer education and life skills training. These methodological approaches must be examined in terms of intercultural competence for their suitability for prevention work with the target groups and will require adaptation in many different ways.[5]

5 For more information, see www.projekt-search.de

References

Lutz, R. (ed.), (2004a) Drug Prevention for Asylum Seekers, Refugees and Illegal Immigrants. Münster. Landschaftsverband Westfalen – Lippe.

Lutz, R. (ed.), (2004b) Drug Prevention for Asylum Seekers, Refugees and Illegal Immigrants. Guidelines 181 – 215. Münster. Landschaftsverband Westfalen – Lippe.

Verbraeck, H. and Trautmann, F., (2004) Papid Assessment and Response on Problematic Substance Use among Refugees, Asylum Seekers and Illegal Immigrants. Münster. Landschaftsverband Westfalen Lippe