

Offering substance misuse services to Accession Eight migrants in London:  
findings from a qualitative study

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### Abstract

This paper 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 paper reports findings in relation to EU accession eight (A8) nationals' entitlement and access to drug treatment. For this part of the study, twenty, in depth interviews were conducted with staff of Drug and Alcohol Action Teams (DAAT) 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, nineteen 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 paper concludes with observations as to how provision might develop to meet a changing context.

## **Offering substance misuse services to Accession Eight migrants in London: findings from a qualitative study**

### **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 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, 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 (e.g. Drinkwater et al., 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 drug 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 five years have seen some coalescence of research into the substance misuse needs of minority populations (Becker & Duffy, 2002; Sangster et al., 2002; Fountain et al., 2003; Mills, 2008), research projects have focused 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 (e.g. 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 focused on labour trends and public service provision (e.g. Audit Commission, 2007; Anderson et al., 2006; Gilpin et al., 2006; Sriskandarajah et al., 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 and Reeve, 2005; Travers et al., 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 minimise 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, 2008a), many recent migrants are making relatively large contributions to the public purse (Sriskandarajah et al., 2005; DCLG, 2008; DCLG, 2009).

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 (Mills et al., 2006; Banton et al, 2006).

Concerns about homelessness, rough sleeping and alcohol consumption among A8 migrants are increasing (e.g. 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 recognise 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 and Wilson, 2004).

Those who have been in the UK for more than two years are not required to demonstrate a right to reside or be subject to the habitual residence test (Kennedy and 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 two 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 utilised 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 organisations 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), Drug Interventions Programme (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 & 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 predefined 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<sup>1</sup> (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**

The findings 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 paper 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

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<sup>1</sup> This is the title given to a local health organisation responsible for managing local health services.

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. 17 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 National Drug Treatment Monitoring System (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<sup>2</sup> 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.*

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<sup>2</sup> UK drug service commissioning is coordinated under the 'Models of care' framework (NTA, 2002 & 2006). Interventions are tiered according to service users' needs and organisational assessment.

*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 Drug Interventions Programme (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 & 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 organisations with a Christian or Catholic ethos, who stated that migrants were likely to seek support from church organisations 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.*



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 minimisation 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<sup>3</sup> 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.

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<sup>3</sup> General Practitioner: Community-based Medical Doctors.

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<sup>4</sup> 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

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<sup>4</sup> *Bed & Breakfast*

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 et al (2008a) posits that different impulses drive travel amongst this more vulnerable group and that while economic advantage 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 Drug Interventions Programme (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 can be 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 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 et al (2003) offer a definition of ethnicity which is composed of shared "language, customs and recent common ancestry" (ibid p40), 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 centralised monitoring agencies. This creates a tension – the requirement of evidence being offset against the desire for timely action. However, 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 galvanise change. Only when this double loop (Morgan, 1997) has been achieved can organisations 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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