

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

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FOREWORD FROM THE NATIONAL TREATMENT AGENCY

This report, commissioned by the London NTA, represents the first detailed examination there has been into the use of drug treatment services by newly arrived populations. The report was commissioned in response to requests from providers, commissioners and local authorities, and was also a recommendation from the NDTMS Analysis Stakeholder Consultation held on 16th March 2006.

The work is intended to facilitate better needs assessment, and therefore better planning of drug treatment services in London. This analysis provides a snapshot of existing legislation, policy and some early headline statistics over a short period of time. It was not intended to provide a robust measure of the rate of change within the population using services.

The NTA recognises that this research sits alongside other broader research into the contribution (both economic and social) that increasing diversity brings to London. Changing and shifting populations of different groups that migrate to live and work in London are the norm, and not the exception. Ongoing needs assessment and service re-configuration will always be required to respond to this.

It is certainly hoped that this work will contribute to further research into need and provision in London and that others will contribute to the evidence base that substance misuse treatment should be built on.

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The authors would also like to thank all of the participants on the study for their indispensable contributions.

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 individuals 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 DAT’s 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 DAT’s 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 Team's) 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 UK's 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 (Sieroslowski & 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 (Sieroslowski, 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, DAT's 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 DAT's 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 interviewee's 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 GLA's 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

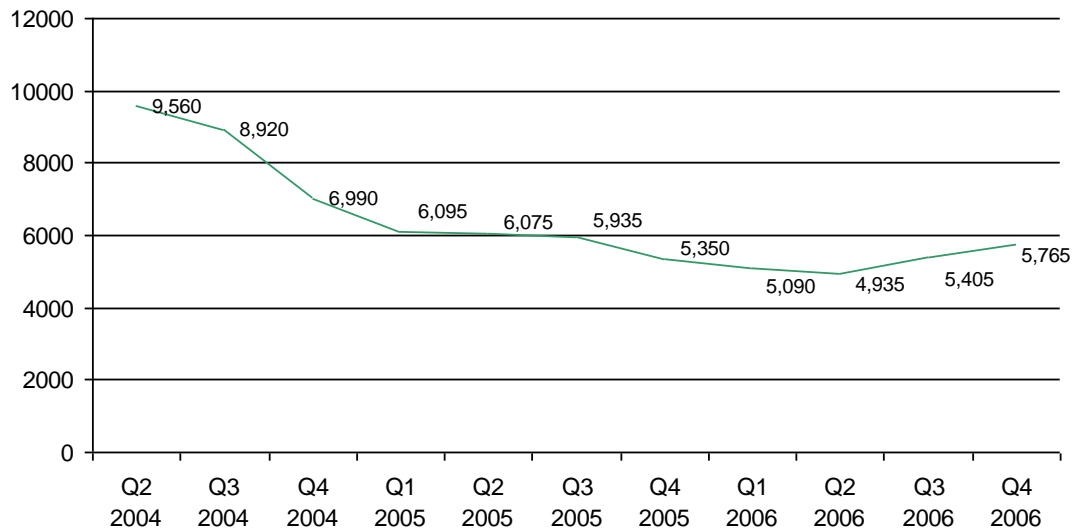
On 1st May 2004, the UK Government established transitional measures to regulate access to the UK labour markets by A8 nationals. Regulation is via the Workers Registration Scheme and requires A8 nationals to register within one month of the date on which they commence employment. Self employed workers 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.

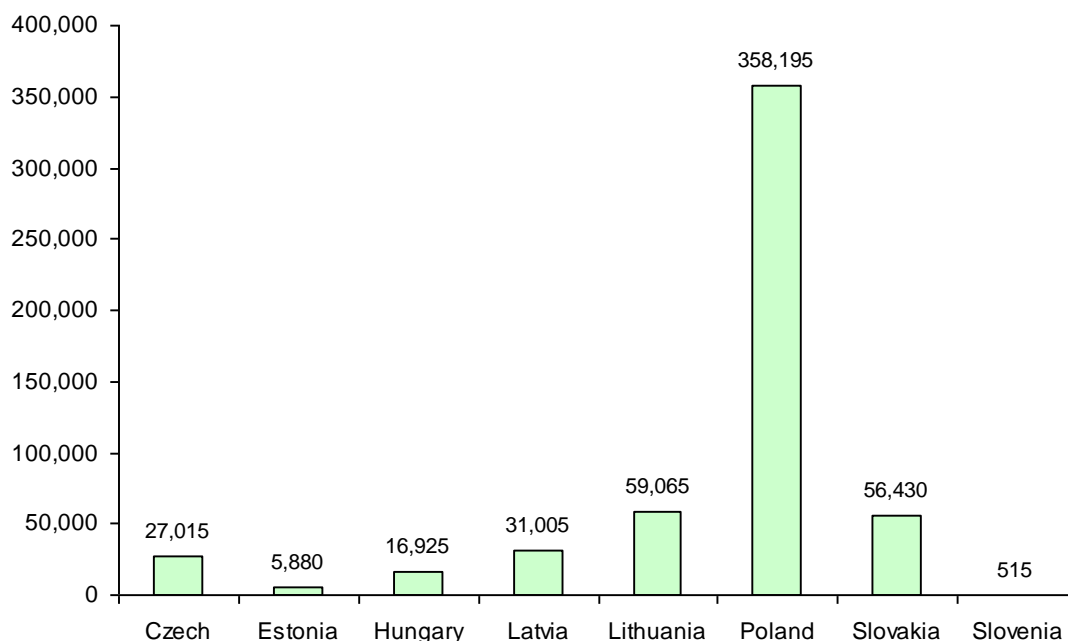
Figure 3. The number of quarterly WRS registrations in London, for the period May 2004 – December 2006



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



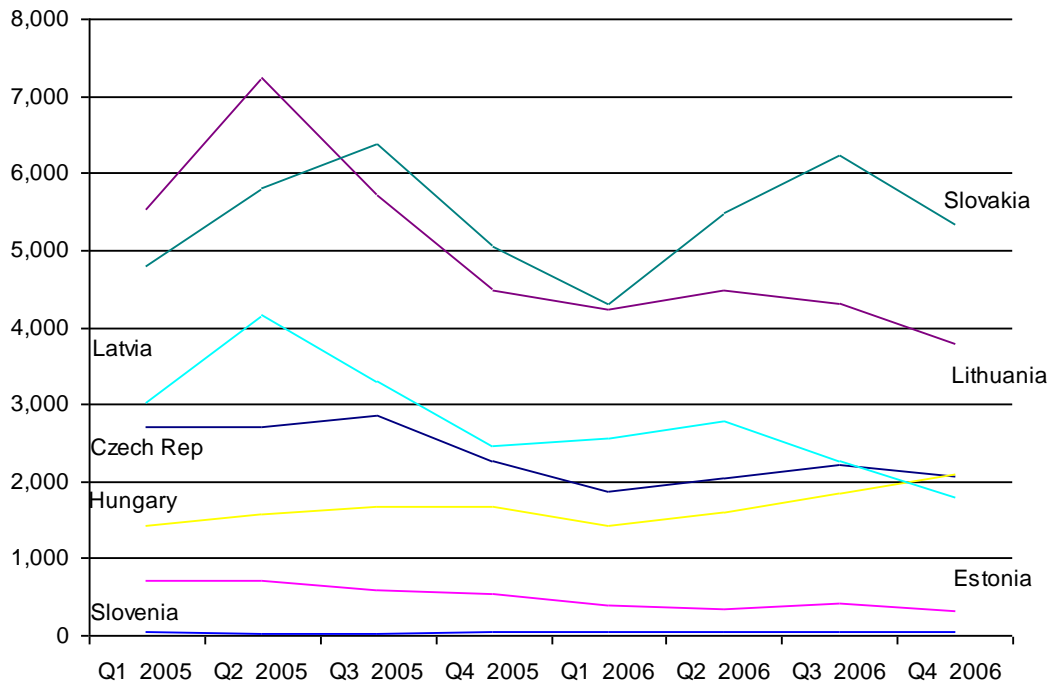
Source: Home Office, Accession Monitoring Report (May 2004 – December 2006).

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 UK's 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).

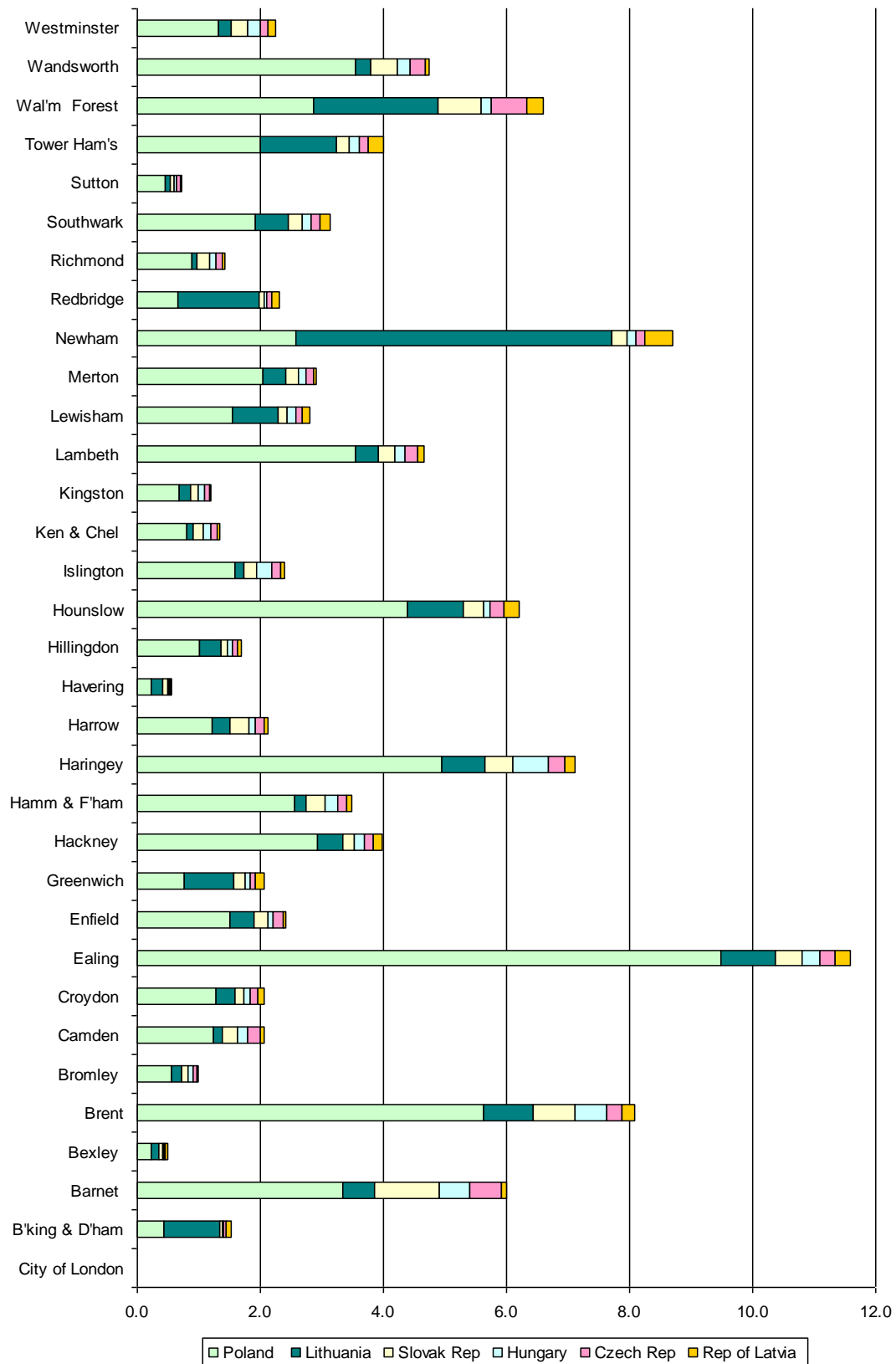
The newest accession countries (A2), Bulgaria and Romania, both had higher numbers of NINo applications in the past, before decreases in registrations in 2004/05 and 2005/06. The DWP (2006) believes that applications from these countries are likely to increase now they have been acceded into the EU. 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).

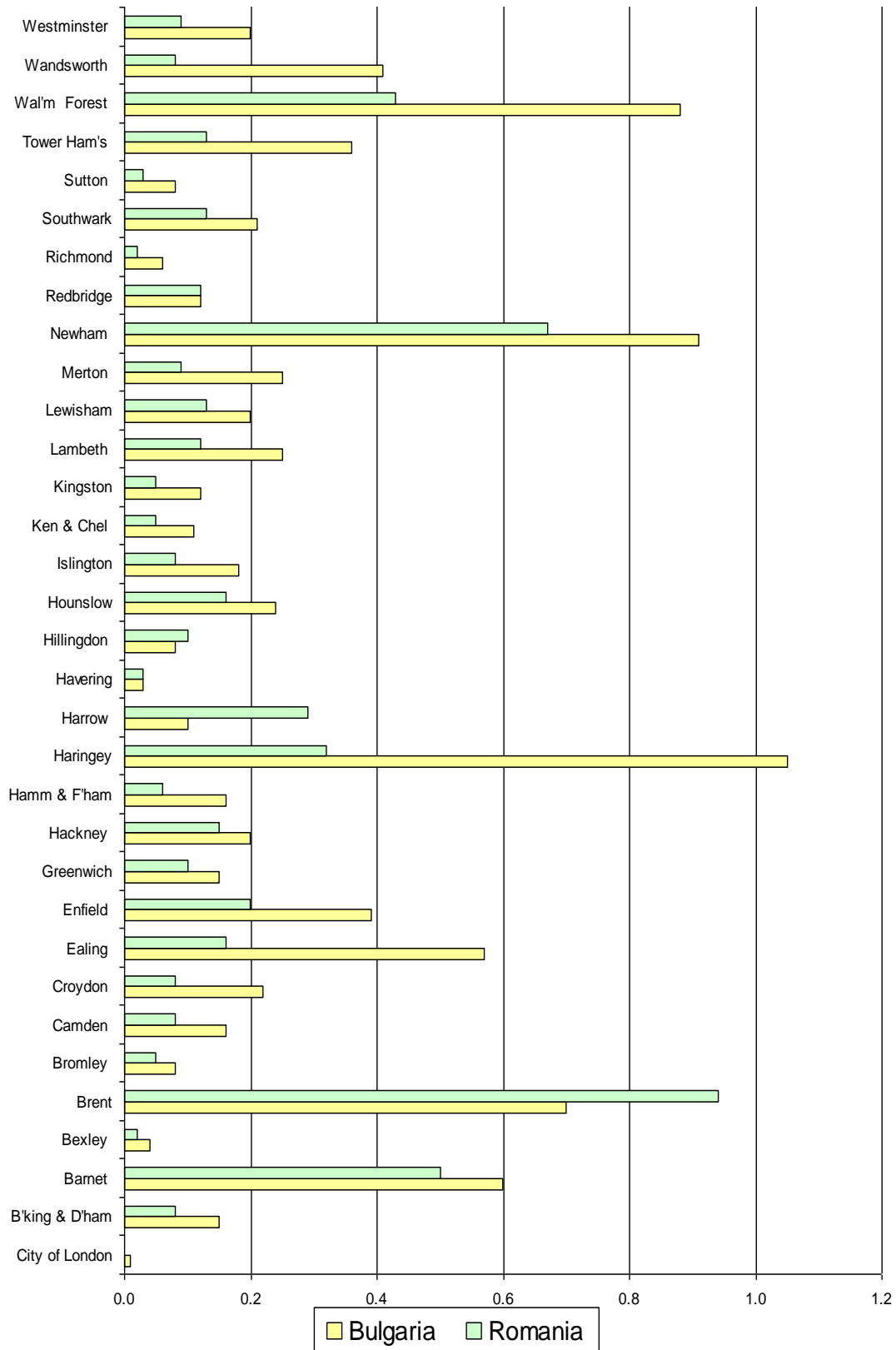
A clearer picture of the nationality of A8 migrants working in each London Borough can be seen from Figure 6 (DWP, 2006). Ealing, Newham and Brent all had over 8,000 NINo registrations from A8 nationals. However, the majority of A8 nationals in Ealing are from Poland, while according to these registrations 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

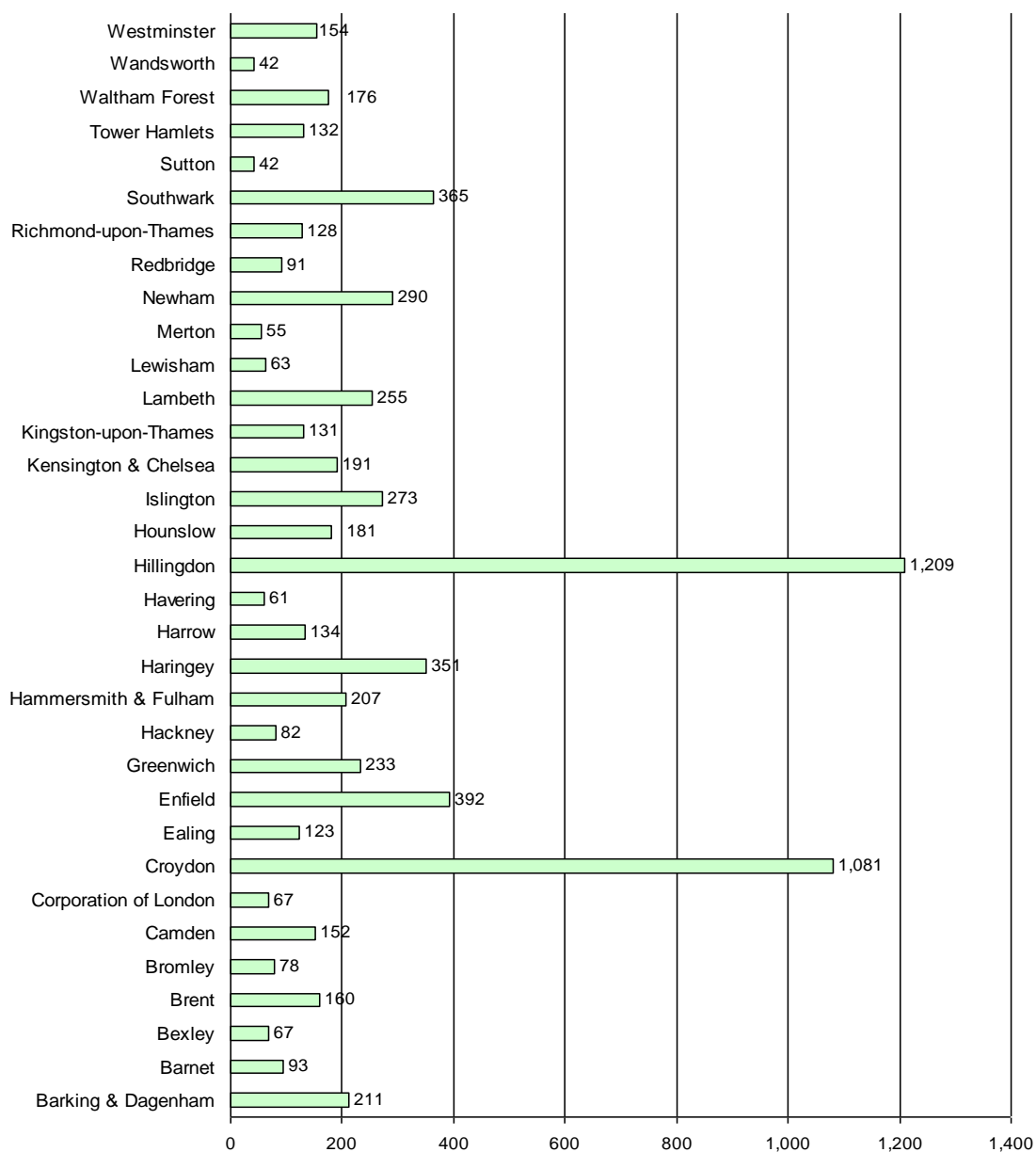
migrants in the UK is 212,000. Findings from the Labour Force Survey found less than half of those registered on the WRS were still in the UK (Commission for Rural Communities, 2007), while other research has suggested the disparity between net and gross flows in the UK and Ireland indicates that as 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 applicant's 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 visitor's 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-patient 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 to 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 DAT's had sought to obtain information about numbers of potential service users and levels of need among new migrant groups within their borough. DAT's 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, DAT's had a variety of strategies. Several DAT's 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 DAT's 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 DAT's (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

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 services 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 A&E 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 sleeper's 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 who 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 scabble 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

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 DAT's 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 DAT's 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 DAT's 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 DAT's:

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 DAT's 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 JCM's 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 staff 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 DAT's – 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 DAT's 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 DAT's 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 DAT's, 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 DAT's 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 DAT's, 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 DAT's 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 DAT's 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 DAT's 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 they 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 where 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 DAT's, 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 Action

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	<input type="checkbox"/>	<input type="text"/>
White: Irish	<input type="checkbox"/>	<input type="text"/>
White: Other	<input type="checkbox"/>	<input type="text"/>
Mixed: White & Black Caribbean	<input type="checkbox"/>	<input type="text"/>
Mixed: White & Black African	<input type="checkbox"/>	<input type="text"/>
Mixed: White & Asian	<input type="checkbox"/>	<input type="text"/>
Mixed: Other	<input type="checkbox"/>	<input type="text"/>
Asian or Asian British: Indian	<input type="checkbox"/>	<input type="text"/>
Asian or Asian British: Pakistani	<input type="checkbox"/>	<input type="text"/>
Asian or Asian British: Bangladeshi	<input type="checkbox"/>	<input type="text"/>
Asian or Asian British: Other	<input type="checkbox"/>	<input type="text"/>
Black or Black British: Caribbean	<input type="checkbox"/>	<input type="text"/>
Black or Black British: African	<input type="checkbox"/>	<input type="text"/>
Black or Black British: Other	<input type="checkbox"/>	<input type="text"/>
Chinese	<input type="checkbox"/>	<input type="text"/>
Other Ethnic Group	<input type="checkbox"/>	<input type="text"/>
Refusal	<input type="checkbox"/>	<input type="text"/>

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 problem's 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.