



Drug Prevention for Young Asylum Seekers and Refugees

A Review of Current Knowledge

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Mentor seeks to undertake, identify, support and share information on effective, proven and promising practices that will protect children and young people from the harm that drugs cause and that will make misuse less likely.

Drug treatment services treat individuals once they have developed a problem. The prevention of drug misuse addresses personal, social or environmental factors in order to contribute to delaying or avoiding the onset of drug use and its progression to harmful or problematic misuse. It is based on the principle that drug misuse is preventable behaviour and that prevention can bring about lasting changes in communities.

The UK government and others have stressed the importance of prevention in tackling the structural problems affecting socially excluded communities across the UK.

This paper, commissioned by Mentor UK, looks at drug prevention among young asylum seekers and refugees in the UK. It includes a literature review, an overview of existing provision and identification of gaps in our current knowledge.

Summary

- The paper includes a literature review summarising existing evidence in relation to young asylum seekers, refugees and drug use; an overview of present provision for asylum seekers and refugees at risk of substance misuse and an identification of gaps in our knowledge about asylum seekers, refugees and substance misuse.
- There is very little available data about the numbers of asylum seekers and refugees using drugs in the UK. Arrest statistics do not always accurately record immigration status, and asylum seekers and refugees rarely access drug services, although this does not mean they are not in need of them.
- A number of barriers inhibit asylum seeker and refugee access to drug services including language problems; a lack of awareness of the services available, a fear of the authorities and the stigma associated with drugs within asylum and refugee communities.
- Frequently the circumstances in which young asylum seekers and refugees to the United Kingdom find themselves involve identified risk factors for the development of drug use.
- Young asylum seekers and refugees, especially those who are unaccompanied, are vulnerable to mental health problems, which is a risk factor for problematic drug use.
- Education is generally recognised to be a protective factor in relation to problematic drug use, but many vulnerable young asylum seekers and refugees experience difficulties in accessing education.
- Asylum seekers are unable to work under UK law, and refugees are over represented among the unemployed. While there is little evidence to directly link unemployment and substance misuse, employment is seen as key to the integration of asylum seekers and refugees. There is some evidence of unemployment among Somali men leading to increased use of khat and, in turn, other drugs.

- There is evidence to link homelessness and problematic drug use. With the policy of dispersal, increasing numbers of asylum seekers are experiencing homelessness and many young asylum seekers are inappropriately housed, living with drug users, or in unsupported accommodation.
- While young asylum seekers and refugees generally report feeling safer in the UK than in the country they fled, they still express concerns about their environment. Many experience social and economic exclusion as well as racism, which have all been identified as risk factors for drug use.
- There are many gaps in our knowledge about young asylum seekers, refugees and problematic drug use.

Introduction

This is a brief paper looking at drug prevention among young asylum seekers and refugees in the UK. It includes a literature review, an overview of existing provision and identification of gaps in our existing knowledge. It was undertaken between June and July 2005.

Young asylum seekers and refugees are vulnerable to many risk factors associated with harmful drug use. They are forced to leave their country of origin, often because they have experienced persecution, torture or violence. Many witness the death of family members or are separated from them. Once they arrive in the UK, often after difficult journeys, they face poverty, xenophobia and social exclusion¹.

There is very little evidence solely concerned with asylum seekers, refugees and problematic drug use. For these reasons, this paper draws heavily on two studies. The first is a drugs scoping study commissioned by the Home Office (Ross Dawson, 2003). It is concerned with whether there is a drugs problem among refugee and asylum seeker communities, and if there is, what the extent of this problem is. This study is also concerned with the implications of these findings on service provision. A literature review was conducted, as were interviews with those with a knowledge of drug use and services; this included refugees and asylum seekers. Whilst this study was useful it was not wholly concerned with young asylum seekers and refugees. In contrast, the second study this paper draws on was concerned specifically with drug use among young asylum seekers and refugees living in London (GLADA et al. 2004). It too conducted a literature review as well as a policy mapping exercise. This second study used research from six community organisations that collected information from 16 young people born in Afghanistan, 11 young Iraqis, 7 Nepali, 11 Turkish Kurds, 11 Zimbabwe and 11 young people from other African countries. They were all aged between 16 and 25 and most had been in the country for less than 3 years. While this is a recent and relevant study, despite interviewing refugees and asylum seekers from a range of backgrounds, the study itself makes little reference to the needs or problems of specific groups of asylum seekers and refugees.

¹ See Appendix A for further information on current refugee and asylum legislation.

There are no statistics on the exact numbers of young people involved in drug misuse² and drug dealing; police arrest data is an unreliable source for many reasons (Ross Dawson, 2003). While many institutions involved with drugs³ and drug treatment conduct ethnic monitoring, refugee status is not usually recorded and, when it is, is not always accurate (GLADA et al., 2004; Ross Dawson, 2003:7). More than most communities, refugee and asylum seekers have strong reasons for hiding any involvement with drugs. Asylum seekers in particular may worry ‘any disclosure will put paid to their hopes’ of being allowed to remain in the UK (Ross Dawson, 2003:7). For this reason drug use by asylum seekers is rarely picked up when they first arrive in the country. This is compounded by the fact that those agencies dealing with recent arrivals are not drugs specialists and drug use is not included as part of initial assessments.

Asylum seekers and refugees who do use drugs are less likely to access drug services than other drug users, in part due to language barriers and a lack of awareness of the facilities available to them. Also, many people applying for asylum have been persecuted by the authorities in their own countries and consequently there are difficulties in persuading them to access any services that are seen to be provided by those in authority. The anecdotal evidence from most drug service providers and refugee workers Ross Dawson interviewed for his drugs scoping study show that while there may be individual asylum seekers who, on arrival, are drug users, it is not a general problem within asylum seeking and refugee communities. Once asylum seekers arrive in the UK, it is argued they are likely to avoid involvement with illicit activities such as drug taking so that they can take full advantage of the new opportunities available to them (Ross Dawson, 2003).

Indeed a number of studies (including Ross Dawson, 2003 and Save the Children and Glasgow Greater Council, 2002) indicate the most serious problems for refugees and asylum seekers in relation to drugs, is their exposure to the drug and alcohol abuse of others. Save the Children’s investigation into the experiences of asylum seeker children in Glasgow found they regarded drug and alcohol abuse as one of the worst aspects of living there, with older children commenting this was one of the major factors in the ‘violence and abuse’ experienced by asylum seekers from the ambient population (Save the Children and Glasgow Greater Council, 2002:18)

2 Drug misuse will be used to refer to ‘drug using which causes harm to the individual, their significant others or the wider community’ (GLADA et al. 2004).

3 ‘Drugs’ refers to ALL drugs including illegal drugs, medicines, volatile substances, alcohol and tobacco.

The government has made attempts to address the risk of substance misuse among young people from marginalized communities. The Home Office 2002 Drugs Strategy included a section on diversity recognising that drug prevention, education and treatment need to be available to underrepresented groups, particularly young people within those groups.⁴ It is acknowledged that an important part of this involves tackling social exclusion and poverty within black and minority ethnic communities across the country. Home Office efforts at crime reduction also recognise the need to persuade young people not to use drugs and to tackle social exclusion. Services developed from this include the Positive Futures initiative, a national social inclusion programme that uses sport and leisure activities to engage with disadvantaged and socially marginalised young people, and Blueprint, a research based drugs education strategy. Connexions, the service offering personal development advice to young people attempts to offer alternatives to drugs. Their clients include significant numbers of young asylum seekers and refugees (Connexions, 2003).

GLADA et al. (2004) identified nine risk factors that expose young asylum seekers and refugees to drug misuse; health, education, crime, employment, housing, family, current and previous drug use, environment and social networks. While statistics about the numbers of asylum seekers and refugees using drugs are incomplete, because they are susceptible to so many of the risks outlined below, drug prevention strategists need to consider how to meet the needs of this vulnerable group.

Health

The Greater London Alcohol and Drugs Alliance (GLADA et al. 2004) explains that the presence of a mental illness can pose a risk for problematic drug use. The combination of deprivation, stress and limited access to healthcare means that refugees and asylum seekers have special health needs, which leave young people and children particularly at risk.

Although refugees and asylum seekers' physical health needs are usually no greater than the native populations this is not the case in relation to mental illness. In a study of 26 asylum seekers and refugees living in Edinburgh, 54% were found to have symptoms indicative of an anxiety disorder, 42% had symptoms synonymous

4 See <http://www.drugs.gov.uk/NationalStrategy/Diversity>

with clinical depression and 33% had trouble sleeping. These all increased with length of time in the UK suggesting that post-migration factors are of particular importance (Ager, et al. 2002). Some, including Meisler (1996) have linked drug abuse with Post-Traumatic Stress Disorder (PTSD) which asylum seekers and refugees, who have often witnessed extreme violence and poverty, are susceptible to.

Young asylum seekers and refugees are especially vulnerable to mental health problems, particularly those with unaccompanied minor status. Westemeyer (1993) explains they can suffer from depression, social withdrawal, violence and anti-social behaviour due to separation from their home, culture and family. However, even those with family present in the UK may find themselves feeling unsupported due to absent parents at work or dealing with other problems, leaving children to fend for themselves. Parents, dealing with their own emotional problems, are often unable to care for their children properly, which in turn can cause psychological and physical problems (Coker 2001).

One of the major problems asylum seekers and refugees face is accessing healthcare services. All refugees, asylum seekers and those given leave to remain are entitled to full NHS care and support. However, both healthcare professionals and refugees and asylum seekers themselves are often unaware of this. Coker (2001) reports that NHS staff are ignorant about the rights and entitlements of immigrants, and are also inadequately trained to deal with their particular needs. Refugees and asylum seekers are not given any information about their entitlements on arrival, and language barriers create additional difficulties. Many asylum seekers and refugees have problems registering with GPs because the National Asylum Support System (NASS – see Appendix A for further details) moves them around the country regularly (Dennis, 2002). Due to staff shortages, GPs' lists may be closed to new patients, especially in deprived and inner city areas where asylum seekers are often housed. It was also reported that some asylum seekers experienced feelings of hostility from GPs who did not give them enough time or were unwilling to book interpreters. Dennis found that of 118 young unaccompanied asylum seekers, 36 were not registered with a GP.

If young asylum seekers and refugees are unable to access healthcare, this leads to concerns around the risks of self-medication. The GLADA et al. (2004) found evidence of refugees and asylum seekers self-medicating and developing a reliance on prescription drugs to cope with their mental and physical health problems. Ross Dawson (2003) reports that khat (or qat) is used by a significant group of refugees

as a way of coping with their new lives. The plant, used widely in Somalia, Yemen, Eritrea and Ethiopia, is a stimulant, mainly used by men. Although not illegal in the UK, khat has been blamed for a number of health concerns and has been identified as a source of social disruption within the affected communities.

Education

Education and academic attainment have been recognised by a number of studies as acting as protective factors against the misuse of substances (see for example Stonski et al 2000). Stanley (2001 in GLADA et al., 2004) asserts education is especially important for refugee and asylum seeker children as it allows for contact with adults and for interaction with children from different backgrounds. Similarly, education is important for asylum seekers and refugees as it can play a role in alleviating boredom, broadens employment opportunities and can offer ‘normality and security’ for young people who have often experienced severe trauma (Dennis, 2002:6).

Under the UN Convention on the Rights of the Child, all children are entitled to an education, while under the 1996 Education Act, Local Education Authorities (LEAs) are obliged to provide an education for all young people who live within their boundaries. However, such statutory rights to education as do exist are often not made available to refugee and asylum seeker children. Dennis (2002) found there are often delays between young people making an application for an educational place and receiving one. According to the DfEE and the Department of Health a delay in commencing education is ‘damaging and causes social exclusion’. As a consequence of this in May 2000 they demanded ‘local authorities set a time limit of twenty school days within which they must secure an education placement for any pupils in care’ (DfEE and Department for Health, May 2000 in Dennis 2002: 6). Whilst not all young refugees and asylum seekers are in care, Dennis asserts this cap of twenty days is a helpful measure to use when looking at all young people. In her study of 118 refugee children, she found twenty-five had experienced delays before being offered an educational placement of twenty days or more. Indeed forty per cent of the young people she studied were receiving no education at all and some children waited over six months to be offered a place. Stanley (2001 in GLADA et al. 2004) found unaccompanied minors were often left to navigate the system of school entry by themselves.

Research also shows that when young refugee and asylum seekers are granted education places, they are often inappropriate. For example, they are often placed with younger children, which can lead to shame and bullying, or in facilities for pupils with behavioral and educational problems that can be extremely intimidating. Kidane (2001 in GLADA et al. 2004) found most asylum seekers had received some education prior to arriving here although this was to differing standards and many African children had not been exposed to any formal education. However, these differences in previous education are not fully accounted for when placing children in education and insufficient acknowledgment is made of previous qualifications. Similarly some young people are offered part-time education that is insufficient to fulfill their needs.

The education of refugees and asylum seekers after the age of 16 is at the discretion of LEAs and head teachers. Some colleges treat asylum seekers as though they are overseas students, meaning they are required to pay substantial fees if they wish to remain in education. There is also evidence that colleges are unwilling to enroll young people on longer-term courses, such as A Levels, if their status is uncertain and if it is possible that they will be deported. Many international studies show such young people often leave education at an early age, largely as a result of language barriers or harassment, and evidence from the GLADA suggests the situation is better in London than elsewhere in the country (GLADA et al. 2004).

Griffiths (2003 in GLADA et al. 2004) found many problems with the provision of English for Speakers of Other Languages (ESOL) programs with there being, for example, insufficient contact between those who organise such courses and community organisations. This evidence suggests that while many young asylum seekers are keen to gain qualifications and attend school, there are many problems with them accessing the appropriate services. These problems can lead to truancy and poor results which is concerning for many reasons, including the important role played by education in protecting against the misuse of drugs.

Crime

There is evidence of a relationship between drug use and delinquency. Windle (1990: 90), in his study comparing early teenage delinquency with later drug misuse, found 'early-adolescent general delinquency, rather than simply substance involvement, increases the risk for late-adolescent substance abuse and alcohol

related problems'. Other researchers also found a strong link between drug misuse and wider deviance and risk-taking behaviours (Miller and Plant, 1999; Clayton et al. 1995).

However, there is little evidence to suggest that asylum seekers are involved in more deviant behaviour than the general UK population. The Association of Chief Police Officers (2001) reported that asylum seekers are, in fact, more likely to be victims of crime than the native population due to xenophobic and racist attacks. GLADA et al. (2004) found that service providers and young asylum seekers reported very low rates of crime perpetrated by young asylum seekers and refugees themselves. The only commonly reported crimes were immigration offences such as illegally working rather than delinquent behaviour.

Lambeth Youth Offending Team reported low levels of contact with asylum seekers and refugees but highlighted some important issues arising from the contact that they did have. Language barriers were a major problem. They reported young people being unwilling to disclose information to interpreters because they feared stigma from the communities they were from. The team also found that asylum seekers and refugees had very little understanding of the British criminal justice system (GLADA et al. 2004).

Employment

From 2003, asylum seekers have been banned from working by the Home Office forcing them to rely on state benefits. Refugees and those with exceptional leave to remain (see Appendix A for further information on leave to remain) can work, although unemployment remains between 60% and 90%. Those that do find employment often have to accept jobs which are low paid and do not match their skills and qualifications (Mayor of London, 2003).

The government has recognised that the integration of refugees can be facilitated by employment (Home Office 2000). The Department for Work and Pensions (DWP) published a green paper in 2001, 'Towards Full Employment in Modern Society', which targeted areas of high unemployment, particularly poor urban areas. These areas included those with high numbers of people from minority ethnic communities and refugees. The Social Exclusion Unit, the Commission for Racial Equality and the Refugee Council have all recognised the importance of employment for minority ethnic communities. However, asylum seekers are unable

even to take part in training schemes despite having to wait up to five years for their applications to be processed.

There is little evidence to suggest a direct link between drug use and unemployment, but unemployment may increase the likelihood of young people joining deviant subcultures (Hammer 1992). Sangster et al. (2002) did find that khat use increased among Somali men as a response to unemployment, which also led to experimentation with other drugs. Bloch (2000) found that asylum seekers and refugees themselves see employment as the key to integration into the wider community.

For refugees, the main barrier to employment is language (Bloch 2000, 2004) and employer confusion (GLADA et al., 2004). Basic language skills are important for all occupations but there are problems across the country in accessing ESOL classes. Also, due to frequent changes in immigration laws, employers are confused as to whom they can employ, fearing prosecution from the government if they employ the wrong people. This has created a situation where refugees, who are legally entitled to work, are being refused employment. In addition, many employers do not recognise pre-migration qualifications, limiting the jobs open to refugees.

Finally, GLADA and others (2004) point out that sex work is an area of serious concern in relation to young asylum seekers and drugs. A number of young unaccompanied minor asylum seekers have gone missing from social service care, and there is some evidence that a number are involved in the sex industry (Ayotte, 2000). Drug use is encouraged by pimps in order to create a culture of dependency. Other children have been trafficked into the country to work as domestic servants and are drugged in order to aid their cooperation (Ayotte, 2000).

Housing

The links between homelessness and drug use have been identified both inside and outside the UK (Downing Orr, 1996 in Neale, 2001: 353). The GLADA report (GLADA et al., 2004) into drug use by asylum seekers and refugees found housing problems, and in particular homelessness, to be an important risk factor in the likelihood of substance misuse.

The current policy of dispersing asylum seekers away from London means that those who receive assistance from NASS have to accept housing on a no choice basis, with those who choose to remain in London receiving no help with housing

costs. The GLADA et al. (2004) assert that as a consequence, an increasing number of asylum seekers are opting to live on the NASS subsistence only package in order to remain in London or are drifting back to London after being sent to other parts of the country. Consequently, many asylum seekers form part of the capital's hidden homeless population. Many of these asylum seekers are likely to be young people. Dennis (2002) found that thirteen out of the ninety unaccompanied minors involved in her study were homeless (Dennis, 2002: 10).

In addition to homelessness there is evidence that many asylum seekers are being housed inappropriately. Dennis found indications of inappropriate housing with 21 of the unaccompanied asylum seekers she questioned living in unsupported residential units and adult hostels (Dennis 2002: 10). Living in such conditions means young asylum seekers not only lack privacy and may be subject to overcrowding but they are also unlikely to receive the full support they need and may well be distanced from their own communities. The GLADA similarly reports that many unaccompanied minors face problems when they leave care because housing is so expensive, especially in London. While unaccompanied minors should not be dispersed, many are because they are dealt with by adult social workers. There is some evidence to indicate unaccompanied minors are being sent to areas where the Local Authority is unaware of their arrival and consequently is unable to offer any support (in areas where Children's Services include asylum teams, young asylum seekers experiences of housing are better, GLADA et al. 2004).

Young people housed with their families also face problems. Families are frequently housed in hotels, hostels, and local authority housing or private rented accommodation that is run down and cramped. A study by Garvie (2001) found that 17% of 154 dwellings used by asylum seekers were unfit for human habitation, 86% were unfit for the number of people living there and 80% had an unacceptable risk of fire. Most were also found to be far away from local amenities such as shops, places of worship and areas where people from their countries were living. Councils often use houses that UK citizens refuse to live in. Private landlords are often aware that asylum seekers have fewer rights to complain and that the fire safety standards specified by the NASS are lower than normal housing legislation.

Once asylum seekers have been granted refugee status or leave to remain they are covered by mainstream housing policy. However there is evidence that they may still face problems in finding appropriate housing due to discrimination and because they are unable to receive housing support outside the area in which they were originally housed as asylum seekers (GLADA et al. 2004).

Family

GLADA and others (2004) argue that the family can act as a protective factor against substance misuse when there is sufficient parental supervision and when there are close family attachments. Similarly, they identify circumstances in which the family acts as a risk factor for young people becoming involved with drugs. These include drug use by other family members, poor attachment to parents, poor communication with parents, lack of consistency in discipline, a disruption in family life, criminality among family members and an acceptance of drugs by parents. Von Sydow and others (2002) also found mental illness among parents and parental mortality to be significant risk factors.

The above issues are relevant to many young asylum seekers and refugees. GLADA and others (2004) comment that the very anxious wait for asylum decisions can impinge on the ability of families to function as effectively as they otherwise might. Linked to the issues of family disruption and attachment is that of unaccompanied minors and family reunification. Indeed, as the GLADA report acknowledges, it is not only unaccompanied children for whom it is important to be reunited with their parents but also those who have arrived with only very distant relatives. While adults, once granted refugee status are allowed to apply for their spouses and children to join them, however difficult and drawn-out this process may be, young people granted refugee status are unable to bring the families they have been separated from into the UK. Prior to 2003, parents had been joining their children. However this was brought to an end when the government introduced Humanitarian Protection and Discretionary Leave to Remain. Given the links discussed above between family disruption, attachment and drugs use, the problem of reuniting families is concerning. Indeed Westemeyer (1993), in a small study in America, found that being an unaccompanied minor played a very significant role in the development of substance abuse. Similarly, Sourander (1998: 720) in a study concerned with the emotional and behavioural difficulties of child asylum seekers in a Finnish detention centre, comments that '[r]efugee children who remain with or are rapidly reunited with families show less emotional distress and better adjustment' than do unaccompanied minors.

Many young asylum seekers and refugees have experienced the death of one of their parents. This is an area that needs careful consideration in relation to drugs use given the findings of Von Sydow and others (2002: 61), that the death of a parent below the age of 15 increases the risk of cannabis use and is an important precursor for dependency.

While the importance of family in the lives of children and young people is central and cannot be replaced, the report by the GLADA and others (2004) comments on the work done by organisations to replace some of the support usually provided by families. For example they mention the Coram Young Parents' Project that operates in Camden and Islington. Aiming to replace absent family networks, this organisation works with asylum seekers, refugees and other minority ethnic communities and focuses on issues such as continuing education, development and healthy eating. The GLADA and others report comments that this service is of particular use to African women. Thus these projects, in supporting the family and helping to provide stability, can be seen to play an important role in preventing the development of harmful drug use.

Previous and Current Drug Use

As mentioned earlier, there is little evidence that there are significant numbers of asylum seeker and refugee drug users in Britain. As Ross Dawson (2003: 14) reports, 'if there (is) a 'drugs problem' in relation to refugees and asylum seekers, it was a problem they faced, not a problem they generated.'

However there were some drug and refugee workers who felt a considerable number of asylum seekers arrived in the country with addictions and continue this involvement in the UK. For example the Redbridge and Waltham Drugs Action Team (DAT) noted that over recent years there has been an increase in drug use at the same time as the number of asylum seekers in the area has increased, implying a correlation between the two (Ross Dawson 2003). Brako and Saleh (2001) report that young asylum seekers from Sierra Leone who were soldiers in the war continue their use of heroin once in the UK. During the war, child soldiers were supplied with opiates in order to encourage cooperation but in Britain, it is used as a coping strategy to deal with their past experiences and new stressors. Khat use is also common among the Somali community in Britain. However, there is evidence that its use has changed. For example, Whittingham and Abdi (2001 in GLADA et al. 2004) found that khat use had spread to new groups in Britain. Previously it was used by older male leaders but now is commonly used by young men and women. Turning Point (2005) found in interviews that more women used khat than previously thought and use amongst both sexes had increased whilst in the UK.

There are grounds for suggesting that drug use may increase over time once asylum seekers and refugees have settled in the UK. Reid and others (2002) found that

in Australia, immigrants had adopted local drug taking practices. MacDonald and Marsh (2002) argue that drug use amongst young people in Britain is becoming normalised and there are fears that young asylum seekers and refugees are adopting these habits. GLADA and others (2004) found in their interviews with young asylum seekers that about one third had used drugs whilst in the UK. There were some that admitted using heroin and others who acted as dealers. It is also important to consider the longer term risks that young asylum seekers and refugees face. Westemeyer (1993) suggests that problematic drug use may develop five to ten years after resettlement suggesting that appropriate support needs to be available during the passage to adulthood.

Environment

The GLADA and others identify a number of risk factors in relation to environment and drugs. Links between social exclusion and drug use, rather than low socio-economic status per se, have been identified by a number of studies including Parker, Bury and Egginton (in GLADA et al. 2004) who found young heroin users in England and Wales are frequently from socially excluded backgrounds.

Clearly, given factors discussed elsewhere, issues relating to environment are of particular concern to asylum seekers and refugees who experience much poverty, particularly asylum seekers who are unable to work and must rely on NASS benefits. GLADA and others comment that many have expressed concerns relating to the amount of money available to asylum seekers with general subsistence amounts being only 70% of that given to the native population. Similarly, although the amount received by families with minors is greater, they are still unable to access other benefits such as milk tokens and Child Benefit (2004: 205). There are at the same time many asylum seekers who, as a result of Section 55 of the 1992 Nationality, Immigration and Asylum Act, are denied access to benefits because they are unable to supply satisfactory evidence as to why they did not apply for asylum as 'soon as was reasonably practicable' (GLADA et al., 2004:205). Ross Dawson (2003) also comments that some of the drugs workers he talked to saw the policy of dispersal as increasing poverty among asylum seekers since many return to London and consequently have nowhere to live.

The situation relating to young asylum seekers is slightly different and families with children under the age of eight cannot be denied support. However Stanley (2001 in GLADA et al., 2004) found young unaccompanied asylum seekers who

were living in unsupported accommodation received very little financial support, although those who were looked after were often financially more secure. Dennis (2002) comments this has many implications for young people, including their ability to integrate with peers as they often have no money to spend on leisure pursuits or transport. In order for these problems to be overcome she argues such expenditure should be seen as a necessary part of a 'socially inclusive life' (Dennis, 2002: 23).

The main scheme at present for combating deprivation is the National Strategy Action Plan For Neighbourhood Renewal, which was produced by the Social Exclusion Unit in 2001. This scheme, which has now been redesigned to promote community cohesion as its core objective, aims to tackle poverty in the most deprived areas over the next 10-20 years through new policies, funding and targets in areas such as employment and crime. While such strategies are not primarily intended to help asylum seekers and refugees, they will benefit from general improvements to deprived neighbourhoods and the government has pledged to keep minority ethnic communities to the fore when tackling such issues.

Community cohesion became an important issue after the 2001 race riots in Bradford, Oldham and Burnley. As a result of a number of reports, including the Ministerial Group and Public Order and Community Cohesion set up by the Home Secretary, deep divisions within communities were identified. It became clear that given the very quick cultural and ethnic changes that can be made to a community by the arrival of asylum seekers, work needed to be done with the host populations to ensure that the new arrivals did not feel threatened. Also, both the host population and asylum seekers needed to help develop a common vision of a community for diversity to be appreciated and for all within the community to have similar opportunities. This seems to be especially important when the high levels of animosity experienced by refugees and asylum seekers is taken into consideration. A study by Carey Wood and others (1995 in GLADA et al., 2004: 209) of 263 (adult) asylum seekers found about half had experienced some kind of racial discrimination, a third had experienced verbal abuse and 13 percent had been physically attacked. Similarly, while those young asylum seekers interviewed by the GLADA and others (2004) generally said they felt safer here than they had done previously, this was generally expressed as a comparative sense of safety and many restricted the areas they visited in order to avoid danger. Sangster and others (2002) found evidence linking the experience of racial discrimination to drug use.

Social Networks

The most significant risk factor in relation to social networks and drugs is substance use by peers. For example, Miller and Plant (1999) studied 2,641 young people and found that those whose peers used cannabis were 15 times more likely to have used the drug themselves within the previous thirty days than those with non-deviant peers. Non-deviant peers are in general seen as a protective factor against substance misuse. Active opposition to deviant behaviour (such as substance use) is often organised and transmitted through faith groups, which provide sometimes the only social networks outside the family for young asylum seekers and refugees.

Bahr and others (1998) studied 13,250 American adolescents looking at mother/father bonding, parental monitoring, family aggression and religiosity. It was found that religious teenagers were least likely to use drugs or have friends who used drugs. Religion was also a greater determinate than any of the other variables studied. In the GLADA and others (2004) study, many adolescents mentioned their religious beliefs as a reason why they would never use drugs. Ross Dawson (2003) mentions that there is a belief that Islam and other religions limit the use of drugs amongst refugee and asylum seeker communities because of the strong taboos associated with their use within Islam. However, he also points out that in any community, it is only a small minority who use drugs. Clearly, a small minority are prepared to risk breaking these taboos. He is also concerned that the Home Office may have over-estimated the social regulatory properties of religion, leading to a failure to tackle the drugs market within certain communities, particularly in northwest England.

Drugs Services

Fountain and others (2003) found the main barriers refugees and asylum seekers face in accessing drugs services are to do with a lack of knowledge both about drugs and drug services as well as stigma surrounding the use of drugs. Other factors that impact on access to drug services are a lack of cultural sensitivity and language problems. These is also, it is argued, a failure to adequately deal with black and other minority ethnic drug users. Fountain and others found some barriers are removed once refugee status is given.

In terms of drug awareness, Fountain and others claim that knowledge about the harmful effects of drugs is particularly lacking within the Turkish and Somali communities. The largest drug problem with the Somali population is the use of khat. Fountain and others argue education programmes are needed in these communities to raise awareness of the issues relating to the use of khat. They claim that this would be particularly useful if it were aimed at the older generation who would then be better equipped to detect the use of khat among the younger generation. There is evidence that while drugs information in a variety of languages is being produced, Fountain and others found that in relation to the Turkish community, there are problems with this information reaching all those who need it, because those involved in community organisations tend to have the best access.

The stigma surrounding the use of drugs within many asylum and refugee communities deters members of those communities from accessing drug services. Fountain and others (2003) therefore conclude that for drugs services to be more effective they should be attached to GPs surgeries rather than community organisations. They also argue greater contact and discussion with other minority ethnic groups may help to tackle this stigma and also aid integration more generally.

Telephone survey

A number of agencies were contacted, in an exploratory manner, to see what approaches and methods they used to tackle the issue of asylum seekers, refugees and drugs. Only a minority of the organisations we contacted were able to help us or had people available to talk.⁵ However a small number we did consult with were able to provide us with useful information. Some of those whom we contacted, especially DAATs, although unable to assist themselves, referred us on to other organisations.

For example, the African Community Involvement Association, which operates in Croyden and Wandsworth and receives DAAT funding, works with African asylum seekers and refugees. Their aim is to raise community awareness of drugs issues by establishing local support groups. They are able to provide literature, some of which they produce themselves and some of which is obtained from FRANK. Other organisations we contacted also indicated that problematic drug use

⁵ See Appendix B for further information on methodology.

exists among asylum seekers and refugees. A drugs worker from Bolton DAT had personally treated two Iranian heroin addicts who had developed their drug use in the UK. She was also aware of three or four other cases that her colleagues had treated. She thought there are probably many more cases but that users were afraid to access help or simply did not know what services are available. A drugs worker from Merton Ethnic Diversity Drugs Team, whilst asserting he had not treated any asylum seeker or refugee drug users himself, argued there was much use of khat among the local Somali population and that there was a worrying lack of understanding as to the health implications. He also told us there is some evidence of people using khat and cannabis together. As with the African Community Involvement Association, Merton had run programmes to improve awareness of drugs services. While both of these drugs workers primarily had experience with adult users, they had both encountered asylum seeker and refugee minors who used harmful substances. In the Merton case, the drugs worker was aware of two Somalian unaccompanied minors who had become addicted to opium whilst they were child soldiers in their own country.

Many of those we spoke to felt that a lack of knowledge was an important factor to consider in relation to asylum seekers, refugees and drugs. Awareness of the health issues surrounding substance use, awareness of the services available and also an awareness of the criminal justice system in the UK. Furthermore, the issues of stigma and trust were also seen to prevent members of such communities accessing drugs services. Whilst the drugs worker we spoke to in Bolton acknowledged translation services had recently improved in the area, she felt services for minority ethnic communities in general need to improve.

Gaps in the Literature

- There is generally very little research into young asylum seekers and refugees and drug misuse. The most comprehensive study (GLADA et al. 2004) only covers the area of London. Other studies, including Ross Dawson (2003), explore a wider geographical area but do not specifically look at young people.
- There are few targeted drugs prevention programmes for young asylum seekers and refugees. There have been attempts to translate literature into different languages and programmes targeted at specific cultural groups, but these have not explored the unique experience of being a young asylum seeker or refugee.

- A major problem is the lack of reliable statistics on the prevalence of drug misuse amongst young asylum seekers and refugees. Immigration status is not recorded by the police in drug related crime or by drug misuse service providers. Therefore, it is impossible for us to ascertain the true scale of the problem.
- Few studies have recorded the experiences of unaccompanied minors in Britain and their experiences in care and following care. With no social support networks, fewer rights than citizen children and experience of severe trauma, they are a group who appear to be vulnerable to drug misuse, particularly those aged between 16 and 17.
- Recent policy changes have not been fully researched particularly in relation to their effect on asylum seekers and refugees themselves. The dispersal system, for example, has had a significant effect but there has been little research into the provision of services in different areas particularly in relation to drug misuse.
- Different cultural groups and communities in Britain experience the risk factors mentioned above differently and so have different experiences of drug misuse. There are few studies that concentrate on particular cultural groups except in relation to khat use amongst the Somali population. Even then, there is little exploration of their use of other drugs.
- Time factors are important. Westemeyer (1993) suggests that immigrants in the USA are vulnerable to drug misuse up to five to ten years after arrival. However, there is no equivalent study for the United Kingdom which would enable us identify at what stage in the settlement process young refugees or asylum seekers who have been given leave to remain are most vulnerable.
- Greater research into the relative benefits of providing services by agencies not directly connected to or staffed by the particular community from which the young asylum seeker or refugee originates may be interesting given Fountain and others' (2003) findings in relation to stigma negatively impacting on access to services.

Appendix A

It should be noted, that in this report, we often use the terms ‘refugees and asylum seekers’ as a collective noun in order to reflect the similar experiences of this population group. However, we also recognise that there are significant differences in terms of the legal status of the two categories. The United Kingdom is a signatory to the United Nations Convention on Refugees (1951) which means they have a legal responsibility to grant asylum to those people who have

‘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 2001: 16).

Once the Home Office has granted asylum to those who fall within this definition, they become refugees. Asylum seekers are those people who are in the process of applying for refugee status but who have not yet received a decision on their case. Asylum seekers are not allowed to work and are therefore forced to be reliant on state benefits. They have no right to family reunification and no long-term security. Refugees, on the other hand, can work and have rights to family reunification. After five years, they are able to apply for British citizenship. More recently, the Home Office has introduced other categories including ‘temporary leave to remain’ and ‘permanent leave to remain’ as a way of offering humanitarian protection for those whose cases do not fit the UN convention but who still require protection. Most young asylum seekers come to the country accompanied by one or more parent and other family members. However, there is a significant proportion that come alone. In 2003, 2,800 unaccompanied minors arrived in Britain from a total of 49,405 applicants. They are automatically given the same legal rights as citizen children, although accompanied children are not.

The most common nationalities of applicants, both adults and minors, in 2003 were Somali (10%), Iraqi (8%), Chinese (7%), Zimbabwean (7%) and Iranian (6%) (Heath et al., 2004). It is important to recognise that there are differences between the different cultural groups residing in Britain and it is therefore wrong to make broad generalisations. Also, the experiences of asylum seekers and refugees must be seen in the wider context of minority ethnic experience. Once a refugee has been given citizenship, they will remain a member of a minority ethnic community.

In the past few years, the immigration system has come under intense scrutiny from all sides of the political spectrum. The government has introduced six new pieces of legislation on the issue in the past twelve years. In May 1998, 52,000 people were awaiting immigration decisions and 10,000 of those had been waiting for more than 5 years leading to calls to speed up the asylum process, reduce the number of people granted refugee status and increase deportations (Bloch 2000). This, combined with hostility from the popular press, has created a situation of great uncertainty.

The government has made attempts to revise the system. In April 2000, the National Asylum Support System (NASS) was established. Housing and financial support for asylum seekers is now controlled by NASS who provide benefits at 30% below the level claimed by full British Citizens. As part of this, the dispersal system was introduced in an attempt to relieve the pressure from local authorities in the South East and London. Once an application has been made, asylum seekers are dispersed across the country on a no choice basis. Language and circumstances are supposed to be taken into consideration but in reality, this is not always the case. Asylum seekers can choose to remain in London but they will not receive any housing or any financial support, meaning they have to rely on family and friends.

Unaccompanied minors are also subject to the national dispersal strategy. They are cared for under the 1989 Children Act. However, because the UK is one of only three countries not to have signed the full UN Convention on the Rights of the Child, they are not given the same rights as British children. Local authority social services take responsibility for them rather than NASS. Over 70% of unaccompanied minors are aged between 16 and 17. They are usually cared for under section 17 of the 1989 Children Act, which means the local authority can use sub-contractors to provide care and does not have to provide care-leaving services at 18. Once they reach their 18th birthdays, their support is transferred to NASS and they are expected to live independently. If those reaching the age of majority have refugee status they are immediately expected to search for work. Younger children are cared for under section 20 of the act, which places more responsibility on the local authority and a responsibility to provide after care support. Age ambiguity is also an issue leading to young people often being treated as adults, which means they can be denied access to important services and support. Accompanied children are provided for by NASS. Children are classed as accompanied even if the person they arrived with is not a parent or guardian. Often the person may be a relative, friend or someone they travelled with. They are not vetted to see if they are willing or suitable carers (Refugee Council, 2003).

Appendix B

Over a three-week period a number of agencies and community organisations were contacted. Initially contact was made via email with DATs and other organisations whose details were available on the Addaction website. We asked these organisations whether they felt there was an issue in relation to young asylum seekers, refugees and drug misuse and if so how they were approaching this. However, no response was obtained from these initial contacts and so (approximately) ten organisations were contacted by telephone in a further attempt to gain information. Organisations were selected in areas where there are high concentrations of refugees and asylum seekers, but efforts were also made to contact organisations outside of London with smaller refugee and asylum seeker populations. Initial telephone contact was with DATs in the hope they could provide an overview of the situation in their area and provide contacts with organisations doing direct work with the communities we were interested in. However, it was almost exclusively the case that nobody was available to provide information. Despite leaving messages and repeating calls, only two eventually made contact and provided contact details for community organisations who were able, and willing, to supply us with information. These initial difficulties were taken as a mark of pressure on DATs and other drug service providers.

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