DRUGS SCOPING STUDY

Asylum seekers and refugee communities

REPORT

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A. **BACKGROUND & OBJECTIVES**

The Home Office commissioned Cragg Ross Dawson to conduct a scoping study to shed light on drug misuse amongst asylum seekers and refugee communities. Amongst the features of the issue that the study was intended to examine were the following:

- the incidence of drug abuse amongst asylum seekers and refugee communities
  - is it a problem?
  - how are different groups of asylum seekers and refugees affected?
  - what is the nature of the problem?
    - what drugs are involved?
    - does drug use predate arrival in the UK or develop here?

- what are the implications of the above for the provision of services?
  - drug services particularly
  - other services, for example housing and medical services

The study sought to give the Home Office an informed idea of what was known about drug misuse amongst asylum seekers and refugee communities, and also identify the difficulties in the way of gathering more precise data on the issue.
B. METHODOLOGY

This study consisted of a literature review and interviews with people who it was reasonable to assume were in a position to know about drug use, and drug services, amongst asylum seekers and refugees. The various sources consulted, the organisations contacted, and the people interviewed in the course of the study are listed as an appendix.

The methodology was exploratory rather than systematic. Researchers followed up leads as these appeared. Many people or organisations contacted suggested other people and organisations that they thought might be better informed about the issue. Sometimes these people were available to be consulted, often they were not. Although many of those contacted said that more research was needed—drugs and asylum seekers was a difficult and uncharted area—a large majority believed that there ‘must be’ other people better informed than they. They were rarely able to say who these people were.

Because of its limited scope, its methodology, and some inherent difficulties discussed in the course of the findings which follow, this study does not pretend to great authority. It is a snapshot of what a number of people thought about asylum seekers’ and refugees’ involvement in drugs at a certain period of time, Spring 2003. The people concerned were either involved with the provision of drugs services, or had some interest in (or responsibility for) the problems faced by refugees and asylum seekers. There may well be people better informed about the issue who we failed to identify, or with whom we were unable to make contact in the time available.
C. SUMMARY

1. Refugees and asylum seekers are not a homogeneous group and it is not sensible to generalise about the likelihood of their having been involved in drug taking or dealing before arrival in the UK.

2. Very little is known for certain about how many refugees and asylum seekers have drug dependency problems. There appear to be no reliable figures from drugs services. Refugees and asylum seekers very rarely access services, but this does not mean they are not in need of them; the reasons why BME groups are less likely than the white majority to access drug services apply yet more strongly to refugees and asylum seekers. Arrest figures from the police and treatment figures from the NHS do not reliably indicate immigration status.

3. This study cannot be authoritative. Such evidence as it has uncovered suggests that problematic drug use by refugees and asylum seekers is rare—at least as rare as amongst long term UK residents. Khat, though not illegal, may be regarded as a partial exception to this; it appears that significant numbers of Somalis, and some others, chew khat with a frequency that may be causing serious problems.

4. Small numbers of refugees from Central Africa are thought to have arrived in the UK with addictions in some way consequent on their involvement in warfare. There is concern that sex workers are being brought into the UK from Eastern Europe and South East Asia, and that drugs play some part in their exploitation by criminal gangs. Firm evidence on either of these groups is lacking but it seems to be assumed that numbers are small.

5. Some refugees and asylum seekers, notably from India and Pakistan, are believed to use prescribed drugs, mainly tranquillisers and anti-depressants, excessively. Explanations of why this should be sometimes conflict.

6. There is concern that some refugees and asylum seekers are at high risk of drifting into involvement with illegal drugs because more established
communities from the same countries of origin control drugs trafficking in some areas of the UK. Poverty and lack of opportunity are believed to make asylum seekers willing to run errands for drug dealers. Kurdish and Turkish people are especially mentioned in this context. On the other hand, it is also argued that the drugs trade is in the hands of second or third generation immigrants and newly arrived refugees have no useful role to play.

7. This point leads into a larger point about the vulnerability of refugees and asylum seekers to drug-taking once they are in the UK. It appears that many asylum seekers are housed in areas where there are a lot of problematic drug users, and even share accommodation with them. It may well be that the majority of refugees and asylum seekers is more likely to come across the example of illegal drug-taking, and have access to drugs, in the UK, than in their countries of origin. The danger of contamination from this proximity is increased by the fact that many refugees and asylum seekers are desperately poor, isolated, depressed and unable to improve their circumstances by employment or education.

8. Refugees and asylum seekers, notwithstanding their diversity, have a strong identity in the public mind. This identity clearly becomes significantly more negative if it is associated with drug taking. The views of some of those consulted for this study may reflect their feeling that refugees and asylum seekers need protection against negative stereotyping. Some informants were also critical of how asylum seekers are treated in general, believing that they suffer from a policy of trying to make the UK a less attractive destination for immigrants. The fact that many of those working with recent immigrants have strong convictions on these issues, combined with the absence of statistical evidence, makes it especially difficult to arrive at an objective view of drugs amongst refugees and asylum seekers.

9. In terms of what should be done, there is a widespread feeling that the vulnerability of refugees and asylum seekers to becoming involved with drugs would be diminished by better support services, in particular better housing and access to health care; “you can prevent stuff if you provide
support”. Khat use appears to be causing increasing concern and there is a growing feeling that something needs to be done—at the least, education for relevant professionals on the effects of khat.
D. **FINDINGS**

1. **How sensible is it to generalise about asylum seekers’ and refugees’ involvement with illegal drugs?**

Asylum seekers and refugees are not a homogeneous group. First, there are important differences between these two categories. Refugees—for our purposes, people who have applied for and been granted asylum in the UK—are not subject to restrictions on where they can live, what benefits they are eligible for, or what employment they can take up. Asylum seekers are subject to such restrictions and of course have to live with the tension that arises from not knowing how their status will be determined—will their application for asylum be granted, or their appeal against refusal allowed? Moreover, ‘asylum seekers’ vary significantly in their status and circumstances; not all those who regard themselves as asylum seekers have this status officially acknowledged.

“Once someone has been placed by the city council it means they have been accepted as being eligible for assistance under the Housing Act. So they are not the illegal asylum seekers that we’re dealing with. Although we have seen a few illegal asylum seekers who have come to us independently, that’s a very small number. Most of the asylum seekers we see are eligible and therefore have a legitimate reason to be here.”

**BUT THEY HAVE NOT BEEN GRANTED ASYLUM YET?**

“No. They’ve been granted leave to enter the country, so they’ve been through probably Gatwick... They’ve had probably two or three weeks in a detention centres and then they’ve been granted at least a leave to stay while their asylum claim is being looked at. They are mostly the people we get... Most of the people who come in are from fairly middle class backgrounds. A lot of the people we deal with are doctors or lawyers or solicitors—people from professional backgrounds who have got the money to get themselves out of their own country and onto a flight to this country. It is very rare that you get any of the real working class peasants because they wouldn’t be able to afford to get here unless they did it illegally. They’re the people who... pay illegal traffickers who provide transport and false papers. But we don’t see many of those.”

Housing Officer dealing with homeless and NASS supported asylum seekers

Second, overlaying the differences between asylum seekers and refugees are a host of other differences that reflect many different personalities, family situations, origins, histories, cultures, communities and
circumstances. On origins alone, the diversity of asylum seekers is hard to exaggerate. A survey carried out in Glasgow registered 40 different first languages in a sample of 738 young asylum seekers aged 5 to 18. Asylum seekers come to the UK from many different countries and for many different reasons.

The differences between asylum seekers and refugees are large in number and impact directly on their levels of exposure to illegal drugs, both in their countries of origin and also when they are in the UK. The nature of some of these differences and their implications are more fully described in the course of the report below, but it is worth summarising some key variables here. The likelihood of asylum seekers and refugees being involved in illegal drugs in the UK is affected, amongst other factors, by: individual attitudes and experiences; religious and cultural influences; the prevalence of drug taking in the country of origin; its prevalence in the localities where refugees and asylum seekers are housed; beliefs about what may jeopardise an asylum application or UK residence; the extent to which UK-resident communities of the same ethnic or national origin are involved in drug taking and dealing.

Because of these and other fundamental differences, people who are asylum seekers or refugees have very unequal propensities to be involved in drugs. It makes no more sense to generalise about these propensities than it would about those of the English, the Welsh and the Scots were it not for two important common denominators. First, the overwhelming majority of asylum seekers and refugees have no money and are highly disadvantaged in terms of educational and economic opportunity. As is well documented, drug abuse correlates with disadvantage and deprivation. Second, all asylum seekers and refugees are displaced and suffer (in varying degrees) from feeling they do not belong in the UK. All asylum seekers of course have the additional anxiety arising from not knowing if they will be allowed to stay. Feelings of insecurity and

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1 Starting Again... Young asylum seekers views on life in Glasgow. Save the Children and Greater Glasgow Council, Sept 2002
depression quite frequently result from these circumstances and, as is well documented, also correlate with high levels of drug abuse.

The many great differences between asylum seekers and refugees mean that it is not sensible to generalise about their propensity to be involved in drugs. But it is also true that asylum seekers and refugees (perhaps especially the former) do have a strong identity in the public mind. It is worth insisting on the diversity of asylum seekers because comment in the press about specific groups is often read (and may be intended to be read) as applicable to all asylum seekers. For example an article in *The Times*\(^2\), reports that lawyers working on asylum seekers’ appeals are disillusioned and cynical. We hear from ‘Sarah’, ‘Jill’, ‘James’, ‘Mark’, and ‘Peter’ (identified as human rights lawyers, immigration officers, immigration adjudicators, and barristers) all of whom are quoted as believing that asylum seekers abuse ‘the system’. “Only about one case in ten is genuine... Most are totally bogus with absolutely no merit... You can tell they are telling lies... They often only wanted money, they were concerned about what material goods they could get. They demand this amount of housing benefit, this amount of disability benefit. A genuine refugee would not be so interested in money, but safety.”

In the same article, ‘Sarah’ a human rights lawyer working with asylum seekers, is quoted as saying—"The majority just made up stories. They all said the same things, which anyone who knew about the region they came from would know could not be true. It’s revolting the sort of people we’re ending up with. The going rate to be smuggled is $10,000 (£6,250), but you have to be involved in drug smuggling or arms deals to get that money – they are part of the warlord families. The ones who are in most need are not the ones who can make it to the West – you’re getting the tough, the aggressive.”

Such articles, and the strength of the identity of asylum seekers in the public mind, discourage appreciation of the extraordinary diversity of

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\(^2\) *Next Stop Fascism*, 17 January 2003
asylum seekers and refugees. This diversity certainly extends to propensity to take drugs and defeats accurate generalisation.

2. **What is the evidence that drugs are a problem amongst asylum seekers and refugees?**

There appears to be very little real evidence on this question, although there is evidence of anxiety about it. Statistics on users of drugs services are not a reliable indication of how many refugees and asylum seekers get into problems with drugs: immigration status is often not recorded, and where recorded, may not be accurate. It is well documented that, for a number of reasons, black and ethnic minority drug users are less likely to access drug services than white users. Refugees and asylum seekers are yet less likely to access them: lack of awareness is more likely, and language is more often a barrier.

“It’s very difficult for them to seek help. There are many reasons for that. First of all, the language barrier. They can’t speak English, so they can’t use the mainstream services... And it’s a scary thing. If a drug user wants to use a service it is an individual choice and it can be scary. Many women don’t come and use services because they are so afraid to lose their children.”

Drug service provider and community worker, London

ASYLUM SEEKERS AND RELATIVELY RECENT REFUGEES ARE NOT SHOWING UP IN NEEDLE EXCHANGES?

“No. It has not been reported at all... But if we can’t get our own young, relatively educated white male opiate users to trust the treatment agencies because they think the information is going to get into the hands of the wrong people, how on earth are you going to engender a trust between on-white, non-routinely English speaking people who are used to being persecuted by the authorities?”

Drugs worker and educator

Police arrest data are unreliable for similar sorts of reasons; it is widely acknowledged that numbers of people arrested for drugs offences are not an accurate indication of numbers using or dealing in drugs. NHS data is often incomplete in relation to ethnicity and immigration status.

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3 See particularly *BMECIE: Literature review on drug use*
It is widely assumed, sensibly, that evidence of refugee and asylum seeker involvement with drugs is hard to find because both of these groups (especially the latter) would be powerfully motivated to conceal any such involvement.

Drug use rarely becomes evident at early assessments related to asylum application, partly because asylum seekers fear any disclosure will put paid to their hopes and partly because the people involved in doing the assessments, arranging housing, etc, are not drugs specialists.

Evidence that asylum seekers are dealing in drugs is of course yet more elusive.

IS IT YOUR VIEW THAT ANY OF THE KURDISH OR TURKISH REFUGEES OR ASYLUM SEEKERS YOU HAVE BEEN IN CONTACT WITH WERE FAMILIAR WITH THE DRUG BUSINESS?

“IT’s difficult to know if they are dealing. First of all, with asylum seekers and refugees, they don’t trust you, they don’t trust the system. It takes a long time for them to trust you and tell you if they’re dealing anything. It’s impossible for me to say that.”

Drug service provider and community worker, London

There being so little hard evidence, it is worth noting briefly the very limited personal contact the people consulted for this research had
themselves had with refugees or asylum seekers involved with drugs. A worker involved in housing refugees in Manchester said she could think of “two or three people over the past two years that have been asylum seekers and drug users”. A Housing Officer in Peterborough had personal knowledge of two asylum seekers who were addicted to heroin on arrival in the UK. A drug worker in Blackburn knew of two asylum seekers on drug programmes; they had accessed the service on their own initiative but it was not known if their problems predated their arrival in the UK. A health worker in Scotland had interviewed two heroin dependent asylum seekers from Rwanda whose addiction was attributed to drugs given them by their commanding officer in the course of warfare. No one else had direct personal knowledge of any asylum seekers or refugees with drug problems.

However some believed that involvement with drugs was a significant problem for some groups of asylum seekers and refugees. Initial results from a substantial research project conducted by community groups were said to indicate that some asylum seekers were using drugs prior to their arrival in the UK.

“[Initial reports from community group research] show some evidence of slightly increased drug use in the UK, but not a huge increase over what they’d been using before coming here. Because they were drug users in their own country. So there was some evidence to suggest that they might have access to a wider range of substances and also that their use might increase... But lots of them include alcohol within that, and it is not always easy to disentangle what they meant about it when they talked about drugs... But there is definitely some evidence that some refugees brought with them drug use from their own countries and arrived in this country already with drug habits, and cocaine was one of the drugs that came up.”

Researchers

People working in the Redbridge and Waltham Forest Drug Action Team noted a rapid increase in problem drug use in the area in recent years and also a large increase in numbers of asylum seekers. They strongly suspected there was a causal connection between the two: “it is very likely they (asylum seekers) are getting involved”. They cited reports from social worker colleagues that young Albanians and Kosovars were drug users.
Barking and Dagenham Drug Action Team had commissioned research recently on the precise issue of drug use by refugees and asylum seekers. The research had reported that there were “no apparent drug problems amongst refugees” but members of the DAT reacted with scepticism to this finding: “the same people did research and concluded that there was no prostitution, and when we told them that at the local community centre they just laughed in our faces”.

The Peterborough Housing Officer quoted earlier believed that some asylum seekers from East Africa, notably Somalia, “arrive with drug dependency problems because where they come from it is more accepted”. He was referring to khat, and there is a measure of agreement that large numbers of immigrants from Somalia and adjacent countries are in the habit of chewing khat, probably including some refugees and asylum seekers. Khat is not, of course, illegal. Issues surrounding its use are discussed below, in section 4.1.

A drugs worker in Ealing believed that asylum seekers and refugees in the borough were becoming involved in drug dealing as well as use. “Without trying to sound too harsh, you do get the impression that they’re often running it... Our impression is that there are a lot of newly arrived immigrants (mainly from Eastern Europe, especially Kosovo) dealing in a very professional way in Ealing.”

A worker with Refugee Action in Manchester noted that some refugees were very familiar with the street names for drugs in the UK, which she suspected meant that they were probably using them. She had also heard complaints about drug dealing and prostitution in accommodation where refugees were being housed in London.

In addition to these various opinions and impressions, some of the resources devoted to refugees and asylum seekers state or imply that drugs are a problem amongst them. For example the Health and Asylum Seekers and Refugees Portal (HARP) website says that “reports from health professionals suggest that drug use is one of the most prominent health problems among asylum seekers and refugees”. However the site
goes on to note that “there is a lack of information on the extent and nature of the use of illegal and legal drugs in this target group”.

On the other hand, most of the people consulted for the research did not believe that drugs were a significant problem amongst refugees and asylum seekers. They said that drug abuse amongst recent arrivals in the UK was rare, at a lower level than drug use amongst the ambient population in the areas where refugees and asylum seekers were housed.

“I would say generally the asylum seekers tend not to be drug users. Of course there are always two or three exceptions... There is a massive drug problem in Manchester but not very much among the asylum seekers.”

Housing Officer dealing with homeless and NASS supported asylum seekers

“The evidence so far is not showing any greater use of drugs, of any kind, than there is in the generic population. You will always get the odd one or two who are hooked on something before they arrive, and the usual problems of them accessing these when they come, through whatever means. But it is certainly no greater than our generic population... No drug service providers are coming to me and saying that there’s a major problem.”

Health Co-ordinator for asylum seekers and refugees, Scotland

“I’m sure it happens, but we’ve not had any evidence of it. I’ve just come across the odd client who may have had an addiction but it is not widespread.”

Refugee worker, Manchester

“I haven’t noticed any drug problems on the surface of any of the relationships I’ve built up with the young asylum seekers I’ve worked with.”

Refugee worker, Liverpool

“I have quite a long experience with asylum seekers and refugees... In my experience... a very small number of them come to the UK with an addiction. I worked with hundreds and hundreds of asylum seekers and refugees... Turkish refugees and asylum seekers, Kurdish, Somali, Congolese, Zimbabweans... “

Drug service provider and community worker, London

Several respondents thought that drugs were a media and political distraction from more pressing issues and problems facing refugees. They did not believe there was any evidence to support the allegations that significant numbers of refugees were involved with drugs on arrival in this country, although they often had concerns about exposure to drugs once they were here (see also section 3, below).
“We’ve got no, none, absolutely no evidence that problem drug users come into this country seeking asylum. None at all.”
AND DO YOU THINK YOU WOULD KNOW?
“Yes... Look at what the refugee community organisations are saying, in terms of where they need help and support. Their concerns are not about the treatment need... It’s not existing drugs problems with recently arrived asylum seekers they’re talking about. It’s much more about... exposure to drug availability in this country... Of course there is going to be an unwillingness across the refugee community organisations to talk about the levels of drug use within those communities because it will just add to discrimination and stereotyping.”
Drugs policy advisor

“It doesn’t strike me as the most pressing issue in relation to asylum seekers, not in Scotland.”
Development worker with young refugees, Glasgow

It was often argued that, so far from being problematic drug users, the overwhelming majority of refugees and asylum seekers were powerfully motivated to make the most of the opportunities the UK afforded them.

“These kids were determined to succeed and wanted to get qualifications, wanted to learn good English and wanted to settle in this country and make a go of it.”
Researcher 2

“The majority of people who come into the UK are determined that this is a big opportunity to break with whatever bad stuff has gone before, and to make a new life and get education... They don’t engage in any illicit activities and are working very hard to make sure they keep their noses clean... But in every large population that comes over here a proportion will take the path of least resistance, will find things are too difficult and this (drug dealing) is the way to get the things that they need.”
Drugs worker and educator

In this context it is worth noting that doctors and nurses are being recruited in the North East (and possibly elsewhere) from amongst refugees and asylum seekers. The Newcastle Evening Chronicle reported that 65 doctors and 25 nurses were being evaluated for employment.

3. Exposure of asylum seekers and refugees to drugs once in the UK

The majority of people contacted for the research felt that, if there was a ‘drugs problem’ in relation to refugees and asylum seekers, it was a

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problem they faced, not a problem they generated. Many refugees and asylum seekers were said to be appalled by the drug taking they observed going on around them.

“Stuff that I saw from the Department of Health needs assessment was suggesting that asylum seekers and refugees, when they come into this country, are appalled by the levels of drug use in this country, and the accessibility of drugs, in London particularly.”

Drugs policy advisor

*Starting Again, young asylum-seekers views on life in Glasgow* lists alcohol and drug abuse among what young asylum seekers regarded as the worst things about living in the city.

It is very widely believed that refugees and asylum seekers are vulnerable to begin taking drugs once they were in the UK. As one drugs worker noted: “the evidence suggests asylum seekers' mental and physical health deteriorates while they are over here”. Moreover, refugees and asylum seekers are often housed in the same accommodation as homeless drug users, or in areas where drug abuse is a conspicuous problem amongst the indigenous population.

“I don’t think primarily people are coming over here with drug habits. I think the bigger risk is that you end up with a lot of people being resettled into areas of urban poverty where substances are widely available.”

Drugs worker and educator

“If we look at the lives of young asylum seekers, to what extent is their interaction with living here... to what extent does this expose them to risk? For example, one of the boroughs in London has a policy of housing young refugees and asylum seekers in bed and breakfast in Kings Cross, but that obviously has risk factors. Young people with no money, in Kings Cross. They’re obviously at risk of drug use and prostitution.”

Researchers
“Among the other homeless population... the number of drug users is about 50%... We have maybe 600 registered with us, and of those about 300 are drug users. But a very small number of the drug users are also asylum seekers... A high proportion of the local homeless people are drug users and are actively involved in distribution of drug supplies. So in the hostels the asylum seekers are going to be exposed to people that are using drugs and dealing in drugs. So sooner or later I think there is going to be an increase in the number of asylum seekers that use drugs...We get a lot of asylum seekers coming in and complaining because they are sharing a room with a drug user or a drinker. They find that very difficult because it’s a kind of different culture and they come in begging to be moved out of the bed and breakfast into somewhere they’ve got a self contained flat unit, which is at the hostel. But there’s not always enough space in the hostel.”

Housing Officer dealing with homeless and NASS supported asylum seekers

The fact that refugees and asylum seekers are housed together with drug users reflected the scarcity of available accommodation. Those responsible have no other option, although they are clear about the vulnerability of asylum seekers to becoming involved in both using and dealing drugs.

“There is a massive problem in Manchester at the minute with finding temporary accommodation for anybody... It would be nice if they could put all the asylum seekers in one place and all the other homeless people in the other place, but there isn’t that luxury. As soon as a bed becomes available, they’ve got ten people sleeping on the floor at Direct Access and whoever has been sleeping there the longest gets the bed... I think it is only a matter of time before it starts to filter down. Because if you are living for six months in a hostel, which is also housing 20 or 30 drug users, and if you’ve got no access to money because most asylum seekers are not entitled to claim benefit, then it is very tempting to get drawn into that kind of underground world where if you pass a couple of packets around you can get £30 or £40 in order to buy food or whatever.”

Housing Officer dealing with homeless and NASS supported asylum seekers

The temptation to become involved in dealing drugs is perhaps especially acute for some asylum seekers because they rarely had any financial resources at all. Desperation to earn money was liable to be intensified for some men by cultural factors.
“Where you have got mother, sisters, and eldest brother/son there and no father—which is going to be quite a common model a lot of the time—that puts the onus on bringing some sort of income very heavily onto the shoulders of the son. It is going to be socially unacceptable to see mother having to beg or trying to bring up the family and you failing to meet that need... Now if I was a young man and found out or got told that I could make a bit of money by getting a phone and a bike and delivering a few packages for this bloke, that is a very powerful incentive... It is socially imperative that I do that, because it is my cultural norm for me to bring in some money.”

Drugs worker and educator

Refugees and asylum seekers usually suffer exactly the deprivation and lack of opportunity that is typical of many white problematic drug users. If their circumstances—personal, financial, educational, accommodation—are described without any reference to their being refugees or asylum seekers, they fit the template of people vulnerable to developing drug problems.

“We know what increases the likelihood of problematic drug use—lack of stable housing, lack of education opportunities, lack of employment and living in an area of high drug usage... Any mental stresses that are also there go to increase risks as well... As well as living cheek by jowl with it, you are also talking about a highly vulnerable group, not just because they are in the environment but because there is colossal amounts of time to fill. So all the risk factors are there.”

Drugs worker and educator

Refugees and asylum seekers are often yet more vulnerable because they suffer discrimination, are displaced from any supportive community and are often not fluent in English.

“The existing system and the treatment of refugees and asylum seekers in this country and the levels of discrimination that they face in this country make them more vulnerable to developing drug problems and other problems... Not that refugees or asylum seekers are more likely to be criminals because of their origins... but because their experience through the asylum system is so negative, and their ability to access public services, ability to have access to resources and employment and training... The system increases the vulnerability and increases the risk to people from within these communities developing drug and alcohol problems.”

Drugs policy advisor
“He [an asylum seeker from the Balkans] was involved with drugs before he came here, but he never used. His father was a dealer and he never used drugs. But after he came here he started using drugs, not heavily but he is using [cocaïne]. I asked him why did he start using them now and he said the reason he was using drugs was the isolation. He doesn’t have friends or anyone and that’s why he’s using drugs. Many of the refugees and asylum seekers who are not dealing, they use drugs because of isolation—the lack of network, lack of support that they used to have in their own country.”

**IS THIS A VERY ISOLATED EXAMPLE?**

“It’s not an isolated example. There are quite a number of examples to match that. For example we had one Kurdish client who never used to use anything but now he’s an alcoholic.”

Drug service provider and community worker, London

It is also argued that the regime governing asylum—a regime often thought of as designed to deter applications by making the lives of asylum seekers difficult—increases the vulnerability of asylum seekers by making it more likely that they will be destitute. The policy of dispersal, for example, is sometimes said to make it more likely that a proportion of asylum seekers will end up homeless and without support.

“Regardless of the government’s attempts to disperse asylum seekers, we’ve seen asylum seekers coming back to London and being very much at risk of destitution through coming back... They come back because this is where their contacts and communities are.”

Drugs policy advisor

Recent amendments to the regulations governing asylum applications\(^5\) are quite often criticised because they are considered likely to increase the proportion of asylum seekers who become destitute, and also because they are seen as likely to reduce the transparency of numbers seeking asylum. It is argued that making it difficult for people to get to the UK drives them to use a criminal route and this of itself increases the likelihood of their being involved in criminal behaviour once here.

\(^5\) These went into effect 8 Jan 2003. Asylum seekers who do not immediately apply for asylum with the immigration authorities at a port once they have arrived in the UK, will not be eligible to apply for support to the National Asylum Support Service (NASS).
“You are forcing people to come from illegal routes and then you lose them... Now we have 100s of people coming to us, some we help, some we can't. They want to claim asylum because they come in the back of a lorry or the boot of a car. But I can't help them because the rules say that you have to apply on the first day you arrive. But you are not preventing immigration, you are creating a new lot that you lose in the wilderness of Manchester or Liverpool... I don't think it will reduce immigration, it just makes it more invisible.”
Community worker amongst Turks and Kurds

There are countervailing influences that, it is sometimes argued, reduce the vulnerability of refugees and asylum seekers to becoming involved with drugs. First, as already noted, it is widely believed that asylum seekers are very unlikely to become involved in any criminal activity because they are so focussed on their asylum applications and believe the slightest hint of drug use would destroy their chances of being granted asylum.

Second, religious and cultural constraints are widely regarded as important. Islam’s prohibition on any drugs that affect mental acuity is often mentioned as a reason why the large majority of refugees and asylum seekers from Muslim countries would not take drugs. Taboos against drug taking are said to be important in Turkish and Kurdish society also.

“Using drugs is a taboo in the Kurdish and Turkish society... Forbidden. You will be expelled from the community, you cannot do a proper marriage. If you want to get married and the girl’s family find out that you are a drug user they will not agree to your marriage. It doesn’t mean that they are not using it but because it is a taboo it is secret.”
Community worker amongst Turks and Kurds

It is highly probable that religious and cultural influences do contribute effectively to the majority of refugees and asylum seekers’ resistance to drugs. But, even amongst the white population, it is only a small minority which takes drugs in a way that seriously disrupts lives. Clearly there are individual refugees and asylum seekers who are prepared to break
religious and cultural taboos. It is argued that the Home Office and others have long had an exaggerated belief in the effectiveness of religious teaching in restraining involvement with drugs and this has blinded them to Muslim penetration of illegal drug markets, especially in the North of England. Muslim women, for long widely regarded as most unlikely to have anything to do with drugs because of religious and cultural taboos, have begun to be significantly involved and no appropriate drug services have been developed for them. It appears that the familiar social factors which correlate with high levels of drug abuse—financial hardship, lack of opportunity, depression, etc—are capable of overwhelming religious prohibition. Religion enjoins secrecy more reliably than abstention.

“The south Asian and Muslim community... Everyone has always said—these people would never do it. Muslims, prohibition, strong family values. Yet when you look at it from a common sense point of view, there is everything potentially there for a young person to get involved with this—poor education, high unemployment, discrimination, inner city area, etc.

Researchers

In summary, belief that refugees and asylum seekers are potential victims—vulnerable to being introduced to drugs—generally appears more robust and is more passionately expressed amongst the people consulted for this study than belief that refugees and asylum seekers are a dynamic or malign influence—aggravating drug problem in the UK by importing dependence or becoming dealers.

4. **Different types of vulnerability to drug use among refugees and asylum seekers**

As already noted, refugees and asylum seekers are not an homogeneous group and propensity to become involved with drugs depends on many factors. However, the attention of those concerned with this issue tends to focus on four principal areas of concern. In no particular order, these are: khat use by refugees and asylum seekers from Somalia and other East African countries; unhealthy dependence on prescription drugs, particularly by women from Asia; addictions resulting from coerced use of drugs, either in warfare or as a means of forcing women into prostitution;
and the particular vulnerability of some national/ethnic groups, notably from Eastern Europe and Turkey, of being recruited by drug dealers.

4.1 **Khat (Qat)**

Khat is a shrub that grows in eastern and southern regions of Africa and is grown extensively as a cash crop in Ethiopia, Yemen and the northern provinces of Kenya. Fresh leaves from the shrub are chewed, and can also be infused as a tea, made into a paste with honey, or smoked in combination with tobacco. Khat is a stimulant and makes people feel more energetic and alert.

> "Khat is somewhere above coffee and below speed, and it is the same sort of pattern as cocoa chewing in South America."
> Drugs worker and educator

Khat is said also to enhance concentration and reduce hunger and fatigue. Using khat is not illegal in the UK. It is widely used in Somalia, Yemen, Eritrea and Ethiopia. There appears to be agreement that many refugees and asylum seekers from these countries continue to use in the UK.

Not everyone is convinced that khat use is problematic. The argument here hinges on whether there are social benefits, and some think that khat use may help people who are culturally disoriented to retain some sense of ethnic or national identity. Nobody seems confident that use is benign, only that there is perhaps a case to be made. “The question of whether or not the social importance of khat remains when people migrate to the West has not yet been addressed in earnest... For the participants in khat sessions, it is a way of redefining their identity and reinforcing their self-esteem as migrants in an alien society. At the same time, the khat session is an important source of news from home.”

Most sources, however, think that khat use by refugees and asylum seekers in the UK is regrettable.

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6 Angelique Beekhuis, Cultural Anthropologist, Waterhoenhof 12, 5672 VH Nuenen, The Netherlands (accessed via the Internet, reference mislaid)
“Khat is not a big problem such as heroin or cocaine, but it causes cancer in the mouth, it affects the gums, and it does cause heart problems.”
Drug service provider and community worker, London

The Somaliland Forum maintains that “this drug is eating at the fabric of society at every level. It is an economic drain as well as a social ill that has a devastating effect on the nucleus of the society—the family.” The website goes on to lists many ills including impotence and increased susceptibility to infectious disease.

Use of the drug is said to become problematic in the UK primarily because patterns of use change under the pressure of changed circumstances.

“It was a pleasant way for them, particularly men, to get together and pass the time. But it was not problematic. In this country what's happened is because men aren't employed, or have far too much time on their hands... you get a big escalation in the level of use and that has a huge impact on family relations and family welfare.”
Drugs policy advisor

“When you have got substances being used by older men in community settings, infrequently, as a social thing, it doesn’t present any problems... In supported housing for young people, where you get one or two young people... chewing khat outside social settings, they are getting all the negative mental health sides of it, the paranoia, anxiety, sleeplessness and weight loss, but they are not getting any of the social interaction and benefits with it.”
Drugs worker and educator

The Guardian published an uncompromising article on khat use. “18 (Somali) women (living in London) unburdened themselves of woes... Their marriages, incomes and family life were being gnawed away by a drug that had gripped their husbands so tightly they seemed lost forever... In Britain... khat has acquired a problematic use linked more to social exclusion than recreation... It is being chewed day in, day out, from late afternoon through the night in derelict houses, or single squalid rooms, by men who have no jobs and no other friends... Unemployment among Somali men is estimated to be as high as 80%.”

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7 The Guardian, 4 September 2002
Much of the evidence on khat in Community Engagement⁸ is equally negative about the effects of its use on UK immigrants. Specific health concerns mentioned included: sleeplessness, malnourished children; mouth problems; paranoia and hallucinations; loss of appetite; diarrhoea; stomach aches; high blood pressure and constipation. The Yemeni Community Association in Sandwell is quoted and reports heavy levels of use. “Majority 75.9% of respondents stated that they use Qat for between 4-6 hours every time, while just fewer than 18.5% stated usage of over six hours. Add this to the effect caused by Qat such as tiredness and sleeplessness and then collectively you have a fairly disruptive form of living, largely dominated by chewing sessions and subsequent after effects.”

Community Engagement quotes Somali Health & Mental Health Link, London, as reporting that whereas “traditionally khat has been a feature of Somali social occasions, at Weddings, Funerals, Parties, and Religious ceremonies... male and female solitary use is consistent with the perception of an increase in ‘problematic’ usage of khat by the community.” The same report notes increasing khat use by women, especially solitary use, described as “partly a result of the extra stigma they face. Other factors reported include, higher rates of employment and child care responsibilities, all of which are thought to limit the scope for more social and peer oriented use.”

One drugs specialist contacted for the research expressed concern that khat use and its symptoms were not well enough understood by drugs and social workers. In his view the effects of khat needed to be more widely known.

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“If I am a worker and I have got a client presenting with signs of anxiety, depression, weight loss, sleeplessness and presenting with feelings of persecution and I am working with an asylum seeker from Somalia, what do you put that down to?... The whole diagnosis would meet the criteria for assessing post-traumatic stress disorder. Symptoms of heavy khat use would match that identically... They are going to end up with a mental health diagnosis and potentially get medicated for that, rather than having a substance misuse diagnosis.”

Drugs worker and educator

4.2 Prescribed drugs

As already noted, it seems to be quite widely believed that some refugees and asylum seekers, predominantly Asian women, are vulnerable to becoming dependent on prescribed drugs. It is not, however, clear what evidence there is for this. Refugee Action Manchester report having heard of concerns about amounts of anti-depressants prescribed for asylum seekers in the Manchester area. One informant in Scotland said she knew of an asylum seeker who had registered with two doctors to double up on prescriptions, but she did not know what drugs were involved.

“I have had one case where prescribed drugs were being abused... An asylum seeker who used his own name to register with a GP and his flat mate’s name to register with someone else, and was getting prescribed drugs from both those GPs. But we caught onto that very quickly and got it stopped.”

Health Co-ordinator for asylum seekers and refugees, Scotland

Opinions seem to differ on whether dependence on prescribed drugs results from people demanding drugs from their doctors, or from doctors urging drugs on their patients. Perhaps this distinction is not worth making. There is a belief that drugs are more freely available, and not just tranquillisers, in some countries, and that therefore refugees and asylum seekers become used to self-medicating with drugs that are only available on prescription when they come to the UK.
“In a number of different countries prescribing regimes—the substances that are available—are very different. So for example, looking at a lot of India and Pakistan, the availability of opium... as over the counter medicines... is very high... You can buy valium over the counter... So there are a lot of people with a mismatch of what they were able to access relatively easily and legally at home and what they are not allowed to access legally and easily in the UK.”

Drugs worker and educator

There is another (not necessarily related) belief that doctors in foreign countries, notably India and Pakistan, prescribe much more freely than do doctors in the UK. Hence refugees and asylum seekers may arrive with a regime of drugs—tranquillisers or anti-depressants are usually specified—that they have difficulty persuading UK doctors to maintain. A Rochdale drugs worker said she knew of Asian women asylum seekers who complained that their prescribed anti-depressants are steadily reduced by UK doctors. Another element in this picture is that refugees and asylum seekers are liable to become depressed in the UK because of their isolation, lack of control over their circumstances, etc, and therefore feel they need anti-depressants.

“Asian women—there is a long history of Asian women being prescribed tranquillisers. South Asian women particularly... Some of these people get depressed very quickly. Even if you come from a war torn country, at least you’ve got your friends round you, warm weather. You come here and it rains every day, you can’t speak the language, you can’t get the food you normally eat. So—I want some tranquillisers to help me sleep.’”

Researchers

It is also argued that some UK doctors are culpable in that they prescribe more freely to refugees and asylum seekers than they would to others, though why they would do this is not clear.
“It seems that GPs in London... are so keen to prescribe tranquillisers, especially to refugees and asylum seekers, and within that group, especially to female patients. Many female refugees and asylum seekers are addicted to tranquillisers... I just talked to a Turkish woman who has been here for a number of years but her daughter is back in Turkey. So she is separated from her daughter and is quite depressed. She was telling me that any time she goes to see her GP, her GP insists that she has to use anti-depressants... I have heard hundreds of stories that if you go to your GP and especially if you are female and from a minority group, you can easily get a prescription for anti-depressants.”

Drug service provider and community worker, London

4.3 Drugs histories related to warfare, injury or prostitution

Several sources refer to Congolese and Rwandan asylum seekers who have been involved as combatants in wars and have allegedly taken drugs in the course of this. Heroin is mentioned, and other drugs are perhaps implied. These men are said to have been given drugs to help cope with injury, or, under coercion, to blunt their sensibilities and make them more willing to carry out atrocities.

“They explained (two asylum seekers from Rwanda) that they were suffering from withdrawal symptoms from heroin. They knew that that was their problem because they had had already experienced it, though until they left Rwanda they had been able to get it... I was actually stunned... I thought, as a health worker, I thought maybe they had malaria. If they hadn’t told me it was heroin I would have referred them to King’s hospital... They had been given heroin by their commanding officer. The only way they could do some of the things they were asked to do was if they were under the influence of drugs.”

Health worker with refugees

“There is quite a complicated story to disentangle from the Congolese Republic... Drugs being used within armies. Young people who were basically child soldiers, and drug use seemed to be part of the way in which they were controlled within the army. Then arriving here and bringing drug habits with them... Sierra Leone too. People were tortured and had opium dripped into their wounds daily. So they came with that kind of addiction. Opium was a big issue as well.”

Researchers

Other than the health worker quoted above, none of the other people contacted for the research referred to having had any personal contact with asylum seekers with addictions originating as described.
Several sources also referred to young women from Eastern Europe and South East Asia, recently arrived in the UK, who were said to have been given heroin in connection with prostitution. The hypothesis seemed to be that criminal gangs smuggled young women into the country, or enticed them to come with false promises of employment or marriage, and then put them to work as prostitutes. Heroin was allegedly supplied to them to create a dependency and make them more amenable to being sex workers. That this has happened, and perhaps continues to happen, is widely believed, but firm evidence is elusive. Articles in the press which refer to drugs, asylum seekers and prostitution in the same paragraph are not uncommon. For example, the *Ham&High* in North London on 11 March 2003—"Brothel raids reveal underbelly of London’s illegal sex trade"—quoted a spokeswoman for the English Collective of Prostitutes as saying that “a growing number of illegal immigrants were being forced into the sex trade by the UK’s punitive asylum system. ‘It is probably that these women have been driven from their own countries by poverty, crime or persecution’.” The same article quotes the government’s National Criminal Intelligence Service (NCIS) as estimating that, in 2002, “half of all the prostitutes working ‘off street’ in London were from the Balkans or the former Soviet Union – with large numbers coming from South East Asia”.

The extent and the nature of the links between problematic drug use and prostitution seems not to be known. Women identified as sex workers are often described as recent arrivals in the UK but we do not know whether they are accurately described as refugees or asylum seekers.

4.4 **Vulnerability of some national/ethnic groups, notably from Eastern Europe and Turkey, to being recruited by drug dealers**

The hypothesis here runs approximately as follows. Dealing in heroin and crack is often in the hands of certain ethnic or national groups; in London, for example, Kurdish and Turkish people are believed to control the illegal drug trade in some areas of North London. “A significant amount of the heroin eventually imported into the UK is handled at some point by UK-based Turkish criminal groups. These groups see their own communities
as providing a natural base of operations... Most groups seem to be able to recruit low-level and expendable runners and couriers to move heroin." \(^9\)

Refugees and asylum seekers, in so far as they are able, gravitate towards existing communities of their compatriots, whose language they speak and whose culture they share. Refugees and asylum seekers are very liable to be impoverished and, being without employment, to have a lot of time on their hands. If they spend time in the company of people who are involved in the drugs trade they are vulnerable to becoming involved themselves; drug dealers need people who speak their language, and whom they trust, to run errands for them, including of course delivering drugs. It is thought that some refugees and asylum seekers may run errands for drug dealers without being aware that what they are doing has anything to do with drugs, or is illegal.

“Where there is involvement of refugees and asylum seekers it is very limited and it is determined by strong family and community ties.”
Drugs policy advisor

“It is no secret either to the police or the local community that the majority of cafés (in East and North London) do not make their money out of simply having fifteen gentlemen in drinking tea and playing pool. There is an amount of supply that goes on out of those premises. If I am going to drift into those arenas I am going to encounter drugs.”
Drugs worker and educator

“It may be that when they come here as a new immigrant, they might have a family member or a friend, or they might mix with somebody who is in a gang. Then they could be recruited very easily. A single person has nowhere to stay, he will be in a hall in Manchester or Liverpool because of the dispersal policy, so he is very vulnerable... He will be vulnerable to being recruited because of no housing, no work, then all this pressure on his head waiting for the Home Office to decide about him.”
Community worker amongst Turks and Kurds

It is widely believed that individuals of Kurdish, Turkish, Albanian and perhaps Kosovan origin do get involved in criminal activity, including drug dealing, directed by gangs controlled by people from these ethnic/national groups. What is not clear is that the people being useful to ‘drug barons’ are recent refugees or asylum seekers. People working with these

\(^9\) National Crime Intelligence Service website
communities acknowledge that there is a strong gang culture within them, but they also argue that it is second or third generation immigrants, rather than newly arrived refugees or asylum seekers, who drift into working for gangs dealing drugs.

“There are lots of people being used as runners. I’ve certainly not heard that it is specifically around asylum seekers. Much more young people in general. People under the age of 16 being used as runners.... They of course are attracted to it because they can make large amounts of money in a short space of time, and if you’re a child you know you are less likely to be prosecuted.”

Drugs policy advisor

“I don’t think we should be putting the blame (for drug related violence in North London) on refugees and asylum seekers. It was their parents who were refugees and these people had their education here and formed the gangs here... Maybe one or two of them are refugees but I don’t believe the majority of them are asylum seekers here. People don’t just come here and start dealing drugs. It is impossible to do that. You need to know the country, to know the law, to know your surrounding environment.”

Drug service provider and community worker, London

Part of the argument here is that asylum seekers, in particular, are highly motivated to avoid any criminal activity of any sort; they would not get involved with drugs because they would not want to jeopardise their asylum application.

“Our experience shows it is the second generation... It is those that we are losing (to crime and drug dealing), not the newcomers, because the newcomers have had a lot of problems to prove to the state that they are good citizens, to get the status.... I have never seen a newcomer being involved in crime or drugs. It’s the other generation, the young generation born here, or who came as very small children and are now 16 or 17. This is the problem.”

Community worker amongst Turks and Kurds

It is perhaps worth noting that the criminal activities of second or third generation immigrants from these communities (activities which are said to put asylum seekers at risk) are attributed to poor educational performance (often due to poor English language skills), lack of opportunity, and discrimination.
“We have nearly 3000 young men from 17 to 25 in prisons. That’s Turks, Turkish Cypriots and Kurds... You look at Kurdish or Turkish immigrants and you see problems. The problems are—long hours of the parents working and not supporting their children. Because they are not getting any support they are failing in schools.

WHY ARE THEY WORKING SUCH LONG HOURS?

“Because of their language problem they are not in mainstream employment. They have created their employment opportunities by opening restaurants, they have dressmaking factories, etc. You go to the restaurant at maybe eight in the morning for preparation and come home maybe at eleven at night. Sometimes they never even come home. It is left mainly to the women to deal with the children and the women have no opportunity to learn English because she is at home continuously. So she can’t help the child. So the expectation in education is very low. Success is very low. So most of the young men—and recently we found out, young women as well—are involved in gangs. The gangs start in the school as a very innocent protection racket, protecting themselves from the black or white harassment.”

Community worker amongst Turks and Kurds

Violence in Haringey in November 2002, widely attributed to turf wars between Kurdish and Turkish drug gangs, was said to have resulted from mafia-type gangs attempting to develop protection rackets out of Kurdish PKK or KADEK10 fund raising efforts.

“They collect maybe once a year. They collect money for this struggle (PKK)... They go to the restaurants etc and say—‘can you pay some money for this organisation? But it’s not force. It’s a voluntary contribution. But if you don’t do it, because most of your people who are part of this struggle come from the same village or the same town, so if you don’t do it you will be ostracised. Therefore you feel—‘yes, I will contribute £1000 or £5000’ depending how big your business is. So the mafia has seen this route and this is why they went into protection money. So on the one hand you have a group of people collecting money for a good cause, the PKK, and on the other hand you have another power collecting money for the mafia and drugs, etc. Both of these two elements are targeting the refugees, their own people.”

Community worker amongst Turks and Kurds

How much truth there is in these assertions is impossible to know. It seems probable that some refugees and asylum seekers, for example Turkish and Kurdish people in London, find themselves in contact with

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10 PKK (Partiye Karkaran-e Kurdistan) renounced arm struggle in April 2002 and became KADEK (Kurdistan Freedom and Democracy Congress)
criminal gangs dealing in drugs without having actively sought out any such contacts.

(It is perhaps just worth adding parenthetically that Turkish and Kurdish groups are frustrated by what they see as the failure of the police to interfere successfully against the various criminal gangs. In relation to the Harringey violence, for example, they claim to have given comprehensive information to the police about the perpetrators, but “nothing happened”.

“In our opinion, and we might be wrong but it is the view of the whole Kurdish struggle, that despite all the information we have given to the police, the police want to divide and rule. Or—’let them fight each other’—that is the culture of the police... There are so many incidents happening and you don’t see the arrests, or the prosecution. So then (Turkish and Kurdish people) say—’OK in that case we are not going to collaborate with the police, it is a waste of time... For example, in the last incident (Harringay gang warfare) the organisation worked very hard to identify all the people involved with it—their names and addresses, car registrations. The list has been handed to the police. What happened? Nothing. So we think—’What the hell, I put my life at risk, my family’s life, collecting all this information, and nothing happened.”

Community worker amongst Turks and Kurds)

4.5 **Other reports of drug abuse amongst refugees and asylum seekers**

One informant believed that some young refugees and asylum seekers from Eastern Europe had been involved in volatile substance abuse before arriving in the UK and were importing this problem.

“In Eastern Europe—especially places like Slovakia and Rumania, volatile substance abuse has been endemic amongst areas of very high unemployment... Petrol sniffing has been a huge issue in Eastern Europe for a very long time... We started to get people working in the field around the Hastings area who were reporting that they were starting to see levels of young people, especially young men, among the seafront, sniffing... They hadn’t come to the UK and started sniffing petrol, it was something that had been going on around them and that they continued doing.”

Drugs worker and educator

This same informant also said there was evidence that some recent immigrants from Iran, Afganistan and Pakistan extracted opium from poppies growing wild in the UK, especially in London, on railway
embankments. These refugees came from countries where opium was cultivated, knew the necessary techniques, had never become accustomed to well developed medical services, which they had, in any case, difficulty accessing in the UK. He found it highly credible that such people, with little money and a poor command of English, would be interested in opium as a means of combating feelings of isolation or depression, or of helping their children to sleep.

The *Black and Minority Ethnic Communities in England: Literature review on drug use* cites a report that Iranian asylum seekers who were using opium in Iran have switched to heroin in the UK. They also report that “heroin use amongst Vietnamese people has been found to have begun in refugee camps in Hong Kong and is continuing amongst those now living in the UK”.

5. **What is to be done?**

The evidence collected, such as it is, does not make a clear case that drugs are a significant problem among refugees and asylum seekers, except perhaps in the case of khat among Somalis and others. In relation to khat there is a perceived need to make training or educational materials available to social workers and primary health care providers to improve understanding of khat use and its effects. The ready availability of khat in East London is regarded as surprising and regrettable by some.

However, the problem with khat is generally seen as a consequence of a deterioration in health and morale amongst many refugees and asylum seekers once they are in the UK. The problem is seen to derive as much from deprivation and lack of opportunity as from khat itself.

This is the case with drugs amongst asylum seekers and refugees in general. There is a measure of agreement that many are vulnerable to becoming involved with drugs and there is a substantial depth of explanation underlying this belief: refugees and asylum seekers may be traumatised by earlier experiences; they often have very little control over their immediate circumstances and many suffer from demoralisation and
depression; a variety of barriers and disadvantages make it difficult for them to benefit from employment and educational opportunities; they are often housed in close proximity to dependent drug users and in areas where drugs are easily available; they are often poor speakers of English and have difficulty accessing services; they feel displaced and, in the case of asylum seekers, their future is highly uncertain.

In this context many of those who are concerned about this issue argue for efforts (and possible changes in legislation) aimed at improving the circumstances in which refugees and asylum seekers live, and the services available to them. However, it is believed that such efforts are unlikely because the government is perceived as attempting to discourage immigration, and applications for asylum, by making entry difficult and life in the UK less congenial for would-be immigrants. Improving the lot of refugees and asylum seekers is seen as conflicting with the government’s objective of making the UK a less attractive destination, and hoping word about how unattractive it is will deter others.

“My intuitive feeling is that the response must be to provide proper services to people when they arrive. But that is so at odds with a policy that says you make it as unattractive as possible for them. Those two things are so far apart... But you can prevent stuff if you provide support.”

Researchers

A more specific suggestion was for better funding for community centres working with the children of recent immigrants.

“Community centres try to steer young folk away from crime and drugs and offer them alternatives including classes in English and homework support in different subjects. But again, money is short for these programmes.”

Community worker amongst Turks and Kurds

Other specific suggestions included: funding to provide alternative activities for khat using Somali youth (khat-free cafés, football tournaments, youth clubs, music projects and IT courses); more drugs education materials in the refugees’ languages, especially Kurdish, Turkish, Eastern European countries, Vietnamese, and Somali; more
effort to reassure refugees and asylum seekers that drugs services are confidential.
APPENDICES

Sources consulted in the course of the literature review

Websites of all major broadsheet UK newspapers

HARP (Health for Asylum seekers and Refugees Portal) www.harpweb.org.uk

BBC website

Starting Again, a joint report published Sept 02 by Save the Children and Glasgow City Council (see www.ncadc.org.uk)

NCIS (National Crime Intelligence Service) website (www.ncis.co.uk)

Various government websites including: www.drugs.gov.uk
www.homeoffice.gov.uk

The Somaliland Forum website: webmaster@somalilandforum.com

Black and minority ethnic communities in England: a review of the literature of drug use and related service provision
April 2003
Published jointly by National Treatment Agency for Substance Abuse, and Centre for Ethnicity and Health, University of Central Lancashire

May 2003
Published by Centre for Ethnicity and Health, University of Central Lancashire
People interviewed

Kamlesh Patel, University of Central Lancashire
Jez Buffin, University of Central Lancashire
Siwan Lloyd Hayward, GLA Drugs Policy Advisor
Ismailoglu Yashar, Halkevi Turkish and Kurdish Community Centre, Dalston
Kevin Flemen, independent drugs education specialist
Maggie Harding, Housing Officer, Manchester
Wendy Howard, researcher
Barak Koyuturk, Drug service provider, Tower Hamlets
Ruby Sloan, Health Co-ordinator for asylum seekers and refugees, Scotland
Judge Hodge (with responsibility for asylum seekers appeals)

Organisations contacted in connection with the study

Drug Action Teams
Suffolk
Barking and Dagenham
Peterborough
City of London
Ealing
Red bridge and Waltham Forest
Blackburn
Westminster

DPAS
Cambridge

Other
ICENI Project, Ipswich
NorthEast Asylum Seekers and Refugees Consortium
Refugee Action, Liverpool
Anatolian Centre: Turkish Social Club and Women’s Group, Walthamstow
Halkevi Kurdish/Turkish Community Centre, Dalston
Turkish Community Centre, Stoke Newington
Peterborough City Council
Community Drugs Outreach Team, Rochdale
Refugee Action, Manchester
The Waterloo Project, STASH, Manchester
The Refugee Council
Lifeline, Manchester
Manchester Refugee Support Network