Under the radar: Impact of policies of localism on substance misuse services for refugee and asylum seeking communities

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Under the radar: Impact of policies of localism on substance misuse services for refugee and asylum seeking communities

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Abstract
Drug services struggle to respond to the UK’s minority communities. Despite some success, suspicion persists. The UK government has advanced localism as a mechanism for supporting communities in developing systems which will meet their needs. Drawing upon three research projects, this article examines the needs of asylum seekers and refugees, the formation of communities and the barriers which leave individuals unnoticed. It explores the potential of localism to engage and support drug users in new communities.

Keywords
asylum, Big Society, drug treatment, drugs, localism, refugee, substance misuse

Notions of ‘localism’ are widespread in the discourses of politics, economics, globalization and sustainability, at a European level and internationally. The notion of ‘subsidiarity’ is a guiding organizational principle of the European Union, and Mohan and Stokke (2000) describe the confluence of...
interests which results in the ‘paradoxical consensus’ (p. 263) of widely opposing political forces hailing the benefit of localism for communities. This impetus towards localism can be observed in UK political activity over the course of the past 15 years (Taylor, 2003).

Localism appeals to those who want to hear the voices of communities who are ‘hard to reach’. Refugee communities fall squarely into that category in terms of both research and practice, and this article discusses whether the pursuit of local drug treatment can offer new approaches or whether barriers to service delivery remain insuperable.

What is localism?

Concepts of localism were embedded in the policy agenda of the recent Labour administration. Lodge and Muir (2010) trace Labour’s interest in pluralist politics to their exclusion from power during the 1980s and 1990s and the corresponding investment in constitutional reform as a brake on executive power.

Taylor (2003) observes politicians as perceiving the potential of localism to answer problems of democratic participation and social inclusion at local, regional and national levels. All these can be seen in the New Labour administration. Examples of national restructuring are the Acts of devolution which passed administrative, judicial and fiscal powers to Assemblies in Wales (Government of Wales Act 1998) and Northern Ireland (Northern Ireland Act 1998) and to the Scottish Parliament (Scotland Act 1998). At a regional level powers were devolved to local mayors (Labour Party, 1997); the 1997 manifesto envisaged further powers passing to local councils (Labour Party, 1997). Locally, community development operated as a tool for public policy development (Taylor, 2003). In truth, however, this rhetoric was not fulfilled. The Labour Party in government held political power to itself with a complex framework of centrally set targets, oversight and governance (Bache, 2003; Smith, 2010).

Drug treatment demonstrates the central control and targets-based supervision of the delivery of local services. ‘Tackling Drugs Together’ (Home Office, 1995) established procedures for local needs assessment and commissioning under the aegis of local joint commissioners. While budget streams have changed, this framework remains in place some 15 years later. Under Labour, the control exerted by national targets was super-imposed upon this model. Key indicators of impact and quality were rolled out from the centre with adherence to targets overseen by the National Treatment Agency for Substance Misuse. With objective evidence of treatment efficacy (Gossop et al., 1998, 1999) and a perceived financial saving seen to flow from drug treatment (Home Office, 2008), money was pumped into the
system; numbers in treatment doubled and new initiatives for drug misusing offenders flourished. Entry into treatment has become much easier for the majority of drug users with shorter waiting times, lower thresholds for service delivery and improved outcomes. However, a concentration on the link between drugs and crime has meant that provision has focused upon Class ‘A’ drugs (heroin and crack cocaine) with central government, maintaining a clear line of sight between national policy and local implementation. This restricts services in delivering treatment to communities who, as will be seen below, have different patterns of use or balance of social and criminal needs.

Localism and the Big Society

The economic downturn in 2008 created conditions where the two main UK political parties could establish a clear demarcation of policy. Faced with the imperative to reduce the economic deficit, Labour’s intended response was to increase taxation and bolster growth, while the Conservatives proposed the reduction in the size of the state, with welfare capacity maintained through the development of the ‘Big Society’ (Smith, 2010).

Elected in May 2010 the UK Coalition Government stated an intention to shift power from Westminster to local areas, the goal being to reduce the state, increase democratic engagement and empower communities (Goodwin, 2011). Localism under the coalition has been expressed in the Localism Act (2010) (DCLG, 2011) devolving power for housing and planning to local government (DCLG, 2010). In addition, in his leadership of the Conservative Party, the Prime Minister has popularized the term the ‘Big Society’ as a banner under which the key themes of modern Conservative/Coalition decentralization can muster. It is envisaged that every part of government will employ six key drivers to transfer power from Whitehall to the citizenry. The mechanisms which exemplify this process are: reducing bureaucracy; empowering community decision-making; increasing local control of public finance; diversifying the supply of public services; increasing transparency in government and strengthening accountability (DCLG, 2010). At its most effective the ‘Big Society’ has the scope to achieve a genuine relinquishing of power by Westminster government (Goodwin, 2011).

Localism and drug treatment

Drug treatment in England and Wales demonstrates several of the hallmarks of localism, particularly local control of finance and diversifying supply of services. Treatment is nested within, and affected by, broader trends within health provision. The 2010 White Paper ‘Equity and Excellence’ proposed
significant organizational change to ‘strengthen the local democratic legitimacy of the NHS’ (HM Government, 2010: 34). The architecture of these changes is yet to be finalized – political manoeuvring, public opposition and the voices of health service professionals having acted as a brake on the legislative process. However, the consequence for drug treatment is to move funding for drug and alcohol treatment from central control to local government, with responsibility for health priorities and spending decisions vested in local ‘Health and Wellbeing Boards’ (Department of Health, 2011). Furthermore, the Drug Strategy (Home Office, 2010) emphasized recovery from dependency, with that recovery being supported by treatment agencies and the wider community (Home Office, 2010). These features of local control and recovery combine within a new outcome-based commissioning system. This shift in NHS procurement will allow ‘any willing provider’ to bid to offer services to drug users and be judged (and paid) on the basis of the successful outcome of their intervention, rather than upon the process.

Simultaneously, the sector has seen the development of ideas of asset-based recovery. Drawing on recovery and strengths-based approaches seen in the fields of justice and mental health (Carpenter, 2002; Farrell, 2004), treatment services work to stimulate the capacity within individuals in order to reduce drug use and concomitant crime and promote long-term recovery.

**Localism in new communities**

In examining the extent to which the trends of localism and asset-based approaches support the needs of the UK’s emerging communities, this article draws on three recent studies focusing on asylum seeking and refugee communities in the UK. These drew on the voices of different interest groups to examine the drivers and the barriers to seeking support from drug treatment services.

The first study, undertaken in the east of England (Mills et al., 2006), explored attitudes to drugs and treatment services. The area studied is a dispersal area within the UK (Sales, 2002) and the 29 respondents (of a wider sample of 96 interviewees) were refugees and asylum seekers from Middle Eastern countries.1 Interviews were undertaken by speakers of the respondents’ mother tongue then transcribed into English. The identity of the respondents was not known at any stage to the research team, a factor crucial to promoting free discussion in this group. Equally, respondents were not asked to identify their asylum status, the limitation this imposed being balanced with enhanced freedom of expression. The majority of respondents were male (n = 27) and the sample was relatively young with 20 interviewees being under 30; none were over 45. The refugee community
in the area is composed generally of young men who fled the Iraq war and who are being joined by other family only insofar as their status has been resolved.

The second sample (Mills et al., 2007) was drawn from service providers within a London-based study. Here semi-structured interviews were undertaken with specialist staff in 40 drug and refugee support services within seven London boroughs.

The third study (Sikora et al., 2010) also took place within a UK dispersal area. It drew on a sample of eight refugees (from a wider sample of 58 interviewees) and 44 providers to explore need and service provision for emerging communities in the southeast of England.

The commissioning of the studies and the responses of the group of service providers in the London study show that there is some awareness of the problems faced by individuals seeking refuge in the UK; however, mainstream providers were not alert to the nature or extent of local populations. As an example, information provided to the London study by drugs agencies stated that recent needs assessment had revealed that the largest local minority community was of Somali refugees. Local refugee organizations refuted this, saying that it was in fact only the third largest but that the Somali community had begun to coalesce and consequently be noticed:

It takes five, six, seven years maybe from when the conflict is at its height to when communities are settled enough to set up community organizations . . . it then takes four or five years for those community organizations to develop enough for anybody to know what they’re doing. It takes maybe 10 years before local authority start to recognize that they have got a big community. There are about 15 Somali organizations in [the borough], and it’s only really in the last two or three years that they . . . have started being heard. (Refugee Worker, London)

Griffiths et al. (2005) highlight the role of Refugee Community Organizations in supporting new communities both in meeting basic needs early in this process and in negotiating the contested ground of settlement and integration as communities coalesce. However, in relation to drug treatment this process has additional complications. Problematic drug users in refugee communities may wish to remain concealed. In part this can be ascribed to a fear of deportation. Forty-five percent of individuals in the east of England study commented upon the importance of securing refugee status and not acting to undermine the process. Respondents were wary of acknowledging the extent of their own drug use and only one described himself as a drug addict.

Equally persistent is the stigma of drug use. Documented in the literature (Fountain, 2010; Fountain et al., 2003; Mills, 2009; Sangster et al., 2002),
this was prevalent in all three of these studies – mentioned by 93 percent of the east of England respondents. Furthermore, communities forming in England are small and do not see themselves as ‘local’, but as national or even European in their orientation. As a result, the ostracism which may result from acknowledging a drug problem may be total, lifelong and global.

Because [the] only people they have to turn to for all their needs . . . are members of their own community and those members – just as in any community – tend to be . . . critical about drug use . . . [it’s a] handful of people, but they are very excluded people . . . excluded from their own community as well as excluded – simply because of being asylum seekers or refugees – from the community at large and on top of that the exclusion any drug user would face. (Refugee Worker, London)

This factor accentuates the reality of individuals’ fear of a loss of confidentiality in approaching services: that information will leak back to family, friends and community with devastating consequences.

Vulnerability to drug use associated with the stress of acculturation is noted by Johnson (1996). The east of England study noted young men as being vulnerable to a mix of dynamic risk factors: rootlessness; disengagement from services and lack of family support. The London study echoed this challenge of acculturation for unaccompanied minors who have fled from privileged backgrounds, are emotionally unprepared for UK life and experience a great deal of pressure to conform to new and unfamiliar norms (Patel et al., 2004).

Interviewees in the London study made particular mention of drug use as an aspect of modern war, a factor which has resonances with Keller et al. (2003) and Pumariega et al. (2005). Traumatic experiences characterize the expulsion, journey and arrival of a great many asylum seekers with consequent elevation in post-traumatic stress and drug use (Sowey, 2005).

The drugs which respondents perceived as problematic were much broader than those contained within the current UK Drug Strategy. Twenty-one percent of respondents in the east of England group mentioned opium/heroin as problematic within their communities. Cocaine and crack were hardly mentioned, while cannabis was mentioned by 31 percent and cigarettes or naswar (a tobacco-like drug) (Merchant et al., 2000) by 51 percent. Alcohol was viewed as problematic by 48 percent of interviewees and tea was viewed as overused by 10 percent of interviewees. The method of administration of drugs was different from that common in the UK and reminiscent of drug use in interviewees’ home nations. For example, respondents mentioned the use of opium smoked using a hot wire plunged into an opium pot.
In the London context the use of khat was described as problematic – and contrasted with the social use of khat in the local Somali context. The social impact of khat use was identified by several respondents. The impact of trauma and of the process of migration as well as acculturation was noted by respondents as having an impact upon the drug use and the consequent need for services. However, this created tensions in service delivery:

It’s been put to us that we should be doing something about khat . . . I don’t doubt that there is a need there . . . providing structured drug treatment for people who are chewing khat in response to feelings of isolation and being a minority within our community . . . having post-traumatic stress disorder, having mental health issues. I can see the need. The issue then is when you are told that the only solution to that need is providing drug treatment . . . and making those people come off that drug . . . instead of going right back to the beginning and thinking systematically about how we support any emerging community, any settling community in our borough. (Joint Commissioning Manager)

The strong link under the Labour administration between treatment provision and crime prevention undermines the provision of services to meet social needs. One Joint Commissioning Manager in the London study put it thus:

Crime and disorder partnership is the wrong focus because this is nothing to do with crime or disorder. It’s about wider social care. (Joint Commissioning Manager)

Seventy-two percent of respondents in the east of England study described carrying with them the myths and perceptions of justice and treatment at home and ascribing them to the UK context. It is interesting to note that these findings, and also those contained in Fountain (2010), show the same persistent mythology about the inadequacy of treatment services despite advances in treatment provision and research to suggest that the retention of people from minority ethnic communities who enter treatment is as good as that of their white counterparts (NDTMS, undated).

The London study noted the assets held by refugee communities in terms of human capital. The education and resource of individuals in flight from governmental upheaval was evident in the responses of staff and in the needs assessments carried out by treatment services – one of which revealed that 48 percent of the local Somali population is educated to degree level or above.
Discussion: Localism in action

These findings suggest an unmet need for drug treatment in refugee communities and prompt the question of whether refugee and asylum seeking communities hold the wherewithal to enlist in the UK’s Big Society, or whether the impulse of localism will exclude these new communities from treatment pressing them into the ranks of the socially dispossessed. These findings would suggest that there are significant factors which inhibit refugee and asylum seeking communities from seeking support from drugs services. Newly arrived populations carry with them residual fears of the power of governmental institutions and a persistent mythology about drug treatment. Fear of deportation back to a situation of war or oppression, certainty that admitting a problem will count against any asylum application and an abiding sense that drug treatment offers only punishment and degradation combine to form a barrier to seeking help. Moreover, these findings show the isolation of minority groups within the wider community, and the isolation of drug users within communities themselves. Shame and stigma lead drug users to remain silent about the issues they face, rather than risk exposure. Moreover, the nature of drug use in the minority communities studied would appear to be different from what is broadly anticipated within recent strategy. A wider conception of what constitutes problematic use and drugs of abuse, and the social disintegration which follows, is such that current policy – predicated on criminal behaviour – meets the needs of refugee communities in only the most partial of ways.

The vision of localism is predicated upon the notion that services will follow the clamour of local activism, but the slow formation of new communities within areas militates against their voices being heard. McCabe (2010) describes local communities which exist beyond the sight of local partnerships as ‘below the radar’. Refugee communities lie still further out of sight, well under the radar of current mainstream drug service delivery. Small communities form glacially slowly and develop as national, European and global diasporas – not local in their perspective. These individuals remain truly ‘hard to reach’.

With these features as a constant background, can a local agenda break through barriers and support inclusion? The commissioning and delivery of treatment services will fall to local ‘Health and Wellbeing Boards’ (Department of Health, 2011). If these are well constituted (and the planning for their formation remains in its infancy) they hold potential to craft services which will balance the conflicting needs and tensions inherent in the provision of services to minority groups. If boards are not well framed, however, the potential for ideologies to grow up and services to develop along lines which are partisan and exclusive is significant (Alcock, 2010).
Kisby (2010) and Parvin (2009) both suggest that a shift towards localism in politics will actively disadvantage ethnic minority communities. Existing services for refugee groups might, under a Big Society, develop a collective voice, loud enough to penetrate the walls of the establishment. This would be no guarantee that such organizations could overcome fears about confidentiality that were a feature of these studies. Nor does it address the fact that refugee communities are by definition global in their composition, outward facing in their perspective. However, the present situation affords no voice at all to new communities, there is little scope for refugee groups to join in creative partnership with statutory agencies and their knowledge of drug use in these communities is lost. Shifting the balance of power would fit the rhetoric of the Big Society. But local refugee groups have very limited funding and little extra capacity for development and campaigning. The proposals for funding small community groups within a new political framework are rather under-developed. The Prime Minister has floated the notion of a Big Society bank (Alcock, 2010), utilizing the untapped resources in dormant bank accounts, but it remains debatable whether the £400m released would be sufficient to grow third sector organizations to fulfil this new function. The issue of continued funding lies at the heart of the matter. Voluntarism cannot meet the case; political will and local action must be matched by consistent funding if any shift is to be made.

Such funding is not available to the UK Coalition Government. Recession presents a threat to the rollout of local agendas with profitability declining, social impact bonds (see e.g. Social Finance, 2011) potentially appearing less fertile, and charitable giving reducing alongside income (Goodwin, 2011). Taylor-Goobey and Stoker (2011) posit that UK fiscal cuts exceed those observed in other EU nations, with the Department of Communities and Local Government being significantly affected. Cuts of this intensity may reduce capacity within a third sector which remains heavily dependent upon grants and subsidies from central sources. This is especially so as funds as well as power will be devolved to local institutions. Localism without any hypothecation of resources has in the past led to reduced services overall and especially for minority groups. Ring-fencing is not envisaged for the implementation of the Big Society (Evans, 2011). This in turn raises the intensely political question of whether the ‘Big Society’ is a genuine attempt to restructure power relations in the UK or an old-fashioned attempt to reduce services for the poor while facilitating tax cuts for the wealthy (Kisby, 2010; Smith, 2010).

And if funding were available to new communities, what other services must wither instead? Racist and nationalist attitudes harden in a context of financial uncertainty (Sibbitt, 1997). Unemployment and perceived inequities...
in service provision act as catalysts in fomenting race hate. The popular media and the political discourse are seeded with notions of new communities being invasive, malingering and threatening. Were drugs services for these new groups to be developed at the apparent ‘expense’ of the indigenous population, the outcry would be significant and the possible consequences for individuals might be grave. If a spirit of inequity and exclusion lies at the heart of localism it will quash unheard voices and provoke bigotry.

But localism does offer the promise of a greater prize for new communities. These findings show that the asylum seekers whose destination is Europe have just the personal resources to benefit from asset-based treatment and ultimately contribute to the Big Society. Strength and acumen are the hallmarks of their history and of their journey. Their experiences have taken a toll in terms of trauma, mental strain and consequent drug problems, and a pressing need for services exists. Mainstream drugs services have not had success to date in overcoming barriers to drug use early in the drug using careers of these individuals. What is needed is truly responsive provision.

**Conclusion**

The traditions of Conservative administration have strong roots in social responsibility and the commitment to ‘do good’ (ACEVO, 2011; Disraeli, 1845). Those roots have become attenuated as a result of ideologies which state that ‘there is no such thing as society’ (Thatcher, 1987) and policy which places a focus on individualism. The Big Society may represent an attempt to return to those roots. If this is the case, it has not occurred at the most auspicious time and the initiative must attempt to establish itself in the context of drastic cuts.

These findings do demonstrate a significant gap in treatment provision which it might be possible for an initiative such as the Big Society to fill. If this were to be realized, then refugees and community agencies might find a mechanism to identify authentic needs and develop drugs services in response. But without active effort to bring new communities up from under the radar, coupled with considerable creativity and consistent funding on the part of the architects of localism, progress will not be achieved and the situation for refugees may in fact worsen. The unfolding of this process will reveal whether inclusion or budget restraint is the true driver of policy.

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Note

1. A further section of the wider sample was composed of interviewees from African countries. These are not included in this article as their reasons for migration cannot be confidently inferred from the interview responses or from the background information provided by the research commissioner.

References


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