



## **European Network**

**For the Target Group of Mobile Drug Users**

### **Reports on mobility and drug use:**

- **summary**
  - supporting mobile drug users
  - minorities in prison
  - mobility and collaboration in border regions
  - immigration and drug use

Authors:

**Jan Visser**

**Sven Todts**

**Enzo Crolle**

**Eberhard Schatz**

Editor:

**Eberhard Schatz**

Adres: AMOC/DHV  
Stadhouderskade 159  
1074 BC Amsterdam  
The Netherlands

[info@ac-company.org](mailto:info@ac-company.org)



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## **Foreword**

This booklet describes some of the issues AC COMPANY worked on in the last two years. The following reports are not based on a survey that can be defined scientific, as such a survey was not possible. These observations are the practical results of our activities. Our aim was to improve the knowledge over the target groups and to put the finger on gaps and needs.

May we thank all involved persons, the funding authorities on European and national level, many extern experts and mobile drug users, who gave us important hints and support

I. Schlusemann

Project leader

E. Schatz

project co-ordinator

## 1. Partner list (inclusive associated partner)

Name		adress
1	Paul Neubauer, Austria	<b>Verein Wiener Sozialprojekte</b> Rotenmühlgasse 26 1120 Vienna Tel.:+43 1 8101301 Fax:+43 1 81013019 <a href="mailto:Paul.Neubauer@vws.or.at">Paul.Neubauer@vws.or.at</a> <a href="mailto:info@vws.or.at">info@vws.or.at</a>
2 3	Cathy Mathei, Belgium Lana Illina/ Salome Shapakidze	<b>Free clinic</b> Van Arteveldestraat 64 B - 2060 Antwerpen Tel. +32 3 2011260 Fax.+3232011299 <a href="mailto:ac-company@skynet.be">ac-company@skynet.be</a>
4	Lars Steinov, Denmark	<b>Ambulatoriet Enghaven</b> Enghavevej 12 DK - 1674 Copenhagen V. Tel.+45 3 3257844 Fax. +45 3 3259844 <a href="mailto:steinov@enghaven.dk">steinov@enghaven.dk</a>

5	Gerard Allard, France	<b>EURO AST</b> Hotel de Ville 57600 Forbach Tel.: +33 3 87843000 Fax: +33 3 87855633 <a href="mailto:allardg@club-internet.fr">allardg@club-internet.fr</a>
6	Jaye Foster, Great Britain	<b>Healthy Options Team (HOT)</b> 564 Mile End Road, Bow London E3 4PH Tel. +44 208 983 4888 Fax +44 208 983 3423 <a href="mailto:jaye.foster@elmht.nhs.uk">jaye.foster@elmht.nhs.uk</a>
7	Rüdiger Klebeck, Germany	<b>BINAD</b> Landschaftsverband Westfalen Lippe Warendorfer Str.25-27 48133 Münster Tel.: +49 251 591 3268 Fax:+49 251 591 5499 <a href="mailto:r.klebeck@lwl.org">r.klebeck@lwl.org</a>
8	Sabine Lorey, Germany	<b>Kesh Arbeitskreis für Jugendhilfe e.V.</b> Bahnhofstrasse 2 59065 Hamm Tel.+49 2381924460 Fax.+49 2381924466 <a href="mailto:accompany@afj-hamm.de">accompany@afj-hamm.de</a>
9	Dora Karvouni, Nico Takis , Greece	<b>ANIKTI GRAMMI helpline</b> Detoxification UnitPsychiatric Hospital of Attica 73 Solomonidou 16121 Athens Tel+302 10 3617089 Fax. +30 10 3617839 <a href="mailto:tendetox@hellasnet.gr">tendetox@hellasnet.gr</a>
10	Fabio Patruno, Italy	<b>Villa Maraini</b> Via Bernardino Ramazzini 31 00151 Roma Tel + 39 06 657530311 /00 /58 Fax.: +39 06 657530302 <a href="mailto:f.patruno@villamaraini.it">f.patruno@villamaraini.it</a>
11	Eberhard Schatz Enzo Crolle, Netherlands	<b>AMOC/DHV</b> Stadhouderskade 159 1074 BC Amsterdam Tel: +31 20 6721192 Fax: +31 20 6719694 <a href="mailto:eschatz@amoc.demon.nl">eschatz@amoc.demon.nl</a> <a href="mailto:ecrolle@amoc.demon.nl">ecrolle@amoc.demon.nl</a>

<b>12</b>	Lorenzo Camoletto, Italy	<b>Gruppo Abele</b> <b>Università della strada</b> Corso Trapani 95/A 10141 Torino Tel: +39 011 3841073 Fax: +39 011 3841075
<b>13</b>	Caroline Corr, Ireland	<b>Merchant's Quay Project</b> 4 Merchant's Quay Dublin 8 Tel. +353 1 6790044 Fax. +353 1 671 3738 <a href="mailto:info@mqp.ir">info@mqp.ir</a> <a href="mailto:Caroline.Corr@mqi.ie">Caroline.Corr@mqi.ie</a>
<b>14</b>	Tim Heule, Sweden	<b>Riksförbundet för Hjälpt          Läkemedelsmissbrukare (RFHL)</b> Norrtulsgatan 45 10435 Stockholm Tel. +46 854556060 Fax. +46 8335866 <a href="mailto:Tim.Heule@malmo.se">Tim.Heule@malmo.se</a>
<b>15</b>	Monika Filipowicz, Poland	<b>C.T.N. Monar</b> Ul SW. Katazyiny 3 <a href="mailto:mfilipowicz@monar.krakow.pl">mfilipowicz@monar.krakow.pl</a> 31-063 Krakow Tel: +48 12 4306135 Fax: +48 12 4305964 <a href="mailto:mfilipowicz@monar.krakow.pl">mfilipowicz@monar.krakow.pl</a>
<b>16</b>	René Akeret, Switzerland	<b>AIDS-Hilfe Schweiz</b> Konradstrasse 20 8031 Zürich Tel.:+41 14471111 Fax.:+41 1 4471112 <a href="mailto:rene.akeret@aids.ch">rene.akeret@aids.ch</a>
<b>17</b>	Jozsef Racz, Hungary	<b>Bluepoint Drug Counseling and          Outpatient Center</b> Balazs Bela utca 21 Budapest - 1094 Tel./fax. 361 2157833 <a href="mailto:bluepoint@matavnet.hu">bluepoint@matavnet.hu</a>
<b>18</b>	Bogdan Glodeanu, Romania	<b>Aliat</b> SOS Berceni No 10-12 Sector 4 Bucuresti Tel : +40 21 334 8406 Fax. +40 21 334 8406 <a href="mailto:boglous@yahoo.com">boglous@yahoo.com</a> <a href="mailto:aliat@fx.ro">aliat@fx.ro</a>

19	Rosa Suarez, Spain	<p><b>Centro de estudios sobre promoción de la Salud (CEPS)</b></p> <p>C/ Valencia nº 327 entlo.C 08009 Barcelona Tel/Fax. 93 208 20 88 <a href="mailto:cepscat@telefonica.net">cepscat@telefonica.net</a></p>
20	Jaana Helminen, Finland	<p><b>A-klinikasäätiön Terveysneuvontapiste Vinkki</b></p> <p>2.linja 15 00530 Helsinki Tel.+358-40-7743225 fax. +358 9 72688081 <a href="mailto:jaana.helminen@a-klinikka.fi">jaana.helminen@a-klinikka.fi</a></p>
21	Evita Leskovsek , Slovenia	<p><b>AIDS Foundation Robert</b></p> <p>Wolfova 8 1000 Ljubljana Tel. +386 1 2441467 Fax. +386 12419999 <a href="mailto:afr@siol.net">afr@siol.net</a> <a href="mailto:Evita.Leskovsek@ivz-rs.si">Evita.Leskovsek@ivz-rs.si</a></p>
22	Egle Pincevicius, Lithounia	<p><b>Vilnius Substance Abuse Treatment Centre</b></p> <p>Gerosius Vilties 3 Vilnius LT-2009 Tel. +370 223 7274 Fax. +370 226 0016 <a href="mailto:Egle.pinc@delfi.lt">Egle.pinc@delfi.lt</a> <a href="mailto:pincev@takas.lt">pincev@takas.lt</a></p>
23	Vlastimil Necas, Czech Republic	<p><b>K-centrum SANANIM</b></p> <p>Osadni 2 Prague 7; 170 00; Czech republic tel.:+420 283 872 186 fax: +420 283 872 258 mobil: +420 777 107 289 <a href="mailto:ac.company@centrum.cz">ac.company@centrum.cz</a></p>
24	Pascal Balthasar, Luxembourg	<p><b>Jugend- an drogenhëllef</b></p> <p>25, rue du Fort Wedell, B.P.2263 1022 Luxembourg Tel. +352 491040 Fax.+352 487134 <a href="mailto:consult.lux@jdh.lu">consult.lux@jdh.lu</a> <a href="mailto:jdh-admin@jdh.lu">jdh-admin@jdh.lu</a></p>



25	Arne Schanche Andresen, Norway	<b>City of Oslo</b> <b>Alcohol and Drug Addiction</b> <b>Service</b> <b>Competence Center</b> Møllergata 4 0179 Oslo, Norway Tel. +47 23427940 -51 direct Fax. +47 23427949 <a href="mailto:arne.andresen@rme.oslo.kommune.no">arne.andresen@rme.oslo.kommune.no</a>
26	Marie Kok, Netherlands	<b>Pauluskerk</b> Mauritsweg 20 3012JR Rotterdam Tel. +31 10 4118132 Fax. +31 10 4113860 <a href="mailto:marie.kok@derf.demon.nl">marie.kok@derf.demon.nl</a>
27	Pierre Gay Le Maitre, France	<b>SOS Drogue International</b> Espace Parmentier 62 Bis avenue Parmentier 75011 – Paris Tel: +33 14 3148150 Fax: +33 14 7007491 <a href="mailto:espace.parmentier@asos.org">espace.parmentier@asos.org</a>
28	Katarina Jiresova, Slovakia	<b>CEE - HRN</b> <b>C.A. Odysseus</b> Ukrajinská 10 831 02 Bratislava 3 Tel : +421 2 52 494 344 Fax : +421 9 03 786 706 <a href="mailto:katjir@yahoo.com">katjir@yahoo.com</a> <a href="mailto:pkata@yahoo.com">pkata@yahoo.com</a>
29	Sven Todts, Belgium	<b>Penitentiaire Gezondheidsdienst</b> Berkendaalstraat 66 B - 1190 Bruxelles Tel. +32 2 3403622 <a href="mailto:sven.todts@pandora.be">sven.todts@pandora.be</a>
30	Marco De Giorgi, Italy	Adiseur <b>SERT</b> Via Ghedini 6 10154 Torino Tel: +39 011 2402371/2 <a href="mailto:degiom@vodafone.it">degiom@vodafone.it</a>
31	Jan Visser, the Netherlands	Evaluator Adress AMOC <a href="mailto:Jhvisser@dds.nl">Jhvisser@dds.nl</a>

32	Friedhelm Brill, Germany Gerard Allard	<b>EURO AST</b> Hotel de Ville 57600 Forbach Tel.: +33 3 87843000 Fax: +33 3 87855633 allardg@club-internet.fr <a href="mailto:friedhelmbrill@t-online.de">friedhelmbrill@t-online.de</a>
33	José Diogo, Portugal	<b>ASSOCIATION ARISCO</b> Rua Pinheiro Chagas, nº 17 - 6º Andar - 1050 - 174 LISBOA - PORTUGAL N° Tel- +351 21 316 27 97 Fax - +351 21 317 24 66 <a href="mailto:arisco@clix.pt">arisco@clix.pt</a>
34	Meinrad Mairl, Italy	<b>Verein Drogenhilfe, Drop - In</b> Garibaldistr. 4/a 39100 Bozen Bolzano, Italy Tel. 0039-0471 324536 <a href="mailto:drogenhilfe@dnet.it">drogenhilfe@dnet.it</a>
35	Jason Farrell	<b>Positive Health Project, Inc.</b> 301 West 37 <sup>th</sup> Street New York, NY 10018 USA tel (212) 465-8304 ext. 32 fax (212) 465-8306 <a href="mailto:jfarrell@phpnyc.org">jfarrell@phpnyc.org</a>

## **2. Summary of the AC COMPANY activities 2002 - 2003**

E. Schatz, project co-ordinator

### **Network**

The third phase of AC COMPANY has realized a stable network of 35 partner organisations in all West European countries, including Switzerland and Norway as well as seven Central European countries. Additional (other) organisations, which requested to join the network, are getting involved as associated partner.

In East Europe and the United States we cooperate with particular organisations and experts to enlarge the contacts across the European Union. We have a lack of contacts in the states of Ex Yugoslavia, nevertheless a relevant region concerning mobility. In the future it would be useful to have contacts in Turkey and Morocco as well.

All partners are practice-orientated organisations working with vulnerable groups in our communities and the point of view and the approach of the network is pragmatic and client orientated.<sup>1</sup> Highest priority is given to exchange of information and good practice. In fact, there always is learning from each other, no one-way approach of teaching others. Organisations in countries of Central and East Europe for example have important experiences in working under difficult circumstances, they often have effective strategies in outreach work and prevention activities.

Dealing with mobile drug users, drug-using foreigners, immigrants and ethnic minorities calls for cross border cooperation, exchange of knowledge and experiences on European level. Therefore, the AC

<sup>1</sup> See principles of good practice 2001

COMPANY network is a core European organisation that depends on good European co-operation and communication structures. We build up contacts with other networks and projects in the field, external experts and policy makers and cooperate with drug user unions and refugee organisations. <sup>2</sup>We can mention in particular the co-operation with Euro-Methwork on methadone for travellers, with ENSDP (project on drug users in prison) and the Central and East European Harm Reduction Network (CEEHRN).

### **From laboratory to models of good practice**

Concrete client work took place <sup>3</sup> at:

- > AMOC Amsterdam with a high number of mobile drug users from all over Europe. The biggest group is from Germany, followed by Italians and drug users from the UK. A slightly increasing number of people from Central and East Europe is mentioned. The trajectory of repatriation is worked out to a model of good practice, as well as the set-up to work with foreign clients on the spot.
- > KESH – our partner in Germany - offered facilities for returned clients and supported the integration process. In Germany, the problems round AUSSIEDLER and the practice of deportations of criminal foreign drug users was followed <sup>4</sup> and documented.
- > HOT – our partner in Great Britain - supported returned clients in Great Britain. The process of repatriation to the UK is complicated and for people without financial resources very difficult to undergo. We prepared documentation on that issue. <sup>5</sup>
- > In Italy – Gruppo Abele and Villa Maraini – supported returning clients by offering them treatment and care. Both organisations work with migrant drug users. A special project for drug using foreigners in Rome was documented as well as the developments in the Italian drug policy.
- > In Antwerp at “ free clinic” a special project was set up to contact and to work with Russian speaking clients. A special questionnaire – also available online – was developed to find out more about the situation and background of this target group. A model of good practice is developed and we are busy to prepare a training module for workers in the field. These activities will be continued in 2004.
- > In Prague, a similar project for Russian speaking clients was installed in July 2003. We expect first results over one year.
- > Other partners gave occasionally support to returning clients to Portugal, Spain, France, Norway, Ireland. Client work of other AC COMPANY partners – like a research project in Dublin on Russian speaking drug users or a snowball project in Helsinki are documented on the website (“maps of mobility”). The partner in Portugal started a little survey amongst the Russian community.
- > Partners in border regions – BINAD in Germany/Netherlands, EURO AST in France/Germany and Verein für Drogenhilfe in Italy/Austria – described their conditions to work transnational and/or supported mobile drug users.
- > We collaborated with associated partners like AIDS Hilfe Switzerland and, since September 2003, with the Positive Health Project from New York, USA in order to support North American clients.
- > The partners from Central Europe joined the network in July 2003, continuing their activities in 2004 with PHARE funding.

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<sup>2</sup> see technical report 2003

<sup>3</sup> see details: report free clinic 2003, report AMOC 2003

<sup>4</sup> dossier: the practice of deportation of foreign drug users in Germany

<sup>5</sup> dossier: the repatriation of British drug users back to the UK

### 2.3. Products

- final technical report
- leaflet for Russian speaking clients
- leaflets with the summary of project activities in 8 languages
- booklet with frequently asked questions (checklist)
- reports on :
  - models of good practice – client work
  - foreigners in prison
  - collaboration in border regions
  - immigration and drugs
  - work with Russian speaking clients
- dossiers on:
  - the repatriation of British Drug Users back to the UK
  - the deportation of drug users with a criminal record from Germany
- cd-rom

with information about the drug helping system of all European countries and frequently asked questions about services (country guide, checklist)

- website

[www.ac-company.org](http://www.ac-company.org) incl. tips for trips and maps of mobility

- general information's about the network in 17 languages
- actual news section about political developments, conferences, network news
- country guide and checklist of 25 countries
- maps of mobility: descriptions about (research) projects for foreign drug users, mobility in border regions, repatriations
- updating, extending and integrating the "tips for trips" website with client related information's
- publishing al relevant material via the website (pdf's, documents)
- online questionnaire for the target group of mobile clients in 12 languages.

### 2.4. Dissemination

Dissemination is given high priority. Every network partner is obliged to disseminate the products and results in his country and to publish news in relevant media. Therefore, a summary of product activities is produced in all European major languages.. The printed booklets are disseminated to selected organizations and key people in the particular countries. With several mailings by e-mail the greater audience is attended on the issues and the website. The website is linked on other major websites in the field. On conferences and seminars, lectures were given and info tables were provided.

### 2. 5. General Conclusions, Forecast

In general we have to conclude that the issue of mobility, foreigners and minorities and drugs still is underrepresented in the international discussion, that there is still a great lack of information, like numbers, streams and tendencies in Europe and from outside the European Union. For many of our surveys it was extremely difficult to get hard numbers and facts, also, because in particular countries, authorities denied access to information, didn't supply them or that such information and data simply do not exist.

Furthermore, organizations, which take the challenge to work under difficult circumstances with these target groups, often face great problems regarding acceptance and funding. Local authorities often don't feel responsible to take care of foreigners, meanwhile national and European bodies don't offer funding at all. So – especially in border regions with a "natural" mobility - support to these groups is a question of occasional circumstances.(see report on that issue later on).

Drug tourism is a phenomenon in particular regions: the tremendous drug use in vacation areas in South Europe asks for special prevention projects for youngsters, the drug tourism to other countries because of cheaper market prices or less repressive drug policies ask for regulation of these streams.

Many mobile drug users from EU countries are refugees of the repressive drug policy in their country of origin, of bad economical circumstances or they just move because of individual reasons. Even if they are European citizens, their legal rights, access to social and health's systems are often far from evident. (see reports Netherlands, repatriation UK).

Drug use amongst immigrants from outside the European Union need different approaches because of the diversities of the groups:

Members of ethnic minorities, who live in great numbers in European countries, often have the tendency to hide their family and social problems and to try to solve (drug) problems internally without external support (drug addicted children are sent back to the country of origin for detoxification – with doubtful success.) There is a dramatic lack of cultural mediators and workers of the same ethnicity in most of the cases and only very few international or also transnational exchange of practices or good practices take place.(see reports “Russians from German origin”).

To support drug users amongst illegal immigrants, persons without permit, denied asylum seekers depend on political decisions. It is evident that authorities shouldn't ignore this issue. Denying this problem involves big risks for public health and safety. Special attention should be given to the group of drug using people from East Europe, who are present in most of the European countries. The approach towards this group requires special skills in order to overcome language problems, cultural barriers and mental behaviors.(See report immigration and drugs, report “work with Russian speaking drug users in Antwerp”).

The network could deepen the information by contacting hundreds of organizations and experts, mobile drug users and representants of drug user unions.

- ❖ our (online) survey clearly shows the need to support the target group on the spot without legal and social exclusion
- ❖ cultural and legal barriers produce a risky “non visibility” of particular groups, but research shows that health risks, like infection diseases, contain a great risk of transfer to the general population.
- ❖ in the case of work with minority drug users a fine-meshed system consisting of a cultural mediator, limited basic health treatment and hygienic facilities, qualified offers for repatriation and qualified support by integration procedures seem to be the most effective approach.
- ❖ To work with this client group one needs a competent database of information, cross border contacts and financial resources. In that sense, it's a core European activity.
- ❖ To improve cross border co-operation, European structures should be developed on different levels: in the Euregions to support structures on regional level, on European level to stimulate exchange and collaboration with European neighbors and immigrant countries too.

AC COMPANY will follow the developments in the future and intend to play a role in this field. Issues, which should be worked on in the near future are:

- ❖ Contact points to Turkey, Morocco
- ❖ Extend the network with an East European partner
- ❖ Increase the focus on health issues as STD's
- ❖ Conflict management in local neighborhoods (social inclusion)
- ❖ Develop a training module for the work with minorities and drug use
- ❖ legal rights of mobile drug user
- ❖ the value of drug user unions and self help groups

The intensity and quality of possible work will depend on available funding. We intend to collaborate with other organizations and networks to create added value.

### **3. Laboratory and Model of good practice: supporting mobile drug users in Amsterdam**

#### **3.1. Help on the street in Amsterdam**

Meanwhile the target group of (illegal) foreign drug users is not welcome in the Netherlands/resp. Amsterdam, the city of Amsterdam support the facilities of AMOC to provide help to (illegal) foreign drug users.<sup>6</sup>

Double approach:

>Limit access to the social and medical system to urgent, emergency help, frustrate people to stay by police actions, non tolerate zones on one hand, provide the target group basic support and counselling in order to avoid public order problems and health's risks for the individual and the public on the other hand.

With the support of the AC COMPANY project, AMOC could intensify and modify the work with the target group in the last years. Compared with the situation in other cities with foreign drug users, an advanced system of help and support is developed and a great measure of experience is build up. For that reason, we describe the structures of help as a model of good practice in detail.

#### **3.2. Facilities**

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<sup>6</sup> see AC COMPANY II, 2002

<p><b>Drop-In Centre</b></p> <ul style="list-style-type: none"> <li>• on weekdays, open from 11am - 8pm</li> <li>• approx. 70 visitors</li> <li>• provision of meals</li> <li>• clothing exchange</li> <li>• showering, / washing clothes</li> <li>• exchanging used hypodermics for new ones</li> <li>• daytime activities</li> <li>• waiting room</li> </ul>	<p>1 staff-member, trainees, volunteers</p>
<p><b>User Room</b></p> <ul style="list-style-type: none"> <li>• Open 7 days a week from 12am to 8pm</li> <li>• 45 persons registered</li> <li>• average of 22 visitors a day</li> <li>• provision of all necessary paraphernalia</li> </ul>	
<p><b>Social work</b></p> <ul style="list-style-type: none"> <li>• Psychosocial counselling</li> <li>• Aid to women who work in prostitution</li> <li>• Male prostitution</li> <li>• Police + prison work / early assistance</li> <li>• Outreach work</li> <li>• Repatriation support</li> </ul>	<p>4 staff-members, trainees, volunteers</p>
<p><b>Special tasks</b></p> <ul style="list-style-type: none"> <li>• Network development</li> <li>• Provision of information to colleagues, politicians and policy-makers from all over Europe about the Dutch drugs policy and the situation of foreign drug users in Amsterdam</li> <li>• Collaboration with other institutions</li> <li>• Supervision of trainees and volunteers</li> </ul>	
<p><b>cooperation network</b></p> <p>Amsterdam: "Passanten Polyclinic" (health service of the city)  Netherlands: Lawyers, consulates, embassies  International: AC COMPANY project partner</p>	

### 3.3. Screen shot intake card

**Screenshot intake card**

Beheermodule AMOC clientendatabase - Microsoft Internet Explorer

Bestand Bewerken Beeld Favorieten Extra Help

Vorige → → → Zoeken Favorieten Media

Adres http://server/amoc/get\_client.asp

**AMOC clientendatabase** **k-node**

Welkom eberhard,  
Er is een [bericht](#) voor u. [Zoeken](#) | [Daily Client List](#) | [Mijn Berichten](#) | [Mijn Klanten](#) | [Naar login](#)

**Vul een clientenkaart in voor nieuwe client**

**Client:**

Naam:  Geboortedatum:  Eerste contact: 04-11-2003  
 Voornaam:  Geslacht:  M  V Via:   
 Roepnaam:  Land van herkomst:   
 Adres:  Deelstaat (Duitsland):

**Basisgegevens:**

Datum: 04-11-2003 **Druggebruik** Ziektekostenverzekering:   
 Intaker:  Sinds  Verblijfstatus:   
 Medewerker:   Heroïne  **Probleem:**

Lokaal intranet

Beheermodule AMOC clientendatabase - Microsoft Internet Explorer

Bestand Bewerken Beeld Favorieten Extra Help

Vorige → → → Zoeken Favorieten Media

Adres http://server/amoc/get\_client.asp

Doelgroep:

**Geschiedenis/Ervaringen:**

Psychiatrie  
 Therapie:  keer  
 Detentie:  maanden

Cocaine   
 Methadon  
 Alcohol  
 Psychofarmakon  
 Amfetamine  
 Cannabis  
 LSD  
 XTC / nieuwe drugs  
 Andere

Categorie:

Dakloos  
 Basisverzorging  
 Psych.probleem  
 Prostitutie  
 Druggebruik  
 Medische Problemen  
 Minderjarig

Werkzoekend  
 Toerist/Traveller  
 Aanvraag documenten  
 Repatriering  
 Detentie NL  
 Leger  
 Uitgeproc. Asielzoeker

**Actuele juridische problemen:**

In Nederland  
 In land van herkomst

Arrestatiebevel  
 Opsporing verzocht  
 TBS  
 Detentie

Voorwaardelijke straf  
 Leger  
 Vroeghulp  
 Nederland verbod

**Contacten in Nederland:**

PPP/AMT  
 Groenburgwal  
 Kruispost  
 Ziekenhuis  
 Wijkpost  
 Psychiatrie

Consulaat  
 Politie  
 Vroeghulp  
 Detentie  
 IOM  
 V D

**Contacten in het land van herkomst:**

Drugshulpverlening  
 Afkickcentrum  
 Therapiecentrum  
 Justitie  
 ENMP-Partner

Psychiatrie/Ziekenhuis  
 Familie/Vrienden  
 ACC-Partners  
 Anderen

Verblijf:

**Repatrieringen:**

Aantal:

AMOC  
 Familie/Vrienden  
 Zelfstandig  
 Anderen  
 Uitgewezen

Lokaal intranet





### **3.5. Agreement user room**

**Agreement User Room**

Amsterdam, dd.....

Agreement between AMOC/DHV and

Name client ..... Social Worker .....

Date of births ..... Nationality .....

**Opening hours of the User-room**

Monday till Friday: 12:00 till 16:00 hrs. and from 17:00 till 19:30 hrs.

Saturday en Sunday: 12:00 till 19:30 hrs., a collective meal will be available on this day at 17:30 hrs.

**All contracting parties of the User-room are obliged to accept and observe the below mentioned rules:**

- Taking care of your own drugs;
- Being fully responsible of taking (the risk of) using drugs
- Taking care yourself of a regular TBC-check up;
- It is not allowed to take along friends or acquaintances;
- It is forbidden to ask anyone for any sort of drugs ( 'to beg for');
- It is forbidden to deal, to steal or to fence;
- Aggressive conduct, verbal as well as non verbal, is strictly forbidden;
- It is strictly forbidden to hang about or loiter in porches in the vicinity of AMOC;
- The use of drugs, outside the User-room is strictly forbidden (this includes alcohol, joints and medicines);
- Re-admittance will be denied if leaving the premises of AMOC for other reasons than for scoring dope.

**This contract will automatically expire if I:**

- break the above mentioned rules;
- not having used at AMOC/DHV for 4 consecutive weeks;
- being repatriated to my home country of costs cq. with the help of AMOC/DHV.

**Workers of the User-room**

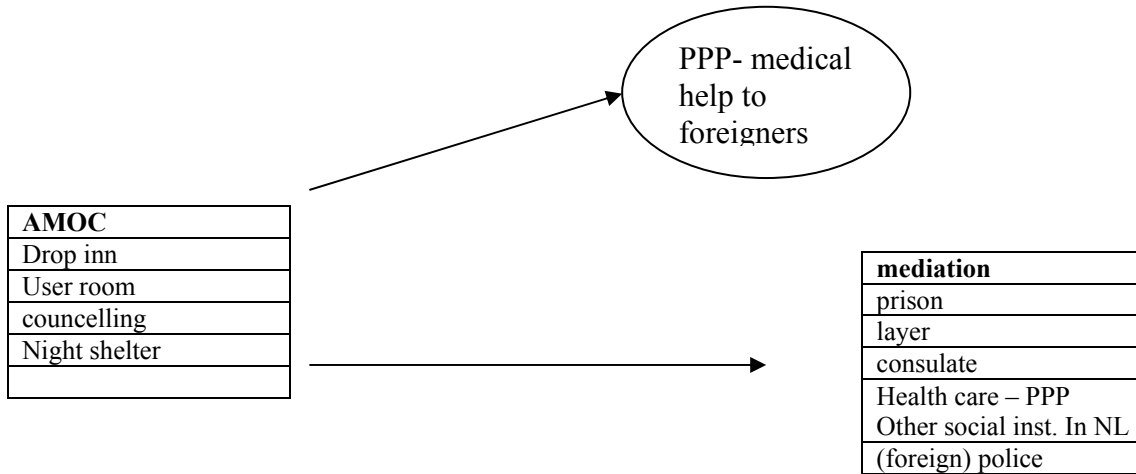
- keep up a list with names of al the users with an contract, the list may be seen by the police;  
Identification can be requested.
- keep up a logbook and one can rapport about you
- give direction and information about "Safe use";
- keep your Methadone in trust during opening hours of the User-room;

I have read and understood the condition. I hereby agree to the conditions and sign:

Co-worker AMOC/DHV .....

Client .....

**structure of help**

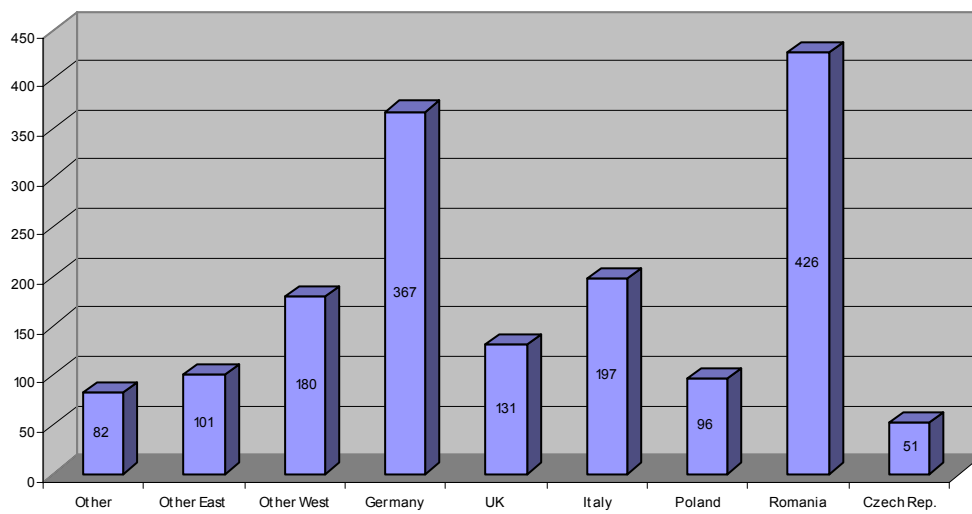


**3.7. streams of mobility**

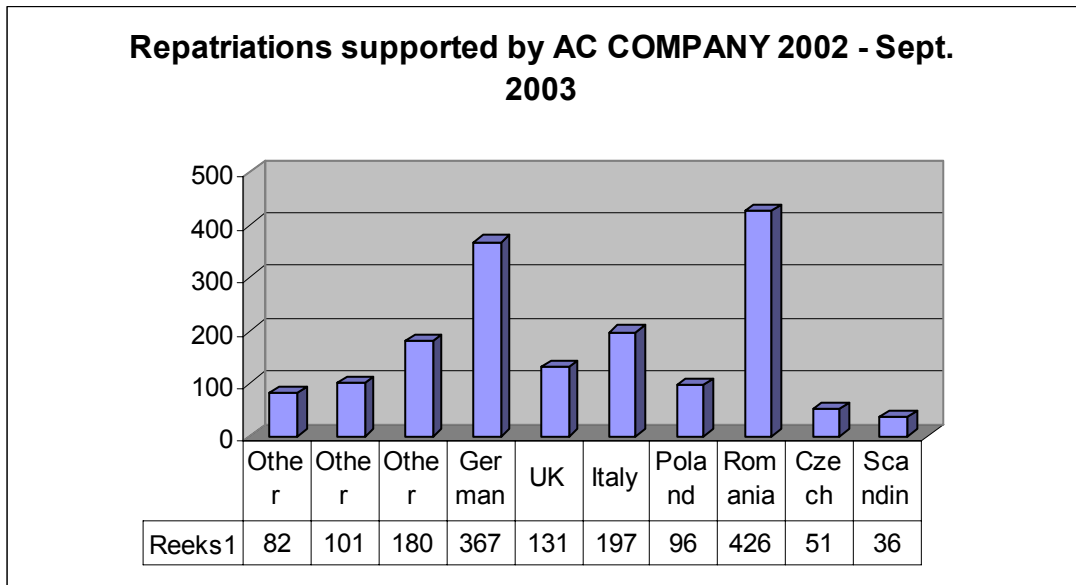
- **stream** of foreign drug users 2002/2003 (last 3 months 2003 estimated))

client numbers AMOC (incl. non drug use)

**foreign clients of AMOC 2002 - 2003**



### 3.8. repatriations



#### 3.8.1. Repatriation to UK

In the case of a growing number of clients, it has become increasingly difficult to fulfil their wish to return to their land of origin. If clients do not have a functioning network, such as family or friends, they find themselves confronted with mechanisms of exclusion, consciously or unconsciously created by political and social ideas. In these cases, the Accompany partner HOT (Healthy Options Team) is called in, to try and smooth the way to enable clients to re-establish themselves as part of the existing society.

> see extra dossier

#### 3.8.2. Repatriations to Italy

In the years 2002-2003 we had 197 repatriations to Italy. The majority of the persons went back to family settings or private circumstances. Most of them were connected to the corresponding local Ser.T. The take in charge by the Health Authority doesn't normally encounter any problems if a person is resident in Italy, but even in cases where they are not, there has been a possibility of having an address by the Municipality. The Ser.T. also pay the costs of methadone programs and/or in-patient or out-patient therapeutic treatment. In about 20 cases, the AC COMPANY partners GRUPPO ABELE in Torino and VILLA MARAINI in Roma were able to give support and service to clients. As mentioned in reports before, the biggest problematic came from clients with juridical sentences. Because of the strict privacy laws, it's, sometimes, difficult to find out more on the situation and to prepare an agreement with officers of justice. We can therefore say that repatriations to Italy proceeded smoothly in practically all the circumstances.

*Client case*

The story of M.

M. got in touch with Amoc at first on Christmas day of 2000.

He came to the usual celebration dinner given by us on that night.

He arrived together with a number of Italian and Spanish squatters and their complementary dogs.

Straight away he behaved loudly and made sure that everybody understood that he was the boss. He was talking in a mix of Italian and Spanish, his distinctive language.

M. was born in Roma from a very problematic family and he is now in his late 30'.

He declared to be a drug user and that his passion was experimenting drugs for his personal study.

Very soon he became a regular client of Amoc and went through a spell of heavy drug use.

His level of aggression was quite high and stayed this way, on and off, almost until the present days.

He was living in the street of Amsterdam and in the occasional squat since a couple of years.

Surely, he wasn't an easy person to deal with and, most of the time he behaved incoherently.

This was the situation that M. was living and remained this way for some time, until the day he decided to try to stop using drugs, tired of the life he was leading.

He had to give up a heroin and cocaine habit. For a short period of time he was on methadone maintenance and then he showed a great strength and determination in his willingness to fulfil this task.

When his goal was achieved he was a different person altogether; very relaxed and easy to relate to.

As said before, his hobby was, and is, the study of the effects of the different drugs.

This time he didn't experience first hand but was concentrated on reading and studying various books and documents on the subject.

He was especially interested in natural drugs (Ibogaine in particular) and had a plan to make a research together with a well-known Dutch organisation.

Unfortunately, during this positive period, he discovered to be affected by a serious illness.

This was a big blow for him and his state of mind.

His good and relaxed attitude gave room to a deep depression and his return to the use of heavy drugs was a consequence of that.

So he started to behave like there was no tomorrow and soon he became the shadow of himself. Until the day he could barely walk.

But, during all this time, he never lost contact with Amoc and his Social Workers.

We referred him to the local health authority (P.P.P., which is a section of G.G.G. & D. which deal with foreigners without insurance) and, with their help, we managed to stabilise the situation again.

The fact of having the possibility of giving M. a bed in our Nightshelter was of great help for his well being.

The idea of going back to Roma, which was at first out of the question, slowly began to enter his mind.

The meaning of the repatriation was in the fact that, in this way, M., firstly and most importantly, would have had the possibility of having access to the therapy against his illness that he so much needed. Having no insurance in the Netherlands was a problem without solution.

Secondly, there would have been the opportunity to tackle his addiction through a therapeutic programme.

So, we took the necessary steps in order to organise his return to Italy.

His legal situation was unclear but through a lawyer we knew that there were no impediments for his return.

Then, our AC-Company partner for Southern Italy "Fondazione Villa Maraini" of Roma, was contacted and as usual a great degree of collaboration and availability was found.

So M. left on a short notice, this time really convinced that, for the moment, this was the best possible solution.

We regularly keep in touch with our colleagues of Villa Maraini and the feedback has always been very good.

Since M. is in treatment in Italy his health improved enormously and, at the moment, he is working in one of the cooperative of the organisation with a position of responsibility.

### 3.8.3.Repatriations to KESH, Germany

Germans still are the biggest group of foreign drug users in Amsterdam. If a person decide to go back, AMOC can offer a detailed trajet to accompany the client in order to a successful reintegration in the country of origin. The most difficult cases got support from the project partner KESH (a part of the “Verein für Jugendhilfe”, Hamm) who supplied intake in their housing facility and mediation of social, medical and bureaucratic support.<sup>7</sup>

	<u>Total</u>	<u>Percent</u>
Women:	12	50,00
Men:	12	50,00
 <b>Age:</b>		
20 to 25 years	2	8,33
25 to 30 years	1	4,16
30 to 40 years	10	41,66
more than 40 years	11	45,83
 <b>Period of stay in the Netherlands:</b>		
• more than 1 years	0	00,00
• more than 2 years	4	16,66
• few years	20	83,33
 <b>Duration of drug use:</b>		
0 - 8 years	2	8,33
8 - 10 years	2	8,33
10 - 20 years	11	45,83
20 - 25 years	9	37,50
 <b>Health situation at intake:</b>		
Politoxicomania	24	100,00
HIV	1	4,16
Aids	6	25,00
Unter- oder Mangelernährung	7	29,16
Hepatitis (specially B and C)	24	100,00
Cramp risk	6	25,00
 <b>Substitution:</b>		
with Methadone	9	37,50
with Polamidon	15	62,50
no	0	
 <b>Experiences:</b>		
Therapy	6	25,00
Detox (stationär)	24	100,00
Self detoxification	24	100,00
Psychiatry	11	45,83
prison	18	75,00
overdoses (serious)	11	45,83
Suicide attempt	6	25,00

<sup>7</sup> see website for trajecyt of repatriation

**Motivation to go back:**

Reintegration	24	100,00
Improving health situation	24	100,00
Mediation to own housing	14	58,33
Mediation to work	9	37,50
Financial assistance	5	20,83
Contact to relatives	14	58,33

**Duration of stay in the project:**

< 1 month	6	25,00
< 6 months	8	33,33
• 6 months	10	41,66

**Perspective (where to go):**

Own appartement	4	16,66
Disciplinary expulsion	0	00,00
Treatment interruption	6	25,00
Residential living with support	4	16,66
Still in the project	4	16,66
Mediation to other projects	6	25,00
Continuous contact to the project (regular or occasionally)	7	29,16

The unique problems faced by repatriated AC-COMPANY clients may be explained on the basis of the following:

- The high average age
- Longstanding drug dependency
- Long periods of residence abroad
- Long periods of homelessness
- Long years spent in prostitution
- Legal problems
- Social uprooting
- Poor physical condition (concomitant illnesses apart from drug dependency, such as Hepatitis, HIV and Aids, heart and circulation diseases, hip ailments, skin diseases, lung infections, stomach and intestinal illnesses, illnesses of the pancreas, dental hygiene problems, etc.
- Psychological instability
- Psychological illnesses such as depression, anxiety neuroses, borderline pathological conditions, etc.

Experience has shown that working with “repatriates” requires a lot of work. In view of the problems mentioned above, great care has to be taken when establishing contact and very intensive personal counselling is required to achieve social rehabilitation and the ability to “cope” within the German structures. The main issue with regard repatriation is the need to resolve the legal situation, find the right agency, apply for the required cost allocation and organise the return journey itself. With this target group, it is extremely important to arrange placement with an agency offering a daily routine and structured framework in which the individuals concerned can orient themselves. It must also offer them the necessary protection, as many of them will have lived on the streets for many years. The initial period involves a great deal of administrative expense. Most of the “repatriates” have not been inside the Federal Republic of Germany for many years and have either no documents or insufficient documents. All the documents have to be acquired all over again. They require support in interfaces with government departments, since they can no longer find their way around the German system. At the same time, their motivation to remain in Germany and to overcome the initial difficulties has to be continually reinforced. Since this client group has a high need for medical attention, with no test



reports being available in most cases, numerous tests have to be carried out and a close cooperation with doctors and hospitals has to be cultivated. Here too, constant moral support is required to keep the client on the right track. Contacting family relations, if any, should be undertaken with great care because of the long periods for which relationships have been interrupted, and most clients respond to suggestions of such contacts with a fear of rejection. As regards reorientation in school or in professional life, there are problems with absence or lack of prior training and certificates, which usually have to be applied for and procured anew. Due to the long periods of homelessness, there are often problems with bodily hygiene and living with other individuals. In addition, there is also work associated with relapses into the former drug-related context. As has already been mentioned, a great deal of morale boosting is required because repatriated clients soon become demoralised and choose the easier option of returning to the Netherlands when problems arise. As a result, it is by no means rare that the same client is repatriated several times over.

### **3.9. Questionnaire/Research**

We developed an extended questionnaire to use in different settings for the target group of mobile drug users. Again, we don't had the sources to set up a scientific research project, but by integrating the interviews in our daily work, to have a useful instrument to get in contact with the target group, to find out more about the backgrounds of the individuals and to compare situations.

Categories of mobile drug users interviewed:

- EU drug tourist (staying short time, recreational)
- Mobile drug user from EU (looking for work, refugee from justice, etc...)
- Mobile drug user from Central Europe
- Mobile drug user from other countries (outside EU and central Europe)

The interview takes about 20 – 30 minutes and can be for the person in question an intensive experience because of the deep of the questions. As feedback we often got into serious talks with the person, even some days later sometimes a process of reflection of the personal situation was started. In the last section of questions, one can give personal estimates, ideas, reflections about the personal fears and hopes for the future.

Of course every interviewed person is informed about the strictly confidentiality of the given information's.

In 2004 we will finalise the first round of interviews with several hundredths of interviews, in first instance in Amsterdam and Antwerp but also in other places. As try out we implemented an online version on the website.

Samples comparison - Microsoft Internet Explorer

Bestand Bewerken Beeld Favorieten Extra Help

Vorige Zoeken Favorieten Media

Adres http://ac-company.s ... Restriction: 500 Ga naar

Restriction: Netherlands (34)

**A. Socio-demographic information**

**01. Sex**

Answer	at home	here
male	27	1
female	4	

**06. How long are you here?**

Answer	at home	here
less than 1 month	1	
1-6 months	1	
7-12 months	2	
more than 1 year	6	
more than 2 years	21	1

**07. Education**

**Menu**

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[Restricted Statistics](#)

[Questionnaire Structure](#)

Samples comparison - Microsoft Internet Explorer

Bestand Bewerken Beeld Favorieten Extra Help

Vorige Zoeken Favorieten Media

Adres http://ac-company.s ... Restriction: 500 Ga naar

**B. Legal situation**

**01. What is your status here?**

Answer	at home	here
citizen	4	
permit to stay temporary (white card, tourist)	15	
illegally and without papers	12	1

**02. Are you afraid of deportation?**

Answer	at home	here
yes	11	
no	20	1

**03. Is the law related to drugs in your country more restrictive than here?**

Answer	at home	here
yes	28	1
no	3	

#### 4. Mobile drug users in prison

by Sven Todts, workshop coordinator

Minorities –cultural, national, social- are over represented in prison systems all over the world. If a member of one of these minorities is also a substance abuser, than he or she has a double burden. Different (although not too many) projects have tried to tackle the problems of minorities in prison, and we can also point to many recent attempts to assist people with drug problems in prison settings. Only very few projects, however, have been installed to assist mobile drug users in prison. In fact, almost no countries have any realistic idea of the magnitude of this group in their prisons. In this report, we first give an overview of the different problems of mobile drug users in detention. Next, we present the results of a small survey on this topic, which was executed by AC-Company.

Table 1: Overview of the number of drug users and non-nationals I European prisons:

Country	Prisoners <sup>8</sup>	Prisoners/ 100.000 prisoners (%)	Non-national (%)	Drug users(%) <sup>9</sup>
Austria	6915	85	30.1	72
Belgium	8764	85	40.4	50
Czech republic	16643	162	1.1	
Denmark	3150	59	17	> 38
England/Wales	72669	139	10.4	69-85
Finland	3040	70	6.2	31-58
France	50714	85	21.6	32-43
Germany	78707	91	34.1	60
Greece	8343	80	45.3	34-66
Hungary	17890	176	5.2	
Ireland	3378	86	7.5	35-86
Italy	55136	100	29.5	> 27
Lithuania	9217	327	1.2	
Luxemburg	357	80	59.1	> 41 (IVDU)
Netherlands	14968	93	30.3	> 29 - > 41
Poland	83113	215	1.7	
Portugal	13384	137	12.1	62
Romania	47406	212	0.8	
Scotland	6417	126	1.9	18-43(IVDU)
Slovakia	7433	138	2.6	8.1
Slovenia	1120	56	17.8 (1)	
Spain	50656	133	23.6	31-70
Sweden	6089	73	27.2	60
Switzerland	4987	68		

##### 4.1. Drug users in prison

As table 1 clearly shows, European prisons hold large numbers of drug users. Although there are large differences, globally one third or more of European prisoners have some sort of a drug problem. EMCDDA estimates that a minimum of 180.000 and perhaps as many as 600.000 drug users pass through EU prisons each year<sup>10</sup>. Their problems are manifold and are well known to people working in the drug field, so we can suffice with a short overview:

Many drug users enter the prison “from the street”, without any connection to treatment services. Often they are in a poor state of health. Because of this disadvantage, they suffer even more from the unhealthy conditions in prison (overcrowding, TB and other communicable diseases, poor hygiene, poor diet) than other inmates.

<sup>8</sup> Numbers of prisoners, prisoner rate and number of foreign drug users: Walmsley, Roy , ‘World Prison Population List’, 4<sup>th</sup> edition, Home Office, 2003.

<sup>9</sup> EMCDDA, 2002 Jaarverslag over de stand van de drugsproblematiek in de Europese Unie en Noorwegen, EMCDDA, Lissabon, 2003. For Eastern Europe: reports from AC-Company members.

<sup>10</sup> EMCDDA, news release 29 august 2001, The challenge of drug users in Europe’s prisons, EMCDDA, Lissabon, 2001.

Research shows that an important number of drug users will diminish or even stop their drug use upon entering in prison. Others will continue their drug use, although the kind of drugs they take may change: prisoners tend to prefer drugs that numb the mind, like heroin, benzodiazepines or cannabis. Prison drug use can be more harmful than use on the outside. First of all, prisoners sometimes switch to more dangerous drugs or to more risky methods of drug taking. They can also get caught up in drug rackets and have to deal with violence and bullying. Finally and for a host of reasons, drug users are at risk of overdose upon leaving the prison. To give just one example: research has showed that when a male drug injector leaves the prison in Scotland, he has a chance of 1/200 to die a drug-related death in the next two weeks<sup>11</sup>.

Most European prison services offer at least some sort of detoxification upon entry. If more services are available, than they are most often drug free-oriented. Only a minority of European prisons offer methadone maintenance programs or other harm reduction oriented interventions. Needle exchange is still very rare in prison settings.

Only some countries have specific policies on aftercare: Sweden recommends after care services for at least twelve months, five other countries recommend after care for at least six months: Spain, Czech republic, Latvia, Malta and Portugal<sup>12</sup>.

#### **4.2. Foreign prisoners**

EGPA, the European Group of Prisoners abroad, estimates that about 40.000 Europeans are detained in countries other than their own. European prisons hold about 70.000 foreigners. Table 1 shows that there are great differences between countries. Because of migration, however, these figures are likely to increase everywhere.

Foreign prisoners live isolated from other inmates because of language barriers and cultural differences. They are also isolated from their family and friends, who live at a great distance. Even telephone calls will be much more expensive or even impossible. Because of this isolation, they experience more problems than other inmates.

Sometimes, foreign prisoners lack even basic needs. In many cases, prisoners rely on financial help from the family or on a prison income to supplement the basic diet with fruit, soft drinks etc.

Sometimes even toilet paper, tooth brushes or soap have to be bought. Foreign prisoners cannot rely less upon their families or partners to help financially. They also have more problems than others in receiving mail (which sometimes has to be translated first because of security issues) and parcels, which can be refused: France and Spain, for example, refuse parcels sent directly to prisoners. Foreigners have also less chance to work because of language barriers. The same problem prohibits them to take part in training sessions, to read books from the library or to understand radio or television.

Even more importantly, language problems (as well as cultural differences) can result in poor communication with prison health services or with psychosocial services.

Because of language barriers and unfamiliarity with a foreign legal system, the foreign prisoner has less possibilities to have his legal rights guaranteed. This can even mean that he or she is not aware of certain options available to foreigners, e.g. prison transfer or the assistance of consular services.

Finally, foreign prisoners have little or no support upon leaving the prison. Whether they stay in the country or return to their home country, in either case they will face serious problems. Sometimes prisoners are forced to leave the country where they have resided legally for years (and where they even may have a spouse and children) to a 'fatherland' that they don't really know and to which they have no ties. This is the so called 'double sentencing'. This practice of expelling (with or without deportation) exists all over Europe. In Germany, the practice seems to become more popular<sup>13</sup>.

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<sup>11</sup> Bird, S. and Hutchison, S., Male drug-related deaths in the fortnight after release from prison: Scotland 1996-1999, *Addiction*, 2003, 185-190.

<sup>12</sup> Turnbull, P. and McSweeney, T, 'drug treatment in prison and aftercare: a literature review and results of a survey of European countries' in 'Drug-misusing offenders in prison and after release', Council of Europe, Strasbourg, 1998

<sup>13</sup> Lorey, S., The practice of expulsion/deportation in Germany, KESH, 2000.

#### 4.3. Foreign drug using prisoners

Although no specific research has been done so far into the situation of drug using foreign prisoners, it is clear from the above that the combination of problems of drug users and of foreigners make this group very vulnerable:

- They have a higher chance of not being in contact with an outside agency upon entry, making their stay all the more difficult.
- They may lack the necessary support from family and friends. Research has shown how contacts with family are important, specifically for drug using inmates<sup>14</sup>.
- They may lack supplements of food, extra clothing or sanitary products, which are sometimes provided by family.
- They may have less access to medical and psychosocial care, while they are the group that needs this help most.
- They have less access to work, training and libraries, which results in more boredom. Boredom is one of the principal reasons of drug use in prison.
- They have less chance of getting bail or penitentiary leave, again resulting in a more difficult incarceration period.
- They are less likely to have their legal rights guaranteed. Some possibilities for foreign prisoners are denied to drug users (prison transfer), while they have to endure specific measures like double sentencing. Some of the possibilities available to other foreigners, may be denied to drug users: prison transfer is sometimes denied to drug users, while different countries refuse transfer when there are outstanding fines. Because drug users often have outstanding fines, they are hit harder by this measure.
- Because of the lack of resources outside, foreign prisoners are more at risk upon leaving the prison. Again, this is specifically harmful to the drug users among them, who are already extremely vulnerable in this period. The practice of double sentencing will only aggravate the situation.

#### 4.4. Legal Issues

##### Consular services

Foreign prisoners often don't know their rights. Because of that, it is important that they get assistance from their embassy as soon as possible. Consular assistance is therefore indispensable. The right to consular assistance is guaranteed in article 36 of the Vienna Convention on consular relations of 1963, which is signed by 114 countries. Local police or prison authorities have to inform a foreign prisoner without delay of his right to ask assistance from his embassy. Prison authorities have no right to refuse contact of the prisoner with his/her consul and the consul has the right to arrange for legal representation. Nevertheless, consular services have to refrain from taking action on behalf of a national who is in prison if he/she expressly opposes such action.

##### Prison transfer

There exist transfer agreements between states which allow that a sentenced prisoner completes his/her sentence in the home country. The purpose is first and foremost humanitarian: the prisoner can complete the sentence close to his family, without having to deal with language problems. Access to services and help upon release should be better.

The most important convention is the Council of Europe Convention for the Transfer of Sentenced Persons ("the Strasbourg Convention"), but there exist numerous other bilateral or multilateral agreements between states.

Under the European Convention, six conditions have to be met for a transfer:

1. The prisoner is a national of the administering (receiving) state.
2. The judgment against the prisoner is final and enforceable.
3. The sentence is of a duration of at least six months at the time of receipt of the request, or indeterminate.
4. The concerned person has to consent.
5. The judgment in the sentencing state must be punishable if committed in the administering state and the person who performed the act could, under the law of the administering state, have had a sanction imposed on him/her. It is not necessary for the criminal offence to be precisely the same under the laws of each state - there may be differences in wording or legal

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<sup>14</sup> Hennebel, L., Fowler, V. and Costall, P., Supporting families of drug-dependent offenders, ENDSP, London, 2002.

classification - however the basic idea is that the essential constituent elements of the offence should be comparable under the law of both states.

6. The transfer requires the agreement of the two states concerned. Each state must choose whether it wishes to provide continued enforcement of sentence or conversion of sentence. It must inform the sentencing state which of these two procedures it follows.

Under certain bilateral agreements, it is possible that prisoners are transferred to their home country against their will.

Generally, procedures for prison transfers tend to take a long time (one year or more). Drug users may not always be eligible for a number of reasons. First of all, drug use can be an exclusion criterion. This is for example the case in Italy. Further, drug users are often serving rather short sentences, not allowing enough time to organise a transfer.

#### Double sentencing (banishment)

As we already explained above, some states sometimes expel non-nationals after the completion of their sentence, mostly on the grounds that the persons involved consist a security risk to the nation or are a threat to public order. It is very difficult to get a realistic idea of the number of expulsions per year.

Banishment after sentencing is very problematic for different reasons:

First of all, it is against the fundamental principles of law. In a democratic state, the legal system offers every author of a crime the possibility to redeem himself and to reintegrate into society. By expelling foreigners, the possibility of reintegration no longer exists for them. Banishment also goes against the principle that one cannot be sentenced twice for the same crime.

Secondly, banishment discriminates. Not every foreign convict is expelled, and there are no laws governing who gets expelled and who not: it is solely the choice of the responsible minister.

Thirdly, banishment does not respect family life. The right to marriage and respect for family life is guaranteed by the European Convention of Human Rights. By expelling somebody who has often lived all his life in a certain country, he is completely cut off from his family.

Finally, banishment is not effective. Most of the people who are expelled from a country where they have firm roots will not leave the country, but will continue living there clandestinely. Even if they are deported, most will return. Banishment therefore will increase rather than diminish problems of public disorder.

#### 4.5. A first survey of potential problems of the target group in European prisons

Based upon discussions in the AC-Company working group on prisons, we questioned a number of official sources, local specialists and drug using foreign prisoners in different European countries on whether they thought that non-national drug users were disadvantaged compared to other imprisoned drug users. The very simple questionnaires are attached to this report. Since this is a first survey, not much attention was given to methodological matters. Some respondents (specifically prisoners) were interviewed, others just filled out the questionnaire. The questionnaires were translated locally by AC-Company members.

Number of respondents:

We got answers from official sources (mostly from the respective Ministries of Justice) from 7 countries: Sweden, Finland, Denmark, Slovakia, Italy, Greece and Belgium.

We got 14 answers from specialists (either in the field of justice or in the field of substance abuse) from 8 countries: Holland (2), Italy (4), Finland, Belgium (3), Luxemburg, Greece, Germany (2) and Ireland.

We got 70 answers from drug using foreign prisoners from 6 countries (Slovakia, Italy, Austria, Luxemburg, Germany and Belgium). The respondents had 22 different nationalities.

Because a significant number of interviews (36) were from one prison in Luxemburg, we excluded these interviews from the tables.

65/70 (93 %) were in prison at the time of filling out the questionnaire. The others were either under house arrest or free after a detention period.

49/70 ( 70 %) were legally in the country at the time of their arrest.

The mean time they were staying in the country was 7.2 years (from 10 days to 30 years).

##### 4.5.1. Opinions of prisoners (N=34)

We asked foreign drug-using prisoners if they thought that they had the same access as other drug using prisoners to different goods and services:

Table 2:

Goods/services	Yes (N)	Yes (%)	No (N)	No (%)	No answer (N)	No answer (%)
Food	29	85.3	4	11.8	1	2.9
Clothing	29	85.3	4	11.8	1	2.9
Medical help	25	73.5	8	23.6	1	2.9
Legal representation	24	70.6	7	20.6	3	8.8
Leaves from prison	17	50	15	44.1	2	5.9
Work activities	24	70.6	7	20.6	3	8.8
Study activities	24	70.6	7	20.6	3	8.8
Leisure activities	27	79.4	5	14.7	2	5.9
HIV/hepatitis testing	28	82.3	2	5.9	4	11.8
HIV/hepatitis treatment	16	47.1	11	32.3	7	20.6
Substitution treatment	12	35.4	11	32.3	11	32.3
Drug free treatment	6	17.6	16	47.1	12	35.3
Harm reduction (condoms, syringes)	13	38.2	6	17.7	15	44.1

As we already mentioned above, we did not include 36 responses from a Luxemburg prison. We decided to do so for two reasons:

- even though this first polling cannot compare to a thorough survey, more than 50% of responses from one small prison system, would distort the numbers too much
- the responses from Luxemburg are very peculiar, in the sense that with two exceptions (two times a respondent answered “I don’t know” to a question), all respondents answered “yes” to all the questions. Although we certainly don’t want to question the validity of the answers, they are not at all representative for the European situation.

#### 4.5.2. Opinion of specialists in the field of penitentiary drug use (N=14)

We asked the same set of questions to a group of 14 specialists. They are mostly working in NGO's that address drug problems in prison, or that have otherwise access to the target group. In some cases, the respondents were government employees (medical services, social services).

Table 3:

Goods/services	Yes (N)	Yes (%)	No (N)	No (%)	No answer (N)	No answer (%)
Food	14	100	-	-	-	-
Clothing	12	85.7	2	14.3	-	-
Medical help	13	92.8	1	7.1	-	-
Legal representation	10	71.4	4	28.6	-	-
Leaves from prison	5	35.7	6	42.9	3	21.4
Work activities	9	64.3	4	28.6	1	7.1
Study activities	8	57.1	2	14.3	4	28.6
Leisure activities	11	78.6	1	7.1	2	14.3
HIV/hepatitis testing	12	85.7	1	7.1	1	7.2
HIV/hepatitis treatment	13	92.8	-	-	1	7.2
Substitution treatment	11	78.6	1	7.2	2	7.2
Drug free treatment	7	50	2	14.3	5	35.7
Harm reduction (condoms, syringes)	10	71.4	1	7.2	3	21.4

We also queried this group about the possibility of prison transfers in their country, and whether convicts who were legal inhabitants of the country prior to arrest can be expelled after serving their sentence. We got responses on this item from 10 respondents.

Table 4:

Item	Yes (N)	Yes (%)	No (N)	No (%)	No answer (N)	No answer (%)
Transfer possible?	8	80	-	-	2	20
Transfer for IDU?	7	70	2	20	1	10
Information on transfers available?	5	50	4	40	1	10
Expulsions?	6	60	2	20	2	20

#### Opinions from official sources (N=7)

Finally we also queried 7 official sources with the same set of questions.

Table 5:

Goods/services	Yes (N)	Yes (%)	No (N)	No (%)	No answer (N)	No answer (%)
Food	7	100	-	-	-	-
Clothing	7	100	-	-	-	-
Medical help	7	100	-	-	-	-
Legal representation	6	85.7	1	14.3	-	-
Leaves from prison	3	42.9	4	57.1	-	-
Work activities	6	85.7	1	14.3	-	-
Study activities	6	85.7	1	-	-	-
Leisure activities	7	100	-	-	-	-
HIV/hepatitis testing	7	100	-	-	-	-
HIV/hepatitis treatment	7	100	-	-	-	-
Substitution treatment	3	42.9	1	14.3	3	42.8



Drug free treatment	6	85.7	-	-	1	14.3
Harm reduction (condoms, syringes)	5	71.4	-	-	2	28.6

Table 6:

Item	Yes (N)	Yes (%)	No (N)	No (%)	No answer (N)	No answer (%)
Transfer possible?	7	100	-	-	-	-
Transfer for IDU?	6	85.7	1	14.3	-	-
Information on transfers available?	6	85.7	-	-	1	14.3
Expulsions?	6	85.7	1	14.3	-	-

#### 4.6. Discussion

First of all, it is reassuring to see that the most basic needs (food, clothing, medical care) seem to be taken care of. As expected, prison leaves –often allowed to prepare for reinsertion- are more difficult to get for non-nationals (only 50 % think they have the same chances as other drug users in prison), because the chances that they would not come back are thought to be too high. Although this might be true, it certainly diminishes the chances of the target group to reinsert into society. Only 70% of prisoners think they have the same access as other drug users to legal representation.

Although testing for HIV and/or viral hepatitis seems to be equally accessible to all prisoners, treatment certainly is not, according to the prisoners: only 47 % think they have the same possibilities as other drug users.

According to prisoners, there are even more problems when it comes to drug treatment: less than 20 % think they can access drug free treatment as easy as the others. Another important find is the lack of information on therapy options: a lot of our respondents do not answer these questions (20% for treatment of viral infection, more than 30 % for drug free treatment and substitution treatment, more than 40 % for harm reduction measures).

The specialists (table 3) we queried are generally a little more optimistic about possibilities than the prisoners themselves, although for some items (work, study), they score less “yes” answers than the prisoners themselves. On the other hand, they probably overestimate the possibilities for our target group to get access to drug free treatment or harm reduction measures.

It is remarkable that a large part of the specialists (5 in the case of drug free treatment, 3 in the case of harm reduction), do not answer: again this could be an indication of a lack of information on these forms of treatment. The possible lack of equal access to legal representation seems to be recognised by the specialists.

The possibilities of prison transfer seem not be known too well by the specialists: 2 out of ten who responded to these questions think their country has no transfer conventions (while all the countries from which respondents come from do have them). Drug users are not eligible for prison transfer in Italy. One Italian respondent did not know this.

Some information on prison transfers that we got from our respondents illustrates the sometimes cynical ways of international politics: the agreement between the Netherlands and Morocco to transfer (illegal) Moroccan prisoners back to Morocco, was signed against a Dutch promise to buy Moroccan tomatoes.

Two respondents answer that their country does not expel people, where in reality these countries do. According to the official sources, only Sweden does not expel people after their prison time. It is another indicator that not enough people have information about this topic.

While in general expulsion is a measure to keep public order, in Luxemburg prisoners can be expelled after their stay in prison because they form a threat to public health.

Finally, the views of the official sources are the most optimistic of the three respondent groups. This does not mean that the answers would be distortions of the truth. Probably, there are only very few problems with equal access in theory: the problems arise though communication problems and cultural differences. Nevertheless, the problem with prison leaves is recognised. Again we find that treatment options seem to be not too well known.

#### **4.7. Conclusion:**

In conclusion, we find that (as predicted), there are huge differences between theoretical access to goods and services, and the day to day reality of the prisoners; While the most basic needs seem to be taken care of, there seem to be serious problems with legal representation and certainly with access to drug treatment services. Specifically drug free treatment seems to be difficult to access.

Although prison transfer will never solve all the problems of mobile drug users in prison, it could potentially help a lot to alleviate some of the more urgent problems. That is why it is a pity that specialists in the drug field do not seem to know much about it.

Not only does our target group have difficulties to access the regular services, there are also hardly any services or projects which are specifically targeted to some of the mobile groups.

Some Western-European prisons are taking measures to get some information across, e.g. by distributing information leaflets in different languages: Denmark, for example, distributes information to its inmates in 17 languages.

One group for which specific services are being created, are Russian-speaking drug users: prison projects for this group exist (or are in the process of being created) in Finland, Lithuania and in Germany. We suggest that the experience of all these services are pooled so that other countries can profit from them: as a newly marginalized group, Russian-speaking populations all over Eastern Europe (and specific in the Baltic region) are prone to drug problems.

Another group that could benefit from a coordinated approach are the Roma, which can be found in prison systems all over Europe. The Roma, possibly the largest ethnic minority in Eastern Europe, have economically and culturally been hit hardest by the fall of communism. Although alcohol use and solvent use was well known to the Roma, it seems that hard drug use was only introduced to them in the 1990s<sup>15</sup>. Not only is heroin use now widespread within Roma populations, it also goes along with high risk forms of drug taking. The importance of reaching this population in the prison systems is even more important than with other populations, since this group is because of important cultural barriers very difficult to reach on the outside.

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<sup>15</sup> EMCDDA, Report on the drug situation in the candidate CEECs 2002, EMCDDA, Lisbon, 2003.

### List of official services

Since 'non-national drug users' are not yet an identified risk group that should receive specific attention, it is not always easy to find out which person or service within the prison administration of a country is the most useful to contact in case of problems. Nevertheless, ac-company members have been able to identify some of these services in their country:

Belgium	Dr. Francis Van Mol Medical Director Prison Health Service Rue Berkendael 66 B 1190 Brussels Tel +32 2 340 36 20 Fax +32 2 340 36 21 <a href="mailto:francis.vanmol@just.fgov.be">francis.vanmol@just.fgov.be</a>
Denmark	Alette Reventlow Direktoratet for kriminalforsorgen Straffuldbyrdelseskontoret Strandgade 100 1401 Kobenhavn K
Finland	Leena Arpo Chief medical officer of the Prison Administration Criminal Sanctions Agency POB 319 00181 Helsinki
Greece	Ministry of Justice Correctional Department of Adults Mesogean Avenue 96 PC 115 27 Athens Tel 0030210 77 15 517 Fax 0032210 77 95 625
Italy	Mrs Pietrina Gagliardotto Ministry of Justice Prison department headquarters Tel +39 066 65 91 682 <a href="mailto:pietrina.gagliardotto@giustizia.it">pietrina.gagliardotto@giustizia.it</a>
Luxemburg	Mme Marie-Christine Perrigault Centre Pénitentiaire de Luxembourg Service Psycho-socio-éducatif Um Kielebiërg L 5299 Schrassnig Tel +352 35 96 21 1 Fax +352 35 96 21 357
Netherlands	Dr Auke van der Heide PO Box 31132 NL-2500 6C Den Haag Tel +31 70 370 26 55 Fax + 31 70 370 29 57 <a href="mailto:a.heide@dji.minjus.nl">a.heide@dji.minjus.nl</a>
Slovakia	Dr Jaroslav Janos General Management of Union of Prison and Justice service Bratislava Chorvátska 3 813 04 Bratislava Tel 02 5068 3220

Fax 02 5068 3270

Sweden

Ulf Jonson  
Head of Unit  
Swedish Prison and Probation Administration  
S-60180 Norrhoping  
[ulf.jonson@hvv.se](mailto:ulf.jonson@hvv.se)

**European organisations who target prison populations**

European Network of Drug Services in prison (ENDSP):

Cranstoun Drug Services  
4<sup>th</sup> Floor, Broadway House  
112-134 The Broadway  
London SW19 1RL  
United Kingdom

Email: [www.cranstoun.net](http://www.cranstoun.net)

Tel. +44 (0)20 8543 8333

Fax +44 (0)20 8543 4348

e-mail: [info@cranstoun.org.uk](mailto:info@cranstoun.org.uk)

European Committee for the Prevention of torture and Inhuman or Degrading Treatment or Punishment (CPT):

Secretariat of the CPT  
Human rights Building  
Council of Europe  
F-67075 Strasbourg Cedex  
France

Tel: +33 (0)3 88 41 39 39

Fax: +33 (0)3 88 41 27 72

*Email:* [cptdoc@coe.int](mailto:cptdoc@coe.int)

*Internet:* [www.cpt.coe.int](http://www.cpt.coe.int)

European Group for Prisoners Abroad

EGPA

p/a Unit Buitenland & Buitenlandse Betrekkingen  
Postbus 136  
3500 AC Utrecht  
The Netherlands

Tel. +31 30 2879 900

*Email :* [info@egpa.org](mailto:info@egpa.org)

*Internet:* [www.egpa.org](http://www.egpa.org)

**5. Mobility and collaboration in border regions**

By Jan Visser, workshop coordinator

### **5.1. Introduction**

During the 2002-2003 period of the AC COMPANY project, a working group described and analysed the special problems that drug users and the helping agencies face in border regions. In many border regions one can recognize mobility of drug users for different reasons (see the AC COMPANY website for further descriptions - "maps of mobility"). In a European context it is important to analyse the reasons of these movements, the effects of the local situation and the strategies to manage these effects.

In the European Union there are still great differences in drug policies between national states. That is the main reason why a number of drug users decide to go abroad, either for a short or for a longer period of time. This leads to many problems, for themselves, for the residents of the area where they end up, for the helping agencies, for health insurances, for the police and for the authorities. The problems are often of a bureaucratic nature, because the drug users use facilities that they are not entitled to use because they are not official residents of the city or area they visit.

We have focused on the different kinds of mobility. First of all we investigated regions where drug users cross national borders regularly, sometimes daily, because they want to benefit from a less repressive policy in a neighbouring country. These drug users live in a region where this border crossing activity as such is not unique, other inhabitants do the same: to go to work or to go shopping. We described the situation in the areas around Saarbrücken, in the border areas between Germany and The Netherlands and in the region around the Swiss city of Basel. Next to this phenomenon we analysed the special case of Luxembourg where drug users are able to go to rehabilitation treatment abroad. And in Bolzano in Northern Italy the foreign drug users are officially excluded from any help, which poses a problematic situation for them.

The working group explored the particularities of the border issues in these five different regions of Europe:

1. Saarbrücken – Forbach: information provided by Friedhelm Brill of the Drug Help Centre in Saarbrücken and Gerard Allard of the Municipal Health Service of Forbach,
2. German – Dutch border: information provided by Rudiger Klebeck of Binad in Muenster,
3. Basel: information provided by Rene Akeret of Swiss Aids Help and Walter Meury of the Addiction Help Basel.

We include two examples of special situations of foreigners abroad; although these are not border region descriptions:

4. Luxembourg: information provided by Pascal Bathasar of the Youth and Drugs Help in Luxembourg,
5. Bolzano: information provided by Kamila Jezerska of Drop In Drug Help Bolzano.

The aim is to describe and analyse developments on a cross the border on three levels:

1. how is the mobility of drug users; often it concerns commuters, that is to say: persons who cross the border practically daily to buy and consume in a country of whom they are no citizens. Because of that they do not have an automatic right to use the (medical or social) facilities of that host country.
2. we want to find out how projects who deal with these drug users collaborate cross the border and if they are capable of integrating their activities and make their offers available for non residents and foreigners.
3. We are interested in the reaction of the authorities, do they see the problems and do they help the projects by lowering or removing the bureaucratic barriers for help to drug users at the places where they happen to be. We do not only speak to local governments but also to health insurance agencies, to see if they are willing to extend their activities across borders.

### **5.2. Saarbrücken - Forbach: the development of a model for integrated co-operation in border-regions**

The German city of Saarbrücken is the centre of a region with a shared cultural and social history. Nowadays the French – German border runs right across it. Many of the inhabitants speak both French and German, and many cross the border on a daily basis: a lot of French people work in Germany for instance. Or they go shopping in the big city: Saarbrücken. The southern part of Luxembourg also belongs to this region, to a certain extent, as there are also many social and economical contacts with this country.

Drug users from these countries – especially the ones that live in a big circle around Saarbrücken - also see Saarbrücken as the central place in their daily life, to buy and consume their drugs. Many French drug users travel across the border every day, so they can be called commuters like their parents. Politicians, civil servant, health and social workers are combining their forces to deal with this situation in a structural way, that is why this region is of special interest to the AC COMPANY project.

The DHZ (Drug Help Centre) is the organisation that provides services for drug users in Saarbrücken. The project is situated just outside the centre of Saarbrücken and is located in an old factory. There are a number of rooms in the building, a lot of activity takes place in the court that is on the premises of the project. Social and health workers are the staff members and they receive about 250 drug users at a given day, 20% of them are French nationals. The basic offer lies in the area of health service and harm reduction. Basic health care is provided, drug rehabilitation support is offered by social workers and there is a needle exchange scheme. During the afternoon and early evening the drug users can inject drugs in the bathroom of the building, were 12 places for safe injecting are available. Until recently the centre was open during the night as a kind of shelter for the female street prostitutes who work nearby. And there were some beds available for persons who – for medical reasons – need a safe place to sleep. The basic philosophy of the project is not to force treatment and abstinence on the drug users, but to offer them options, like the possibility to do therapy with methadone in a hospital in Saarbrücken. Next to the native Germans there are two special groups that call for special attention. One consists of Russian immigrants, whose forefathers were Germans; therefore they can successfully claim German citizenship and can come to Germany and be a German citizen. Since the fall of the iron curtain, a lot of ‘Russians’ have come to Germany and the government placed them many cities all over Germany. Technically they cannot be called ‘mobile drug users’ as they live where they legally and administratively belong. But because of their linguistic, cultural and social difficulties and because of their economic deprivation they constitute a category of special interest for the AC COMPANY network.

The other special group constitute the French, who come to the centre of the region to buy and use drugs. Thus they come to the DHZ project and claim its services too. They cannot use them officially, as they do not have the German nationality. But sending them away would not be the right answer to this problem. The project staff believes that the right attitude is to help them were they momentarily are. Saarbrücken is the natural capital for many functions in the region, to deny and fight that is unrealistic. But as they have a different nationality, the drug users cannot automatically be integrated in the helping system. To face the direct problems of the existence of these French nationals, a French nurse comes to the DHZ project regularly to attend to the needs of his countrymen. And thanks to personal contacts between a social work colleague and a doctor of the French national health insurance, it became possible to be treated in Germany (Tholey: Schaumberger Hof). This is an important first step, a kind of precedent.

But for more structural solutions, fundamental legal and administrative obstacles have to be conquered. The primary issue is that the social security system and the health insurance systems are not compatible. When a French person is treated in Saarbrücken, the costs will not simply be paid by the French social security system. To change this basic bureaucratic logic, one practically has to orchestrate an administrative revolution.

In order to do so, an association has been founded, called Euro Ast. The members use this association as an instrument of pressure to lobby for legal and administrative reform. The grass root political work has been done at the communal level in both countries; and at this moment is on the table of the Minister of Social Affairs in Saarland and the Préfecture in Metz. A complicating thing is that the legal and state systems of France and Germany are very differently organised, the persons that can exercise authority do not work on the same level and the system of decision making is working so differently. But progress is gradually made and it might be a good example of European integration at work. At this moment it is already possible that French drug users are treated in Luxembourg and that the French national health insurance pays for the costs. Another complicating factor is that French drug users are used to the French policy that drug rehabilitation takes place in a psychiatric setting and climate. That is why they are suspicious of German offers.

So on a first glance it seems that the medical bureaucracy is rather rigid. But for Germans from Saarland it is possible to get detoxified anonymously in France; it is paid for by the Caisse Mutuel Universelle. This is thanks to the benefit of the French system that provides basic care for anyone, regardless of status.

And if a French person has worked in Germany and paid for social security, he will be able to get treatment in Germany.

The ideal of Euro Ast is that French and German citizens can find treatment where they are; and that the states will be covered by the insurances in their home countries.

The members of Euro Ast do not only want to integrate the financial aspects of social and health work amongst drug users, they also want to integrate the social and health work itself. One of the schemes that awaits to be realised – hopefully in the near future – is to open the facility of detoxification at the psychiatric hospital in Sargemund for all nationalities. The second stage is to allow the patients that have been detoxified to go to a living-community set up by the Emmaus organisation, where in a relaxed atmosphere of solidarity furniture is being made: the ‘Maison de la Liberte’. This structure is ready for use, Euro Ast is awaiting the go ahead from the respective judicial authorities, so that the costs can be covered. Then the ideal approach can be offered to drug users: first a detox and then a living community.

Another example of the international co-operation in the region is the development of a mobile project of needle exchange in the French part of the region. With the gift of a bus from the colleagues from Luxembourg, the French social workers hope to start soon an extensive project, where they will cover the neighbourhoods where drug users live. A large number of the drug users are from Algerian descent. Their parents or grand parents were brought to this region after the Second World War to work in the coal mines and the steel industry. Recently a lot of this capacity has been shut down, hence social deprivation in the area.

The association Euro Ast is working on the practical level in the direction of harmonising French and German drug policies in their region. The strategy is not to change the big political structures, but to stick to the practical level and – by thinking flexible – to look for and to develop practical solutions. In other words: to set up concrete projects for the direct needs of the clients. One practical success of Euro Ast was to persuade the manufacturer of Subutex (well known in France) to import it in Germany and get German doctors to prescribe it.

The latest development (fall of 2003) are that the DHZ has problems with the residents in the neighbourhood, and that the city of Saarbruecken is no longer willing to finance all activities. The German politicians want to exclude French drug users, even expel them from the city.

### **5.3. Binad: developing mutual understanding and cooperation along on the border of Germany and The Netherlands**

Binad is a project for cooperation between The Netherlands and the German state of Nordrhein-Westfalia in the area of drug treatment, prevention and policy. Initiatives are organised to set examples and stimulate mutual communication. This cooperation can partly use the also existing economically based cooperation between these countries (and Belgium) in the Euregio, that is focussed on economic issues. The execution of drug treatment policy is mainly made on the German side on the province level (Landschaftsverband) and on the Dutch side on the level of the councils. The treatment itself is done partly by private, partly by public organisations. The public health services are organised on a regional level in both countries. The police forces cooperate in various ways across the border. Local politicians only express interest in the drug issue when public order is threatened and the population becomes active. A permanent political theme are the Dutch ‘coffeeshops’, where cannabis is sold. German authorities do not like their citizens to go shopping there; and the Dutch politicians do not want too many foreign customers. But the border crossing element of drug policy does not seem to be high the political agenda on both sides of the border. Long term activities to improve border crossing collaboration is not funded, even though one could get additional EU money.

There is more political interest on the province level. For instance: KESH in Hamm (a low threshold treatment center is financed to also take German drug users who are repatriated from The Netherlands (often Amsterdam). It is generally expected that there will be budget cuts, because of the recession in the economy. The Dutch have terminated their financing of structural cooperation. And the repatriation

of German drug users has become more difficult to organise, because of financial cuts to the receiving project.

So although the politicians on the state, province and region level do acknowledge that cross border cooperation and exchange is worthwhile, they do not see that as a very important issue. Binad organises workshop of experts from both sides of the border; in the Aachen – Limburg area, the Kleve – Gelderland area, the Munsterland – Twente area and the Emsland – Groningen area. The following topics are discussed, with the aim to have a concrete follow up: to minimise German commuters of buy cannabis in Venlo, to set up combined information and prevention activities in schools and discotheques, to deepen knowledge on party drugs, to stimulate self help organisations (The Netherlands) and integrated treatment of alcohol and drugs. Not much structural activity is developing, due to budget problems.

The cross border collaboration can be build in two different ways.

1. On the basis of personal relations amongst colleagues, Binad is supporting this networking by bringing the relevant persons together in workshops and producing a periodical. The advantage of this method is that no extra money is required.
2. By building structures of cross border cooperation. There are three preconditions for this strategy:
  - a. On both sides of the border the various key persons have to share the same analysis and a common problem definition,
  - b. They also need to share a common (political) interest.
  - c. There must be funding available to build the structures. As described above, money is lacking; applications are made to the EU regional funds Interregio.

Given the current budget problematic the politicians treat these initiatives not as a necessary action to improve the efforts in drug treatment and prevention on both sides of the border, but as if it is something extra, on top of the existing national drug policy; as if it is a luxury issue that is dispensable.

#### **5.4. Basel: absorbing French and German commuters**

8 to 12 percent of the drug users in Basel come from abroad, some from Germany (Lorach area) but more from France, a total of 100 on a daily basis. They hang out in the scene during the day and visit the userroom (“Fixerstube”). There are 3-4000 drug users in Basel altogether, 1500 get methadone and 300 are in a heroin programme. The Swiss harm reduction policy dates back to the 80s: HIV was exploding, there was a large open scene and there was much drug use amongst Swiss youth. The political need arose to react effectively, even if necessary in unusual ways. The politicians believed that it was a temporary need. But the policy became structural. The additional advantage of the user room is that social workers can early detect and contact drug users.

The French have a need for syringes. Swiss drug users from other Kantons (autonomous provinces) also come to Basel, an estimated 10 – 15 percent. The city tries to discourage all these users from outside the city, but as long as there are not many it does not pose a great problem: there are allowed to use the harm reduction facilities of Basel (although it would welcome a financial contribution from the other Kantons, France and Germany).

Whenever the number gets too high in the eyes of the Basel authorities, the police will intensify its border control. But on the whole there is no constant repression of foreign drug users. This has been decided on the Kanton level in 1993/94. The drug project workers will notify the police when there is an increase of foreign drug users, so they can take action and keep the number of these commuting foreigners on an acceptable level.

The vast majority do not stay overnight in Basel. A German social worker from Lorach and a medical doctor from France visit the drug projects regularly. The drug-criminality has diminished because drugs have become cheaper.

The commuting of drug users does not create an uproar within the general public; possibly because large numbers of French and German workers commute daily to Switzerland. The crossing of borders is a normal phenomenon. It is acknowledged that Basel is the natural center of their ‘life world’ for the French and Germans who live in this border area.

Protest against foreign drug users has risen somewhat recently, due to the shrinking of services for drug users (budget reasons). These services consist of the user room, needle exchange, a cafeteria, anonymous first medical aid. For the drug users from Basel there is also the possibility to get a meal, a crisis night shelter, a day centre, methadone and a controlled heroin programme. This is not considered by foreigners, the treatment costs are relatively high in Switzerland. The national health insurance will



not pay, so only if one has private resources this will be possible. (From Luxembourg one client went to Switzerland).

On the policy level there have been tri-national conferences and there is collaboration with prevention activities. The staff of drug projects meet on an informal basis. France and Germany are not prepared to pay for the costs of their drug users in Basel.

But all in all do the foreigners not pose a great problem, also because they are not considered 'very' foreign; as cross border commuting is traditionally common. In the case of incidents or when the number rises rapidly, social and political unrest will arise though. Since 1998 there has been no great policy change, the politicians are passive and hope that the number of users will not rise. But the nature of drug consumption has changed: more cocaine and poly drug use.

There are no Eastern Europeans in Basel, they can be found in Bern. Asylum seekers from the Balkans use drugs as self medication against their war traumas. Being asylum seekers they are not allowed to work, which increases their vulnerability for drugs and alcohol.

### **5.5. Luxembourg: buying rehabilitation abroad**

The "Jugend und Drogenhelfer" has a shelter as a daily centre for drug users in Luxembourg.

Luxembourg exports its steel, banking business and diseases.

It is a common use for ill people from Luxembourg to go abroad for treatment. The funds that finance it are used to it, so it is a natural option for drug users to. Here are the main arguments:

1. There is only one therapeutic centre in Luxembourg (Manternach), if one looks for privacy one will have to look for a more anonymous option.
2. The waiting list is in general shorter for foreign treatment centres, and choice for an alternative is bigger.
3. The client can find a kind of treatment that suits him or her best; the large choice of alternatives makes it possible to look for instance for psychosomatic or double diagnostic treatment places.
4. All the costs are covered by the health funds.
5. In Luxembourg we find drug users who have a background in Portugal, Belgium, Italy, Germany and France. Clients that have these foreign backgrounds can look for a treatment address in their country of origin (or actually that of their parents).
6. For the Health funds it has a financial advantage: treatment abroad is cheaper.

The drug help project in Luxembourg refers the clients to both inland and abroad, Manternach has 23 beds, that would be too few. The clients are informed of the possibilities abroad so that they can make a calculated decision. Before they can go to a therapy centre, the clients must go to a hospital in Luxembourg for detoxification. A psychiatrist then sends a request to the social assistance fund. Another doctor and a social worker speak with the client about the possible treatment centres. The first period is three months, but that can be extended. And after care for a month is possible after the therapy. If the client interrupts the therapy regularly, then treatment abroad is no longer permitted. Although this system is a welcome extension of the possibility in Luxembourg, the potential negative aspects must not be forgotten:

1. the client has limited contact to his or her family during the therapy abroad
2. the after care in Luxembourg is not prepared well.
3. the diplomas or certificates of education abroad is not recognised in Luxembourg.
4. reintegration into the job market is difficult to achieve.
5. it is nearly impossible to look active for housing.
6. the social worker can maintain contact when client goes into therapy in Luxembourg, this contact is most of the time lost when clients go abroad; so follow up of treatment and reintegration is much more difficult.

### **5.6. Bolzano: the gateway to the South**

Bolzano lies in Tirol, and is the first larger city when one comes by train from Austria. For Eastern Europeans who are looking for work (harvesting fruit) it is a stop over on the way to Rome, Naples or Sicily. Most of them are not drug users on arrival, they start using in Bolzano or in the south of Italy. It is a bilingual city, some Italians do not speak Italian, they will be allowed by their health insurance to go to Austria to get treatment. This goes also for Italian drug users. The therapy is shorter than in Italy. Some Eastern European, like the Czech, stay in Bolzano. They are not actively prosecuted, although

they are illegal. They can visit the drug project and they can get simple medical treatment. The judge does not give them a sentence when they beg for money on the streets, but drug dealing will lead to deportation. The Drop In centre has to abstain from help to non citizens of the region, the Italian law says so. It is therefore more and more difficult to give them even the basic medical support. This is the reason why Bolzano is the least optimistic example of cross border policy. Non EU drug using citizens have an even harder time to survive and they are excluded from the medical and drug rehabilitation services. A grim political reality.

### **5.7. Conclusions: preconditions for effective cross border collaboration**

Cooperation along European borders is far from optimal at the moment. In many regions there is no cooperation at all, or – as described - exist only under great financial and political pressure. At the moment, there is nowhere an integral, common system of the drug helping agencies on both sides of a border.

The analysis of the stories in the border regions showed us that there are some common features. When we focus on the preconditions that facilitate a better and improving cross border support system for mobile and commuting rug users we are able to mention the following elements.

1. There has to be a tradition of intense contacts beyond the border, there has to be experience to solve mutual problems on a regional level.
2. One has to take into consideration the different cultural, political, medical and administrative structures (for instance centralised vs decentralised); and one must be willing to find ways of linking these structures.
3. On the political level there has to be a climate of tackling issues in an experimental, “risk taking behaviour” way and one should be able to think in international dimensions.
4. this way of thinking also has to be flexible, one has to be ready to analyse the changing situation and be prepared to find new solutions. The border region is often an area where new development occur first.
5. One has to realise that because of that there will never be a stable situation; there is a danger that when additional problems arise, the residents or the politicians will fall back on old policies.
6. Aims and strategies of the cross border cooperation have to be published regularly, to create political clarity and to inform the public in order to get its support.
7. To develop solid collaboration there have to be good personal relations and networks between key persons (political, medical, social) on all sides of the border. This is often overlooked, as one tends to think that formal structures are decisive in shaping new possibilities. But maybe on the contrary, unless there are good personal relations between functionaries on both side of the border, who are willing to take a change and stretch their official competence, no renewal of structures will take place. It seems that laws and regulations will only be passed after daring officials have tried out new paths in their everyday practice. Creative and daring minds lead the way.
8. Money has to be available for the funding of activities; preferably from all involved countries. Sometimes money from one of the countries will do, as that country might have the biggest problem.
9. The exchange of experiences and collaboration with colleagues in other European countries, who work in similar situations, is very fruitful. Especially when this is facilitated by additional funding through European programmes

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## **6. Immigration and drugs**

by Enzo Crolle, workshop co-ordinator

*This report is based on findings of the immigrant workshop of the project.*

## 6.1. Introduction

Groups of people who migrate from one country to another have always been recorded since the beginning of civilizations. The big differences of life conditions in the different countries made mobility more significant.

The majority of the “regimes” who took power in the post colonial period has been of dictatorial and authoritarian kind. People facing persecution and oppression in their native countries because of their race, religion or political beliefs, the one who live in great poverty and with no hope for the future looks at European nations as lands of opportunity.

The increasing economical differences between poor and rich countries and the consequent request of a more even redistribution of wealth; the uneven demographic increment at world level. The widespread integralism and phanatism.

All this elements had played in favour of an escape from more disadvantaged countries.

The increment of migration in the last years found many Nations unprepared and has given way to a reaction from part of the populations, which did not see as positive the arrival of a great number of people. There is a general feeling of insecurity and the foreigner is looked upon with suspicion and fear. In some European countries, without a tradition of multicultural civilization, this perception is even greater.

The tragedy of September 11 had a significant impact on future developments, even if changes were already mature. A trend of reaction has taken place and, from many sources there are requests of stricter laws and harshest legislations.

A proof is the common tendency in many European countries, and not only, in which we can see a general switching by many governments towards more conservative laws with all the related consequences.

Our working group decided to focus, in particular, on studying people coming from countries outside the E.U., since the movement of European drug users within Europe is significant, but not as much in terms of number and modality as the extra-European one.

Generally speaking, the two groups with a more numerous presence and, consequently, of particular interest as regards to our research were the one from the Maghreb region (Morocco, Algeria, Tunisia) and the one from East European countries. .

It is also important to say that immigration from Eastern Europe has reached big proportion and with the next integration into the E.U. of a number of Countries this will give us increasingly substantial numbers.

There has always been a certain difficulty to have access to accurate data regarding migrants and particularly concerning the one who use drugs.

The opinion is that: First: the majority of the data does not correspond to reality.

Second: the data is generally lower in percentage of what are the common beliefs and /or the perception of the population.

Going back to the two main groups (North Africa and Eastern Europe) we can see that the first is particularly large in Mediterranean countries such as Italy, France and Spain and also in the Benelux. People coming from the East in increasing numbers are beginning to settle down all over the Continent. Shall we stop for a second in order to understand the differences and the relationship with drugs.

## 6.2. Countries, regions

In **Italy**, immigration is a relatively new event and we will have to talk about first, or at the most, second generation.

The ever increasing difficulties and laws such the Bossi-Fini have made life for foreigners very hard. According to the “Caritas” in 2002 the 4 nationalities with the biggest presence in the country were: Morocco 20%, Albania 15-20%, Romania 10-12% and Nigeria 7-8%. In 2003 the immigrants from the ex Soviet Union and from the Balkan regions are catching up fast.

It is difficult to say about drug related mobility, however a large part of illegal foreigners coming from Morocco, Albania, Romania and Central Africa are involved in the drugs market, generally as small or medium dealers and quite often as users.

Popular destinations for Italian drug users are the Netherlands, Spain, Germany, Switzerland and England.

An unpublished report of October 2000 prepared by a mixed commission from the Ministry of Justice and the Municipality of Turin, Concerning the IPM (Penal Institution for Minors) and CPA (Centro di Pronta Accoglienza) named “Ferrante Aporti” reports that approximately 82% of the minor prison population is made up by foreigners (28% gypsies) and 38% were involved in drug crimes (mostly as dealers). In the opinion of the Director of the institution, most of them were also drug users.

At the time of writing the proposal of a new law on drugs has been completed. It implies no distinction between hard and soft drugs with a clear indication of a minimum dose after which the person involved will be accused of dealing (the doses are extremely low, for example 0,250 mg. for cannabis). The guidelines are stricter than the one of the Vassalli- Jervolino law of 1990, which was modified by the referendum of 1993.

**France** has a long history of immigration, especially from North African countries and ex-colonies. This has led to more integration and also more services, including the one drugs related. Anybody has the right to health services and drug treatment is free and anonymous but not so for HIV treatment. Policy makers have given particular attention to the phenomenon of the “new drugs” with the setting up of numerous projects.

“Medecins du Monde” is probably the busiest organization in this respect. I could mention that exist a popular service, which assist people and test pills in Bayonne, near the Basque countries, where there is mobility of young people to and from Spain.

M.d.M. are also present in most of the raves which take place in the French territory, again with the important and organized “pill testing”. They also have a project directed in particular to North African drug users that in the city of Marseille are present in prominent number.

The drug users group ASUD have a long history in this country and fight relentlessly in the name of the auto determination of the person using substances.

“Espoir Goutte d’Or” is a project based in the homonymous district of Paris and is known that amongst their clients, North Africans (Maghrebians) are the largest group together with Black Africans and Black Carribeans. French and other E.U. nationals are in the minority.

French drug users don’t move so much from the country. Rotterdam used to be a popular destination, but not anymore. In Amsterdam they form a restricted group as they do in London.

**Spain** has a similar situation to France in terms of availability of treatments, even if lack of funding contribute towards a far from ideal situation.

Similarly to Italy, a couple of years ago, there was a lot of talks about the necessity of opening Users Rooms and the ever increasing needs of Harm reduction programs but it appears that, at the moment, the situation is stalled. At present the only official User Room is in Madrid.

There use to be an open drug scene in the area of Can Tunis in Barcelona, where many illegal drug addicts use to congregate. The Police tolerated the use of drugs in, and immediately close, the Mobile Unit of the Health Services, but not long ago the area has been close.

Also in Barcelona in the “barrio La Mina” there is tolerance on the open use of drugs.

In here we can see a great number of users from the Roma community. This is a group firmly established in the South of Spain. In Andalusia they have rooted for a long time and the use of drugs within their community gave input to the setting up of a few projects in the area.

Methadone programs are easily accessible to everybody and (as an example) we found a ready response in the cases of repatriation of Spanish citizens from the Netherlands.

Mobility of Spanish drug users is quite significant, particularly towards the northern European countries like Germany and Great Britain.

There is a conspicuous movement across the border to France and also in the opposite direction of young people involved in the rave scene.

At present, the entry of illegal immigrants from the African continent through unsafe routes is a much debated subject. Mafia organizations are involved in the trade. This is a very similar situation to the one we see in Italy.

The Search project (Drug prevention for Asylum Seekers, Refugees and Illegal Immigrants) point out in his report that at February 2002 there were no addiction prevention programs in Spain specifically developed for immigrants and their children where their language is used or which are specifically oriented to their cultures and their most important needs.

South American national’s lives in Spain in significant numbers and cocaine use is high in percentage amongst this ethnicity.

I will mention the situation in Amsterdam as an example of what is happening in **the Netherlands**. (see report “North Africans in the Netherlands”) There is no possibility for a foreign drug user without insurance to have access to a substitution therapy or, most of the time, to the most basic medical assistance, being this person European or not.

The general approach and way of thinking related to this issue is “go back to your country”.

And this is obvious when the Health Services agree to give Methadone only in case of repatriation. But when we are faced with the issues that brought the person to leave his/her own country, in first instance, then we will realize that, many times, their return is not an option. So, we are left with a

whole significant target group who is merely trying to survive in the streets with all the related criminal activities which, so much, society as a whole tries to counteract.

Thus the Italian, French and Spanish laws are less restrictive and (for example) an illegal Moroccan in Rome will have the possibility of accessing anonymously a methadone programme through a particular Ser.T. or a certain organization. Furthermore, in Paris, depending from the funding is left to the discretion of the corresponding services of the various "arrondissement" the anonymous take in charge of any single addict.

People from the ex-colonies (Suriname and the Netherlands Antilles) and from Moroccan origins are involved in drug use and small-medium size trafficking in a higher percentage than the average.

The flow of drugs mobility is very significant towards the country (but not as it use to be 10 years ago) while is almost non-existent from the country in terms of drug users of Dutch origins.

Obviously if we talk about drug smuggling then the picture is very different having Holland an important position in the map of drug trafficking.

Cocaine in the Netherlands is the most popular drug, smoked as a free base or injected as a speedball together with Heroin. It is important to mention that many foreigners who started to use heroin in their home country, once arrived, change their habit, mixing it almost always with coke.

Our colleague from Rotterdam who works closely with asylum seekers reports

that "the political debates on immigration are very impassioned on the acceptance of new migrants.

The real meaning of integration is total assimilation to the Dutch life and society; the expression of cultural differences is not popular anymore".

**Belgium** is a very multicultural country where numerous ethnicities are represented and is mirroring this condition also in the problematic of drug use.

There is a growing susceptibility towards the problem of illegal migrants, which tend to increase in times of economic depression. This trend is reflected by the popularity of the extreme right nationalistic party "Vlaams Blok".

As a reaction, a counter movement, the Arabic European League, came up last year in Antwerp, defending the position of Muslim people in Belgium. Around the 9% of the population has foreign nationality. In the last three years the biggest number of request of asylum came from Russians, Congolese and Serbians.

Moroccans are the second largest foreign group (other E.U. nationals form the largest).

So we noticed that, aside the extra-Europeans, drug mobility is composed by many people of different E.U. nationalities, covering the all continent as we can see also in the Netherlands.

At the moment there is a marked intolerance towards drug users and sex workers.

The drug using patients seen by the AC COMPANY partner Free Clinic in Antwerp in 2002 were 477. Of those 32 were Moroccans (6,71%) 17 from Portugal (3,56%) 12 from Turkey (2,52%) and then many other foreigners in smaller percentages.

The Free Clinic, with the financial support of AC COMPANY, started a project directed to Russian speaking clients in the city (see report "model of good practice").

**Luxemburg** see an interesting situation. There is historically a big community of Portuguese immigrants and amongst them a significant number of drug users who stay a reasonably long time, also in the hope of finding shelter and possibly work.

This is in counter tendency with the mobility of German, French and Belgian drug users, who cross the border to buy heroin or cocaine, stay a few days and then go back to their countries.

The Reitox National Focal Point reported that 3 years ago the 51% of foreign drug users in treatment were Portuguese.

No mobility from the country except sometime to the Netherlands, but not for a long stay.

The official number of register drug addicts is 307 and in 2002, 672 persons asked for asylum.

On a political level there is a tendency of simplifying the procedure for a permit to stay in the hope that there will be less illegal immigrants.

**In Germany**, almost one third of the population categorized as foreign is Turkish (about 2 million people). Is thought that drug use (especially heroin) is higher amongst the second generation and that drug use begins at an older age than amongst Germans, due to "culture, family" factors.

German nationals are moving all over Europe and so do the users. Holland is a particularly clear example when we consider that many German addicts established themselves in this country since a long time. Drug immigration into the Nation is also a fact.

Many come from E.U. countries, but here is where drug migration from Eastern Europe is consistent. For two main reasons: the first is geographical, that means the vicinity to Poland and Czech Republic and the other is the relatively liberals policies.

There is a considerable number of Russians and is reportedly said that little is known about drug use amongst them, but a couple of things can be mentioned.

One is that severe problems of dependency had mostly begun in Russia and the other is that opiate use is by far the most common. We should also mention the Russians of German origins, who come to Germany in great scale. Drug use in this group is very problematic and to approach them is very difficult. (see report 2002).

Deportations from the country are common practice in case of drug crime and we had some clear example of Italians, born and raised in Germany that, because of their drug related crimes, were obliged to leave (deported) forever.

Outreach work is well developed at national level and is oriented to both demand and harm reduction. Local organizations and self help groups were the first to implement outreach work in Germany. Most cities have outreach teams targeting both, users of "old" and "new" drugs, and in recent years a number of Crack projects has also been set up.

In 2001, a new law was introduced in **Greece** (2910/2001). According to this law the Ministry of Interior Affairs is in charge of the Immigration Policy and every district establishes its services for foreigners and immigrants. The opinion of the services involved with foreigners is that the law will bring much more bureaucracy and make things more difficult for people who stay illegally in the country.

No significant presence of North Africans is detected in the country, where the Albanians represent the biggest group of immigrants followed by Bulgarians and Rumanians.

There are a few organizations targeting this group of people with project starting to be set up for them. For what drug use is concerned there is a great lack of services and a marked stigmatization of users. The waiting list for a methadone programme is still in the order of a couple of years with all the problematic involved.

Greece is a country of transit regarding drugs. There is no much of mobility in the two directions. Mostly the users who come into the country do so in the summer period and are part of the travelers who flock into this area. Users of Greek nationality are found in the Northern European countries but not in big numbers.

**Portugal**, where there is an awareness of the drug problematic, waiting times for treatment are almost not existent and generally the Health Services are functioning, even if there is not an homogenous efficiency.

The people from Ukraine are in big numbers (65.000 legalizations in 2002), but, apparently they are seldom touched by drug problems. It is reported that alcohol is a major problem.

Drug use and abuse is much more common within the immigrants from the ex-colonies, Angola, Cape Verde etc. Street dealing and trafficking is a strategy for survival for many individuals of these African countries.

The Roma population (which is the second after Black Africans) has many problematic drug users, some of them as young as 10. Services believe that, in terms of treatment, the Roma community is more receptive to family therapies rather than individual.

There is a drug mobility between Portugal and Spain and is more evident towards the second country, even if prices are similar.

Portuguese drug users are numerous in Benelux and Great Britain.

In the Scandinavian Countries, where harm reduction has historically been accepted with some difficulties there are not steps forwards towards an approval of such approach, with the result that recently Oslo topped the European cities in terms of overdoses.

Perhaps this can be related to the fact that is common practice to use, together with heroin, high doses of benzodiazepine and alcohol.

In **Norway** the waiting list for treatment, included Methadone maintenance, is very long for a citizen of the country. No wonder that we should expect insurmountable circumstances for an illegal foreigner.

The drug using street scene in Oslo includes injecting heroin users from Iran, Iraq, Pakistan, North Africa. Qat is used amongst Somalis. Problematic use is hidden within the communities. Little research has been conducted on these issues.

Still in Oslo there is a bus distributing clean injecting equipment and is estimated that 5% of the clients is from the above mentioned nationalities.

It is common opinion that people from the ex Yugoslavia and the Maghreb regions have a central position in drug related activities.

**Sweden** has a similar situation with a bigger number of immigrants but has always had the reputation of a very tough country regarding the drug policy. Needle exchanges schemes are not allowed and you can not buy needles or syringes in the pharmacies (except in the Malmö area) so people must buy it illegally. Due to the strong stigma that foreign groups encounter in asking for help in Sweden, drug use amongst them, many times, is hidden within their communities. This is particularly evident if we take as an example the Ethiopians who live in the country. Asians are by far the largest non-European group. Their pattern of drug use is very difficult to identify but it appears that people addicted to drugs are in very small numbers. Sweden is where the ideal of a society free of drugs is very much alive and due to this fact we can see a growing mobility to neighboring Denmark.

Mobility of users to **Denmark** comes mainly from Swedish and in less respect, German nationals. Germany is the main destination for the Danish. No big numbers of foreign users are recorded. Heroin is the most common substance available in the streets. As in other Scandinavian countries Qat use is common amongst the Somali but they are never seen by the Danish drug system. Eskimo form a vast community being Greenland a Danish territory and they are much more involved in alcohol consumption than drug using.

In the nineties **Finland** became a country of immigration. In 2002 there were about 160.000 residents of foreign origins (difficult to know about the illegal but is estimate that they are in lower percentage than in most of the other European countries). Approximately 40% of the foreign community is from the former Soviet Union (many from Estonia). (see report of the Finnish AC COMPANY partner.) Swedish citizens make up the next largest group. The foreign community is only the 2% of the population; this are small numbers in comparison to other European countries, but is growing. The Somali, ex Yugoslavian, Iranian, Iraqi, and Turkish forms the new groups. The main principles for drug control are in a law of 1994. Parliament passed a government initiative on drug offences in June 2001. Consumption is now differentiated from trafficking (they were categorized in the same way in the former version). Some harm reduction programs including needle exchanges have taken place in recent years. If then we go into the British inlands we notice that politicians have taken a clear stand. Immigrants are needed (as they are all over Europe) and they are not recognized as a problem in first instance, which makes Great Britain a preferred country of immigration (about 170.000 legal and 30.000 illegal immigrants a year)

Concerning drug use, there is a noticeable culture of solving things within the communities. An example are the Bangladeshi, Indians, Pakistani and Somali using drugs in **Great Britain** or the Nigerians in **Ireland**. They are practically only approachable by native workers and there are a few services targeting their issues. There can be a series of reasons for such behaviors. Stigmatization by their own communities is certainly one of them. Fear of relentlessly getting in trouble with the Police is another one. There are researches that report that Bangladeshi drug users are sent back home by their families rather than getting in touch with drug agencies. There are some services that work with a high number of drug users from Italy, Spain and Portugal. The ever increasing popularity of crack is a daily occurrence in the streets of London, Glasgow and everywhere in the country. Crack cocaine was introduced by the Yardies, the Caribbean criminal organization, and is still identified with them. Solvents are also used by the youngest and poorest. In the East End of London some doctors prescribe injectable methadone on very high doses. Heroin is used amongst Arabs from the Middle East. I should mention that, in Amsterdam, we have the experience of frustrating cases of British citizens wanting to go back to England into treatment and having to face enormous bureaucratic problems because of the Habitual Residence Test (Ac-company has published a report on this subject). Also, in Great Britain and Ireland there are more and more immigrants from Eastern Europe with persons from the ex Soviet Union representing the biggest slice. They are very often employed in building construction (employed is probably not the right word since, most of the time they are paid cash in hands) and they have a reputation of being good workers. It is early to say what their exact involvement in the drug world is. The largest groups of immigrants are Indians, Pakistani and Black Caribbean.

In these countries the Moroccan community is integrated. These are similar conditions to the one seen in the Netherlands, which has a long history of immigration and people being there for generations. Few illegal immigrants from North African countries go all the way, up north, to Britain. It is too difficult also in geographical terms.

**Switzerland:** In the past election immigration was an important topic, and the result has been that the centrist parties (CVP, FDP) lost many seats to the far right party (SVP). At the same time the left wing parties won as well. Basically there are now two huge poles (left/right) and the result could be that political adjustments will be difficult to achieve.

Early to say what the repercussions will be on a country that is at the forefront of a liberal politics on Drugs. Users Rooms and heroin programmes are well established in the country.

A revision of the drug law is in the agenda.

For the Swiss population methadone treatment is easily accessible and there are differences within the several Cantons. Drug users commute in the border regions of France, Italy and Germany

Neighbor **Austria** has already adopted though measures since two or three years.

This is another example of a society going towards a more pragmatic approach but suddenly deciding of being more repressive. There is hardly drug related mobility in or out of the country. A Phare twinning project between the Czech Republic and Austria, aiming to strengthen the Czech drug policy came to a close in 2003. (Emcdda news).

This collaboration resulted in a fully established and operational national focal point in the Czech Republic, which now acts as the national drug-monitoring centre.

In Eastern Austria a specific fact is that most of the "street dealers" are asylum seekers from Nigeria whose request has been rejected.

Immigration from **Eastern European** countries is the most noticeable phenomenon of the last few years and it will keep developing more and more in the future.

Therefore we will need to study the causes in depth, in order to be able to give realistic help to many people that, by leaving their own countries in search of a better future, will eventually find themselves aiming to an impossible and frustratingly unachievable dignified life.

In the last few months I can say that in Amoc (Amsterdam) an increasing percentage of our clients is made out of persons coming from practically all the eastern European nations with a prevalence of Rumanian, Polish and, lately, Russian citizens.

On a more general level can be said that their pattern of drug use once in Western Europe is still difficult to describe with accuracy being the phenomenon at the early stages. But there are signs that is following the lines already seen in the North African communities.

That means a first phase of approach to the substances through a small dealing favored by criminal organizations, which includes people from both Eastern and Western Europe.

The small dealing, at the beginning, is mainly done in order to have a source of income and many times leads to the person involved starting to use the substance.

Every single country can have different situations in respect of this heterogeneous group of people because a crucial factor is the way they can relate to different culture and nationalities. In the Netherlands, for example, they are younger and use more drugs than what they do in Italy where they are older and use more alcohol.

### **6.3. Conclusions**

We can therefore certainly say that mobility, and that implies also drug mobility, is on a fast rise. The implementation of the approaches planned for drug users in need are even more complex for drug using immigrants.

Things are not easy for foreign addicts living in the different countries of the E.U.

The expectation is that those persons, worn out by the difficulties, at the end will go back to their own countries. There are talks about repatriating more people. But how can we encourage them to go back to a place that they left because the future looked so difficult? Where do you send them when most have no papers? And what about the one that, for a series of reasons, can not? This approach is in contradiction with what a Europe of personal rights and free circulation should dictate since I am also talking about deportation of E.U. citizens.

Auto determination of the person is the key word for us in our assistance in terms of repatriation.

Funding has been cut everywhere and, translated into the daily reality it means that the possibilities of starting new projects, or even continuing the existing one, are increasingly slim.



There are only a few services for illegal drug users, and, if we consider that Europe, on a world level, is the most sensitive continent towards this problematic, then we could have a general global picture. More researches would need to be done on the legal possibilities and rights of a person in need of medical assistance. At the moment there are different interpretations and approaches in the various countries. Shouldn't that been everywhere the same?

Harmonization of the policies and strategies on drugs within the European Community should be a priority.

Our recommendation is to focus on the possible implementation of new services seen the enormous importance of working with flexible approaches. These services will function more effectively if specifically taking in account the nationality, culture, values and problematic of the person who require assistance.

It goes with it that the employment of worker from the various ethnicities could be a very effective tool in approaching the one who most needs help. Cultural mediators should also been involved. Integration based on the respect of the single cultures and religions is a must.

#### **6.4. Model of Good Practice**

As a model of good practice we describe the project “**Senza Frontiere**” (Without Borders) initiated by the **Fondazione Villa Maraini** one of the Ac-company partners in Italy.

The description regards the activities of the first year up to 03/02/2003.

It does show that many things are possible when there is the full commitment and belief of the persons involved.

The project is financed for three years by the “Ministry of Work and Social Politics- Department of Social Politics” and is currently in his second year.

The coordinator of the Project “Senza Frontiere” is Roberto Chiarelli of the Fondazione Villa Maraini of Rome.

##### **“Senza Frontiere”**

*a project by the Fondazione Villa Maraini of Roma*

##### **Description of the activities and the objectives achieved**

The project called “Senza frontiere” (Without borders) has begun the 4/2/2002.

After a first organizational phase, three different typologies of intervention has been activated:

- 1) Mobile Contact Unit;
- 2) Low threshold Center;
- 3) Consultations targeting extra-European people, detained or with juridical problems related to drug use.

##### **Mobile Contact Unit**

In the first phase, through an informative campaign, we wanted to inform the existing structures in the area,

being these the Public Services (Institutions, Ser.T., Social Services) or those private (bar, pharmacies, hotels, cinema, taxi stands, social centers).

We contacted the structures present in the area (House of Social Rights, night shelters, drop in, Caritas). All institutions who deals with drug addict, homeless, young users; offering our collaboration.

The Mobile Unit, in the first six months, had 2.852 interventions, of which 605 on drug users (554 men,

51 female) and 1977 on no- drug users. We had 48 first contacts. The syringes distributed were 756, while we had 270 in return, that means the 35.7%. We distributed 447 units of distilled water and 14 units of Naloxone cloridrato (Narcan, in case of overdoses). We had 38 medical emergencies: 6 overdoses, 9 were taken to First aid and the remaining 23 were taken care on the spot.

The referral to the Services were 36, of those 22 drug users went to the Centro di Accoglienza of this project in Villa Maraini and the other 14 were sent to the territorial services (Ser.T., Night Shelters, Caritas and House of Social Rights).

In the second six months (between 4/8/2002 and 3/2/2003) the informative campaign has given way to an exchange of information between the clients, giving the service more visibility and with the result of making it more approachable by foreign drug users but, mostly, by people who does not use drugs but wants anyway more information on AIDS/Drug use.

We had positive feedback by the institutions (Police, Carabinieri etc.), the associations of the Social Private and the public who helped us to inform about the project.

For the Winter period the service has distributed, apart basic food and beverages given by the Fondazione Villa Maraini, in the framework of the project "Aiuta chi Aiuta" also clothing material (blankets, sleeping bags, bed sheets, shoes etc.)

The interventions of the Mobile Unit in this second part of the year were 4.062, of which 905 on drug users

(774 men, 161 women) and 3.157 persons not drug users. There has been 54 first contacts. The syringes distributed were 1138, and the returns 371, that means the 36%. We distributed 670 units of distilled water.

There was a significant increase in the distribution of condoms (3278). Furthermore we gave out 86 units of Narcan, against the overdoses.

There has been 41 medical emergencies of which: 4 persons in overdose, 10 has been taken to First Aid and the remaining 27 has been treated on the spot.

The referrals to the services has been 114, of which 65 drug users went to the Centro di Accoglienza of this project in Villa Maraini while 49 people has been sent and in some cases accompanied to the territorial

Services ( Ser.T., Night shelters, Drop in, Caritas and House of the Social Rights).

For the recording of the first contact, for overdoses intervention and for the distribution of Narcan, we used the data collection of the Agency of Public Regional Health.

The daily recording of the distribution of health materials is done on the appropriate sheets intended for this type of interventions.

### **Low threshold Center**

In the first six months we had a bigger number of clients of what we originally thought: there were 25 persons (22 men and 3 women) of which 12 not on a regular basis with more entrances and exits in the same period.

Six persons (4 men and 2 women) have has been clients, for a short period, of the night shelter.

The service is also taking care of foreign drug users, who on their own will has enter the Medical center of our project.

In the second six months we again had a bigger number of clients of what originally thought.

102 persons used the services (87 men and 15 women).

Of this group the regular clients were 22 (18 men and 4 women).

31 persons were present in the night shelter at least once.

This typology of clients is not always regularly present. In many cases their presence is related to the specific offer (meals, shelter, medical therapies and counseling).

A big number of people approached by us, are today in charge of the services. In some cases they had access to pharmacological and therapeutic treatments since "to give a therapeutic and/or medical continuity is one of the basis and/or objectives". This in order to build efficient and direct interpersonal relationship and reinforce the trust between workers and clients.

The Service provides assistance also to foreign drug users, which of their own will approach the medical services that are in offer for them by the services of the Center. This has become a referral point for all the territorial services.

This increase of activities has implied a major commitment in terms of human resources and economical investment particularly for what the management of the project is concerned.

### **Consultations targeting extra-European people, detained or with juridical problems related to drugs.**

The Fondazione Villa Maraini has begun a service called "prison project" targeting also foreign drug users

having legal and juridical problems related to drugs use.

The drug using extra-European detained population who use this service is in constant increase.

It is 10% of the people followed by the services inside the Prisons. At the moment, the foreign drug user detainee in charge of our service are 31 (28 men , 3 women) of which 13 have been referred to the Groups of Accoglienza, while with the other 18 the communication is by letter, waiting for the possibility of having them in the groups. The female detainee needs just a simple request. From the actual data we can see that the extra-European population with juridical problems related to the use of drugs is the 12% of the people followed by the project.

### **Collaboration with EMCDDA**

With this project the Fondazione Villa Maraini has offered collaboration, through the compilation of a specific questionnaire, to the Center for Ethnicity and Health (Center for the defense of ethnic minorities) and to the EMCDDA, which is leading a research on the use of drugs within ethnic minorities.

### **Partnership in the AC-COMPANY project**

Since many years the Fondazione Villa Maraini is involved at European level with AMOC-DHV of Amsterdam and has been one of the first organization to actively participate to the AC-COMPANY project, which has as objective the development of a European Network for the repatriation in the home countries of the persons who use drugs.

With the implementation of the project “Senza Frontiere” this collaboration can further contribute towards the repatriation of European drug users that wish to go back to their countries.

### **Description of the employed methodology**

The employed methodology is based on the necessity of answering the basic needs of the person: low threshold offers depending from the various typologies of addiction; stimulate the attention of the person towards the preservation of his own health with a related decrease of the chances of being involved in infective or mortal situations; and, last, the implementation of an operative network that facilitate the targeting of the biggest number of needs of the extra-european clients encountered.

### **Mobile Contact Unit**

The Unit is present for six hours a day, every day, in the places where there are the major number of clients.

The biggest concentration of extra-european people, apart Piazza dei Cinquecento , near the Termini Station, has been recorded at the Tiburtina Station and at the Ostiense Station.

For every round of operative service, two workers are present. The Unit, depending from the needs of the moment, can use the Camper of the street Unit of Villa Maraini, which is regularly standing outside the Termini Station in a quiet and protected space, useful for the assistance of people contacted in the streets. Furthermore, the camper is employed for medical and psychological consultancies and various information linked to the problematic of drug use.

### **Low threshold Centre**

The Low threshold Centre for foreign Drug Users is open every day from 3 p.m. to 9 p.m.

In the Centre are present two Social workers every day.

The take in charge is immediate, without waiting lists. There is a specific telephone line.

Other interventions are:

Information and Counseling on drugs, services, Hiv etc;

Dissemination of information materials on Hiv prevention;

Information on prevention of hepatitis, on the risks of overdoses and on intervention of first aid and assistance;

Distribution of ampoules of Naloxone (Narcan);

Free meals;

Possibility of having a shower, washing and exchange of clothes;

Psychosocial, legal and administrative consultancies;

Medical consultancies and referral to other services only after request of the client;

Possibility of access to the Night shelter without waiting list.

### **Meetings and Supervision**

Twice a month is taking place a workers meeting in order to discuss the work done.

Furthermore, all the workers have constant supervision with an extern professional.

The workers employed are prepared and qualified, with years of experience in the field of Drugs dependency.

#### **Analytic description of the target persons.**

The project is targeting foreign drug users, homeless, alcoholics, young drug users, foreign sex workers involved in drug use etc.

Percentages are has follow:

- Men 81%
- Women 16%
- Transgender 3%

Countries of origin are:

- North Africa 51,4
- East Europe 24,8
- Central Africa 10,2
- Western Europe 6,1
- Central Asia 5,1
- Others 2,4

In the second part of the year has been confirmed a constant rise of contacts with drug user coming from East Europe, and the majority of them were Russians or Ukrainians. Another important data is given by the contacts with the Mobile Unit by people who declare not to use any drugs. They were 77,7%.

#### **Interventions on foreign drug users by the services of the FONDAZIONE VILLA MARAINI.**

One of the main characteristic of the Fondazione Villa Maraini is that has never been made a distinction or selection of any kind, putting always first the needs and requests of help of drug users, becoming through the years a center of recovery for everybody without discrimination in terms of race, religion or political belief.

This interpretation has made Villa Maraini an organization which is at the forefront in the topic of possible therapies. Moreover, the Fondazione has always tried to intervene in that “shadow zone” not always reachable by the Public services.

In order to have complete information we want to bring to attention also the interventions targeting Foreign drug users, not foreseen by the project and which are made by the services of Villa Maraini inside the main premises (ambulatory service, night shelter, prison project), and also out of the premises by the Tribunal of Roma, the Carabinieri offices, the Police Stations and in the various emergency cases.

With the project “Senza Frontiere” we have the chance of consolidate and develop the daily work in favor of Foreign drug users.

## **7. Attachements**

7.1. INTERVIEW FOR DRUG USERS LIVING ABROAD

7.2. Questionnaires for survey on foreigners in prison

*(interviewer : please mark the category after the interview)*

### **1. INTERVIEW FOR DRUG USERS LIVING ABROAD (VERSION 1.4)**

Dear friend,

Thank you to take part in our research. Its results help us to understand what sort of problems have drug users who stay in another country. Because this interview is developed for different situations, maybe not all of the questions fit to your circumstances. All answers will be treated strictly

anonymously. Your participation in our research will help us to find the precise focus on the problems of mobile drug users. Thank you for your time.

**A. SOCIO-DEMOGRAFIC INFORMATION**

- A1 Sex
  - 1 male
  - 2 female
  - 3 transgender
  
- A2 Age /Place of birth ...../.....
- A3 Nationality .....
- A4 Last place of residence (before you came here) .....
  
- A5 How long are you here ?
  - 1 less than 1 month
  - 2 1-6 months
  - 3 7-12 months
  - 4 more than 1 year
  - 5 more than 2 years
  
- A6 Education
  - 1 secondary school
  - 2 high school
  - 3 college
  - 4 university
  - 5 profession.....
  - 6 other.....
- A7 Why did you decide to move to .....  
? drugs (you may circle several reasons)
  - 1 legal problems
  - 2 economical problems
  - 3 civil rights problems
  - 4 drug problems
  - 5 other.....
  
- A8 Under what circumstances you would  
decide to go back to your home country? .....
  
- A9 How many times did you cross the border  
of .....already?
  - 1 one time
  - 2 two times
  - 3 more than two times

**B. LEGAL SITUATION**

- B1 What is your status here?
  - 1 citizen
  - 2 permit to stay temporary (white card, tourist)
  - 3 asylum seeker in procedure
  - 4 illegally and without papers
  
- B2 Are you afraid of deportation?
  - 1 yes
  - 2 no
  
- B3 Is the law related to drugs in your country  
more restrictive than here?
  - 1 yes
  - 2 no
  - 3 don't know
  
- B4 If yes, has it influenced your decision to  
move or stay here?
  - 1 yes

- 2 no
- B5 Would you like to obtain an official permission to stay here? 1 yes  
2 no
- B6 Do you have any legal problems in your country or here? 1 yes  at home  in .....
- 2 no
- B7 Is it possible that going back to your country will mean your imprisonment? 1 yes  
2 no

**C. DRUG USE**

C1 What drugs did you use in your home country?

DRUG	Used	Injected	daily	weekly	once a month
C2 Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C3 Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C4 Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C5 Speedballs (cocktail heroin and cocaine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C6 Amfetamines (Speed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C7 XTC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C8 LSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C9 "Khanka" (Russian opiate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C10 "Vint" (Russian opiate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C11 Methadone (street)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C12 Opiate substitution treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C13 Hallucinogenic mushrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C14 Benzos (Hypnotics/sedatives/barbiturates)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C15 Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C16 Other, namely : .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	weeks?	4	more than 5
C39	Did you ever had a drug overdose?	1 2	yes no
C40	Do you feel that you should use less?	1 2	yes no
C41	Did you ever try to stop using drugs or to decrease the dose?	1 2	yes no
C42	What was the longest period you did not use?	1 2 3 4	less than 1 month 1-6 months 6-12 months more than 1 year
C43	How did you manage to stop?	1 2	independent with professional help
C44	Why do you use drugs (you may circle several reasons)?	1 2 3 4 5 6 7 8 9 10 11	relief of tension to avoid my problems for pleasure to avoid the pain I feel because it is my habit to use drugs because I am bored to decrease my aggression because I am encouraged to do it by other drug users to enhance my confidence to feel part of something (avoid loneliness) as an act of rebellion to society

D. HEALTH

Remember, that this questionnaire is anonymous. If you don't want to answer these questions please go to E (social situation).

D1	In general, what can you say about your health?	1 2 3 4	excellent good not too bad bad								
D2	When was the last time you were blood	never	<table border="0"> <tr> <td><b>HIV</b></td> <td><b>HepC</b></td> <td><b>Hep B</b></td> <td><b>TB</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<b>HIV</b>	<b>HepC</b>	<b>Hep B</b>	<b>TB</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HIV</b>	<b>HepC</b>	<b>Hep B</b>	<b>TB</b>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								



	tested in your home country?	1	more than one year ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		2	<input type="checkbox"/>				
			during the past year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		3	no answer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		4		<b>HIV</b>	<b>HepC</b>	<b>Hep B</b>	<b>TB</b>
			positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			negative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D3	If you don't mind, please, tell us about result of these tests	1	no answer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		2					
		3	<b>HIV</b>				
			<b>HepC</b>				
			<b>Hep B</b>				
			<b>TB</b>				
D4	When was the last time you were blood tested in this country?	1	never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		2	more than one year ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>				
		3	during the past year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			no answer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		4					
			<b>HIV</b>				
			<b>HepC</b>				
			<b>Hep B</b>				
			<b>TB</b>				
D5	If you don't mind, please, tell us about the result of these tests	1					
		2	positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		3	negative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			no answer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D6	<i>If you have a steady partner:</i> During sexual intercourse with your steady partner, how often do you use a condom?	1					
		2	never				
		3	from time to time every time				
D7	During sexual intercourse with occasional partners, how often do you use a condom?	1					
		2	never				
		3	from time to time every time				
D8	How often do you share your injection material (syringe, needles, spoons, filters, water) with your sexual partners?	1					
		2	never				
		3	from time to time every time				



	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
	<b>totally</b>	<b>rather</b>	<b>neutral</b>	<b>rather</b>	<b>totally</b>
	<b>agree</b>	<b>agree</b>		<b>disagree</b>	<b>disagree</b>
<b>I 1.1. I worry about my general health</b>					
2.1. I feel safer here than in my home country	5	4	3	2	1
<b>I 3.2 I have no relatives/friends in my country</b>					
	5	4	3	2	1
<b>II 1.1 I feel unhappy in here</b>					
	5	4	3	2	1
<b>II 2.1. I have more money in here than I had in my country</b>					
	5	4	3	2	1
<b>II 3.1. I I enjoy to live here, because I feel more free here</b>					
	5	4	3	2	1
<b>III 1 I worry about my future</b>					
	5	4	3	2	1
<b>I 1.2 I have no reasons to worry about my health</b>					
	5	4	3	2	1
<b>I 2.2. here I should always think about my safety because nobody helps me if something happens</b>					
	5	4	3	2	1
<b>I 3.3. I have many relatives/friends in here</b>					
	5	4	3	2	1
<b>II 1.2 I had more fun in my country than here</b>					
	5	4	3	2	1
<b>III 2.Right now, I don' t worry about my future</b>					
	5	4	3	2	1

**I 1.3 here I cannot receive the medical help I need**

5            4            3            2            1

**II 2.2 At home I have to deny myself more of 'the good life' than here**

5            4            3            2            1

**I 2.3 I try to avoid contacts with the local police**

5            4            3            2            1

**II 3.2 In my country I felt more free than here in .....**

5            4            3            2            1

**I 3.4 I feel lonely because I have nobody to help me**

5            4            3            2            1

**II 1.3 It is more interesting to live in here than in my country**

5            4            3            2            1

**II 2.3 I can not say that my life here is well-provided for**

5            4            3            2            1

**II 3.3 In here I can afford things I couldn't afford at home**

5            4            3            2            1

**III 3 I feel annoyed because I always have to think about tomorrow**

5            4            3            2            1

**II 1.4 In here I feel more happy than in my country**

5            4            3            2            1

**I 2.4 In my country I must hide from the police**

5            4            3            2            1

**I 1.4 I have more possibilities to care for my health here**

5            4            3            2            1

**I 3.5 I feel more lonely here than in my country**

5            4            3            2            1

**II 2.4 In here I'm always short of money**

5            4            3            2            1

**III 4. At home I can't be sure of my future**

5            4            3            2            1

**I 1.5 My health became worse since I arrived here**

5            4            3            2            1

**I 2.6 In my country I have enemies I have to hide from**

5            4            3            2            1

**II 2.5 here I must always think how I can get money**

5            4            3            2            1

**I 3.6 I came here because I couldn't relate with people of my country**

5            4            3            2            1

**II 1.5 I feel bad about coming here because, in the end, my life in my home country was better**

5            4            3            2            1

**I 2.6 I don't have to hide from anyone here**

5            4            3            2            1

**II 3.4 I feel no difference between the freedom I enjoy in here and in my country**

5            4            3            2            1

**III 5. I am sure that nothing bad will happen in my life**

5            4            3            2            1

**I 1.6 here I feel that the government cares about the health of the people**

5            4            3            2            1

**II 3.6 I cannot say that life here is more free than in my country**

5            4            3            2            1

**II 2.6 At home I earned money easier than here**

5            4            3            2            1

**III 6. I suppose my life will end badly**

5            4            3            2            1

**II 1.6 My life changed for the better after I came here**

5            4            3            2            1

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**7.2. questionnaires for survey on foreigners in prison**

<p>AC-COMPANY p/a AMOC/DHV Stadhouderkade 159 1074 BC Amsterdam The Netherlands</p> <p><b>The situation of foreign drug users in prison</b></p> <p>This questionnaire is about foreign drug users in the prison system. With “foreign” we mean people who do not have the nationality of the country in which they are in prison. The definition of “drug use” varies from country to country. In general, this survey is about illegal substance users, not about alcohol users. Please use the definition that is most current in your country. Of course, we would welcome it if you would like to expand on your answers.</p> <p><b>Part 1: Identification of the respondent</b></p> <p>Your name and occupation:</p> <p>Your address/telephone/fax/email:</p>
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**Part 2: Number of prisoners**

1. How many prisoners do you have in your country?
2. How many prisoners are not nationals? How many of them were legally in the country, how many were illegal?
3. How many prisoners are drug users?

**Part 3: Access to services (please the appropriate boxes):**

Do foreign drug using prisoners have the same access as other drug using prisoners to...

	Yes	No	No answer
Food			
Clothing			
Medical help			
Legal representation			
Leaves from prison			
Work activities			
Study activities			
Leisure activities			
Treatment: HIV and Hepatitis testing facilities			
Treatment: HIV and/or Hepatitis treatment			
Treatment: substitution treatment (methadone etc.)			
Treatment: drug free treatment			
Treatment: harm reduction (condoms, needles, bleach)			

**Part 4: Prisoner transfers**

Sometimes it is possible for a sentence prisoner to be transferred and to do the rest of his/her time in his/her own country. The Council of Europe Convention on the Transfer of Sentenced Persons (the Strasbourg Convention) and the Schengen Agreement are international treaties that cover this topic.

1. Does your country transfer sentenced persons according to the agreements mentioned above?
2. Can drug users profit from these agreements?
3. Are foreign prisoners informed on the existence of the agreements mentioned above?





Momentarily we are doing a survey on the situation of foreign drug users in prison. With “foreign” we mean people who do not have the nationality of the country in which they are in prison. We would appreciate it if you would be so kind as to fill out this questionnaire. Of course, we would welcome it if you would like to expand on your answers.

**Information about the respondent:**

Your nationality:

The country where you were put in prison:

Are you in prison now?

How long were you living in the country where you are in prison?

Were you a legal resident in that country when you were put in prison?

**Access to services (please the appropriate boxes):**

Do you have the same access as other drug using prisoners to...

	Yes	No	No answer
Food			
Clothing			
Medical help			
Legal representation			
Leaves from prison			
Work activities			
Study activities			
Leisure activities			
Treatment: HIV and Hepatitis testing facilities			
Treatment: HIV and/or Hepatitis treatment			
Treatment: substitution treatment (methadone etc.)			
Treatment: drug free treatment			
Treatment: harm reduction (condoms, needles, bleach)			

We thank you for your cooperation.

[www. ac-company.org](http://www.ac-company.org)

- check the website for all reports
- updates
- online questionnaire for mobile drug users
- maps of mobility
- tips for trips
- country guides
- FAQ about drug help system in all European countries
- news

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