PATTERNS OF SUBSTANCE USE AMONG ETHNIC AND CULTURAL MINORITIES

A COMMUNITY BASED PARTICIPATORY RESEARCH (CBPR) PROJECT

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1 INTRODUCTION

1.1 Situating the research

The objective of the current study is to contribute to a better understanding of the nature of substance use among 4 ethnic and cultural minorities and their access to treatment facilities in Belgium. During the last decade, research on Belgian ethnic and cultural minorities has demonstrated that their presence in and access to general health care including drug treatment facilities, is disproportionate when compared to the general population (Eggerickx et al., 2006; Lodewijckx, 2014; Rouws, 2007; Vassart, 2005). Furthermore, some ethnic and cultural minorities make less use of drug treatment services than others (Alegria et al., 2012; Derluyn et al. 2008). Research in the European context also demonstrates that ethnic and cultural minorities appear to be underrepresented in drug treatment statistics (Fountain, 2004; 2012). The underutilization of drug treatment services as well as the lower treatment completion rates among ethnic and cultural minorities have also been documented in the Belgian context (Vandevelde et al., 2003; Verdurmen et al., 2004).

The associations between stressors in the social and physical environment and the socio-economic status on the one hand and health status on the other is well-documented (Schulz et al., 2008; Warnecke et al., 2008). Epidemiological research demonstrates that ethnic and cultural minorities, because of the risk factors they are confronted with, are more susceptible to substance use disorders due to, among others, higher unemployment rates, limited language skills, less educational opportunities, discrimination, intergenerational conflict, acculturation difficulties and higher peer pressure (Otiniano Verissimo et al., 2014; Reid, 2001; Savage & Mezuk, 2014).

Yet, little is known about the prevalence and nature of substance use among ethnic and cultural minorities in Belgium (Burkhart et al., 2011; Derluyn et al., 2008; Fountain et al., 2004). Derluyn et al. (2008) made a significant contribution to the field, especially in relation to the care trajectories of substance users from ethnic and cultural minorities in Belgium. The study demonstrated that some substance users who feel they belong to an ethnic and / or cultural minority have limited knowledge about the used substances, their effects and potential harm. For many, the step to treatment is a bridge too far, given their limited knowledge about the treatment offer and/or biased views on addiction and treatment. Many clients of non-Belgian origin do appear to be supported by their network and community. The findings also indicate that community organizations and institutionalized treatment services are interested to collaborate more closely to help those substance users who feel they belong to an ethnic and / or cultural minority. Still, we know little about these phenomena and the reasons why the participation of these groups to treatment remains limited.

Derluyn et al. (2008) raise some conceptual (e.g. distinguishing between ethnic and cultural minorities) and methodological (e.g. recruiting via treatment services) issues that remain unresolved. We wish to address these issues in order to obtain a better understanding of specific patterns, expectations and needs of ethnic and cultural minorities in substance abuse treatment care in order to be able to inform innovative practices in mental health care, prevention and treatment practices. Further, we wish to fill the knowledge gap in existing research on specific ethnic and cultural minorities. Undocumented migrants and refugees, the Congolese community in Matonge and the Turkish and Eastern-European communities in

Ghent have not been sufficiently studied when it comes to patterns and the nature of substance use and abuse (Derluyn et al., 2008).

We do not want to examine these ethnic and cultural minorities because we believe ethnicity or culture is a primordial analytical category, nor do we consider it as a statically bounded entity (Cahnman, 1962; Said, 1979; Vermeulen & Governs, 2003; Wimmer, 2013; Zemni, 2009). We recognize the need to distinguish between the dynamic nature of cultural identity (Zemni, 2009), the unidirectional discourse of integration (Schinkel, 2008), and structural inequalities (Elchardus & Glorieux, 2012) when researching ethnic and cultural minorities. We acknowledge the complex interplay of these aspects, and therefore want to focus on four specific ethnic and cultural minorities (instead of 1) and by studying social mechanisms and the way they interfere with specific patterns of substance use.

1.2 Research questions and goals

- What is the nature and what are the patterns of substance use in the four target groups?
- What are the expectations and needs of the four target groups towards substance abuse treatment care?

The use of alcohol and illicit substances among ethnic and cultural minorities is understudied in the European context (Tieberghien & Decorte, 2008). Professionals have signalled significant differences in the prevalence and nature of substance use among ethnic and cultural minorities (Derluyn et al., 2008; Fountain et al., 2004). However, existing studies are insufficient, because variables such as nationality, ethnic origin and type of substance use are often not operationalised in an equivalent way across research. Furthermore, treatment facilities only offer dispersed information on the ethnic and cultural background of their clients, which hinders quantitative analysis of the phenomenon.

Therefore, we have chosen a qualitative and exploratory research design in order to increase the knowledge about the underlying determinants and mechanisms of substance use and the existing barriers concerning prevention and treatment services, both at the individual (micro) and the social (meso) level among ethnic and cultural minorities. We conducted about 260 semi-structured open interviews with substance users who feel they belong to an ethnic and / or cultural minority to understand individual, interpersonal, organizational and social determinants and the social mechanisms they influence (Bernard, 2011; Bronfenbrenner & Bronfenbrenner, 2009). We countered methodological difficulties in accessing the target group (e.g. language and cultural barriers) through recruiting researchers in the communities themselves. One of our main goals was to support the actual use of our research outcomes within these communities.

We studied use and determinants of use and access to treatment among undocumented migrants, asylum applicants and refugees, in Congolese communities, and in the Turkish and Eastern-European communities in Gent. We focussed on these groups because they are representative for the major migrant groups in Belgium, and because so far, no extensive study on this topic has been undertaken (Derluyn et al., 2008).

At the individual level, we analysed the relationship between acculturation processes, discrimination and ethnic identity formation as moderating factors in substance use, barriers and access to services. At the meso-social and macro-social level we focussed on the interplay between ethnic conformity pressure, ethnic density and social capital in the urban context and substance use and access to services.

Existing research has led to little or no change or improvement, neither in local service provision, nor within ethnic and cultural minorities (Belone et al., 2014; Bogart & Uyeda, 2009; Fountain et al., 2004). Therefore, we addressed these issues by applying a community based participatory research model (CBPR). This model implies that the research questions will be refined in close collaboration with the respective communities (see chapter 4).

1.3 Methodology

This report is the account of a 15-month research project. The CBPR model is the crux of this project. Consequently, the model and the specific way of data collection, analysis and dissemination will be reported upon in a separate chapter (see Chapter 4). In this chapter we also include our experiences in the four target groups.

The preparatory phase of the project, however, consisted of a literature review including peer-reviewed as well as grey literature on the nature and prevalence of substance use among ethnic and cultural minorities, determinants of substance use and barriers to substance abuse treatment care. We want to improve knowledge concerning substance use in ethnic and cultural minorities, without adhering to cultural relativism. To this extent, we explored social mechanisms of ethnic boundary making that have already been studied in the Belgian context and may reveal risk and protective factors for problematic substance use. Furthermore, we reviewed the existing literature on prevalence and research that links social and individual determinants to patterns of substance use in and access to substance abuse treatment for ethnic and cultural minorities.

We included grey literature, i.e. publications that have not been peer-reviewed, with limited circulation, master dissertations and documents resulting from mailshots to professional (treatment and prevention) centres in Belgium requesting relevant reports of research undertaken in their areas. Some research reported in grey literature has used qualitative research methods or has been conducted by those with unique access to the ethnic and cultural minorities under investigation. Some of this research may be lacking academic rigour, but we included all relevant literature we could identify. The result of this all-inclusive strategy is beneficial to building up a knowledge base in the dearth of relevant peer-reviewed publications. In the literature review, we focus on illicit substances, but where appropriate, the use of legal substances such as alcohol, prescription drugs, solvents, etc. and ‘traditional drugs (such as qat (khat), pan, bhang…) is included.

In our exploratory literature review we have included ethnic conformity pressure, the urban context, social capital and ethnic density as new sensitizing concepts in the research of ethnicity and substance use. Furthermore we study acculturative stress, discrimination and ethnic identity. Hence, we allowed research questions and new concepts to emanate from the communities themselves because this could lead to novel findings and solutions grounded in

the local instead of the academic context (Bogart & Uyeda, 2009; Charmaz, 2006; Salsberg et al., 2015). Consequently, rather than testing a hypothesis, the study mainly focusses on collecting new, original data on the topics mentioned above in the four particular ethnic and cultural minorities. It is hence of an exploratory nature.

1.4 Structure of the report

- Introduction
- Substance use and ethnic and cultural minorities
- Prevalence and nature of substance use
    - Prevalence
    - Social Mechanisms
    - Barriers to treatment facilities
    - Good practices
    - Preliminary conclusions
- Community based participatory research
- Case study: Turkish community in Ghent
- Case study: Eastern-European communities in Ghent
- Case study: Undocumented migrants in Flanders
- Case study: The Congolese community
- Conclusions and recommendations

2 ETHNIC AND CULTURAL MINORITIES AND SUBSTANCE USE

In this research we start from the observation that lower socio-economic status (lower education, lower income and unemployment) is associated with the prevalence of mental disorders including substance use related problems (Chartier et al., 2014; de Graaf et al., 2012). Ethnic and cultural minorities are more susceptible for a lower SES (Manço, 2004; Van Kerckem et al., 2013). We thus recognize a higher vulnerability but stress the fact that membership of an ethnic cultural minority group is not necessarily an indicator of vulnerability to substance use or problematic use (Adrian, 2002; EMCDDA, 2013). Furthermore we depart from the observation that ethnic and cultural minorities are underrepresented in drug treatment facilities (Vandevelde et al., 2003).

2.1 Substance use and society

In speaking of culture we have reference to the conventional understandings, manifest in act and artifact, that characterize societies, the understandings are the meanings attached to acts and objects. The meanings are conventional and therefore cultural in so far as they have become typical for the members of that society by reason of inter-communication among the members. A culture is then an abstraction: it is the type toward which the meanings that the same act or object has for the different members of the society tend to conform.

(Redfort in Becker, 1963; 1991: 80)

Culture is a dynamic concept created and recreated through communication and within groups. Becker (1963) argues that being a regular substance user often implies positioning oneself in a subgroup. Becker's *Outsiders* (1963) has deeply influenced sociological research on substance use (Taïeb et al., 2008). The concept of deviance is especially interesting for our research, because it offers a framework to study deviance as a social phenomenon, the role of social control and the relationship between insiders and outsiders in society. Outsiders are considered as those who don't follow the rules of the dominant social group (Becker, 1963). Becker employs a symbolic interactionist approach which enables him to analyze the actions of individuals and the meaning they give to these actions through interaction and negotiation of social norms in society.

According to Becker, every social group institutionalizes rules and attempts to apply these rules in precise moments and under certain circumstances. These social rules define situations and appropriate behaviour. This is especially true for certain ethnic and / or cultural minorities (see infra). Those who break these rules are considered outsiders, strangers to the group. Social rules are produced by social groups and are highly differentiated depending on the criteria of social class, ethnic group, profession and culture. Different social groups do not necessarily share the same social rules. They develop different normative systems. Groups succeeding to impose their rules are those whose social position gives them resources and power (Becker, 1963).

Becker (1963) defines different types of deviance. His typology allows us to take into account several characteristics of deviance when analyzing substance use: its changing character through time and the social construction, its dynamic and interactive nature and the stages in career of deviance. In the case of our research, this typology impels us to distinguish between regular users and occasional users and to understand why some occasional users become regular users and under which circumstances this is the case.

Being publicly designated as deviant is in fact crucial in the process of deviant behavior (Becker, 1963; 1985, p. 54). Being identified and stigmatized as deviant has important consequences in social life and on the image of the self. It is usually a prevailing identity category or social status that turns it into a self-fulfilling prophecy. Various forms of deviance produce difficulties because they cannot correspond to the expectations of other life sectors. One way to resist to the social control that defines deviance is to amplify the deviance in one's social and individual life. Deviant motivations do not necessarily lead to deviant behavior, but deviant behavior induces deviant motivation over time.

2.2 Ethnic and cultural minorities

Martiniello (2013) defines ethnicity as the constitution of one of the major means of political and social differentiation on the one hand, and structural inequality in contemporary societies on the other hand. Ethnicity is based on the production and reproduction of social and political translations of the physical, psychological and cultural difference between groups said ethnic which develop relationships between them. Ethnicity emerges in situations and interaction between groups. Max Weber (in Wimmer, 2013) defines ethnic as 'a subjectively felt belonging to a group that is distinguished by a shared culture and by common ancestry. This belief of belonging (…) rests on cultural practices perceived as "typical" for the community, or on myths of a common historical origin, or on phenotypical similarities indicating common descent'.

The introduction of the concept of ethnicity in Anglo-Saxon social sciences reflects the constitution of ethnic groups as interest driven and lobbying actors in the political system (Martiniello, 2013). In political sciences, the concept is used to describe the ways of integrating minorities in a political system (Guy et al., 2005), and is related to the notion of cultural minority. This concept of ethnicity implies that political communities are based on ethnic references. In this perspective, ethnicity is one of the variables of political mobilization. In social science literature, other definitions of ethnicity have been distinguished.

For social sciences, ethnicity is not based on objective differences between groups, but on the perception of the importance of these differences in social relationships. Ethnicity is a social and political construction of perceived differences (Martiniello, 2013). The ethnic dimension is not always as relevant in social relationships and contexts (Martiniello, 2013), since people may emphasize it in certain situations, while trivializing it in other contexts.

Martiniello (2013) distinguishes three levels to identify and analyze ethnicity: micro, meso and macro level. At the individual level, ethnicity is largely subjective and refers to the feeling and the consciousness to belong to an ethnic group. Thus, people may be characterized by multiple identities. At the meso-social level, ethnicity corresponds to ethnic mobilization and ethnic collective action, structured by a collective ethnic identity. At the macro-social level, ethnicity refers to the structural constraints that shape ethnic identities, and provide individuals a determined social position depending on their attributed belonging to an ethnic category.

Contemporary scholarship on ethnicity is based in Frederik Barth's (Barth, 1969; 1998) non-substantialist notion of ethnicity. Barth argued that ethnic identity is a means to create boundaries that enable groups to distance themselves from one another and consequently argues that ethnic boundaries define a group rather than "the cultural stuff that encloses it". He considers ethnic groups as deforming and dissolving entities by means of social and categorical boundaries.

Moreover, ethnic identities and boundaries are constructed by individuals and groups in social situations. The feeling of belonging to an ethnic group is the result of a process of imputation and self-imputation. The ethnic group's recognition of an individual as a member implies that this individual will feel as a member of this ethnic group and this feeling will be translated in a singular characteristic of the group in terms of social organization. Wimmer (2013) dynamizes Barth's ethnic boundaries by infusing the analysis of how such boundaries are produced in a Bourdieusian perspective and how these processes are entangled with non-ethnic boundary making processes. For Wimmer, the dynamic factors for ethnic boundary making are the inclusion of power, networks and institutions in the analysis of ethnicity.

Ethnic expression does not only depend on the individual rational choice, but also on the state's impact on the perception developed by ethnic groups members, the resources for the community organization and the collective mobilization as well as the reciprocal recognition of ethnic groups in the political process. In this perspective, the state plays an important role in the processes of ethnic imputation. The recognition of ethnicity and the institutionalization in politics increase the level of ethnic mobilization among all ethnic groups and shape the boundaries of ethnic mobilization and conflicts by defining political participation rules.

Depending on the context, ethnicity can be defined by, on the one hand, referring to common patterns such as language, collective memory, future projects, origin, physical appearance, dress codes, or, on the other hand, by making a reference to the boundaries between groups and the way these groups attempt to appear distinct (Leloup & Radice, 2008: 5). A particular element to be stressed is that once individuals identity to a particular ethnic community, they will be more likely to be subjected to social pressure with regard to appropriate behavior and taboos, which can vary from one group to another.

The interaction between individual behavior and ethnicity will be explored in order to understand how substance users who feel they belong to an ethnic and / or cultural minority adopt specific behavior. This behavior implies the way individuals experience their ethnicity and how they act in their everyday life, as well as how they deal with structural constraints.

2.3 Substance use

When studying substance use in ethnic and cultural minorities, we argue with Muys (2010) that this phenomenon should be studied as a social construct within its context (Berger & Luckmann, 1967). Previous studies have mainly put forth three determining factors of substance use among individuals with an ethnic and / or cultural background, i.e. the post-traumatic stress syndrome, acculturative stress and goal striving stress (Muys, 2010). These approaches offer important insights but tend to isolate individual determinants and therefore

often overlook the social embeddedness as well as the social origin of the phenomenon studied.

The definition of substance use and misuse in societies and even in academic debate should be regarded as the reflection of the nature of that society (Dingelstad, et al., 1996 in Muys, 2009), and its social institutions (Ruggiero 2000 in Muys, 2009), social values, expectations and milieu (Young, 1971). When studying the patterns and determinants of substance use and the barriers to treatment services in this social constructivist perspective, we are more interested in the forces that lie behind this use than in the prevalence itself. This enables us to study the social contexts of use that inspire individual choices as well as the barriers afore mentioned. The normative perception of Becker's outsiders in society is particularly interesting when applied to substance use in ethnic and cultural minorities. In many cases, ethnic and cultural minorities are already perceived as outsiders in societies ruled by migration restrictions and varying policies of integration that distinguish nationals from new or non-nationals.

Recognizing that substance use in ethnic and cultural minorities is in its core a social construct has large implications for our research methods and principles. It primarily implies that the concept of substance use will be studied from the perspective of the communities and people identifying with these communities themselves. Any type and use of substances will qualify for our study when it proves to be meaningful in the narratives of these individuals. We do not dismiss literature that confirms higher risk of health inequalities and substance use disorders in ethnic and cultural minorities (see infra). We wish to rejuvenate the existing research by studying substance use and access to treatment within the framework of ethnic boundary making (Wimmer, 2013) and social mechanisms (Hedström & Swedberg, 1998).

3 PREVALENCE AND NATURE IN OF SUBSTANCE USE ETHNIC AND CULTURAL MINORITIES

3.1 Prevalence of substance use

The link between immigration and health is widely explored in research in psychology and epidemiology (Taïeb et al, 2008). These are mainly quantitative studies and compare various groups of migrants in relation to the prevalence of substance use. They highlight the risk and protective factors of substance use among these groups. Two explanatory models emerge in this literature (Taïeb et al., 2008), i.e. the acculturation model and the cultural identification model (see infra).

Some studies demonstrate clear differences between natives and migrants concerning the degree (more/less) of substance use and the type of substances being used (Argeriou, 1997), whereas others state that there are few to no differences (Adrian, 2002). These research results require to be interpreted with some caution. Adrian (2002) for example warns about how research on substance use among ethnic and cultural minorities often takes off with the wrong premises, which may lead to further stigmatizing of minorities. Also, some clinical studies demonstrate that clinicians tend to diagnose psychosis or symptoms of substance use more quickly for clients from minorities than for other clients (Minsky et al., 2003). Possible explanations for the latter include (1) self-selection, (2) culturally determined expression of symptoms, (3) difficulties in the accurate application of DSM-IV diagnostic criteria, (4) bias related to the lack of clinicians' cultural competence, and (5) imprecision inherent in the use of unstructured interviews, possibly combined with clinician bias (Minsky et al., 2003).

In what follows we discuss the **Anglo-Saxon and Dutch literature** concerning the prevalence and nature of substance use among ethnic-cultural minorities. We focus on this literature because the concept of ethnicity has long been and still is an anathema in for example the French literature. Scholars working in the tradition of rational choice theory as well as critical classical Marxism are less inclined to accept the concept of ethnicity as a unit of analysis, although both from a very different perspective. This has, in the rational choice tradition resulted in more quantitative, variable-based research that considers individuals as units of analysis (Wimmer, 2013: 17). In the critical traditions this research focusses on structural elements and social stratification, rather than ethnicity. Both traditions avoid some of the pitfalls of community studies. Consequently no literature on prevalence is to be found in this tradition.

Research in the **United Kingdom** (Ramsey et al., 2001 in Rassool, 2006) has indicated that the prevalence of substance use is lower among South-Asians in comparison to white communities, although this discrepancy diminishes. Another UK study (Moselhy & Telfer, 2002) states that Asian participants report a higher use of opiates in comparison to the British group. The African-Caribbean group reports a higher use of crack-cocaine. Ecstasy, amphetamines and LSD are said to be used less frequently by ethnic and cultural minorities in the UK and are considered a drugs of white youngsters (Chaudry et al., 1997). However, khat is a specific substance that is often used by Somalian communities, Yemenites, Ethiopians and Arabs from the Middle East (Fountain et al., 2004).

A large-scale **Swedish** study (Hjern, 2004) demonstrates a significant increase in hospitalization among second generation migrants for treatment of illegal substance use. This elevated risk, however, is almost completely neutralized when socio-economic indicators are taken into account. In this aspect, second generation migrants are struggling a lot more than the native Swedish population.

Research among Turkish migrants in **Germany** reports a higher prevalence of addiction in these communities in comparison to native Germans (Haasen et al., 2004).

Dutch research assesses that approximately 40 to 50% of the registered substance users consist of people of Surinamese, Moroccan, Netherlands-Antillian or Turkish origins (Lempens et al., 2000 in Verdurmen et al., 2004). In the **Netherlands** increased substance use and earlier onset of substance use was found among adolescents ten to twenty years ago (Monshouwer, 2008; Monshouwer et al., 2005). These subjects have now become adults and their (former) substance use might have contributed to an increase in adult substance use disorders (de Graaf et al., 2005). The NEMESIS-2 study (de Graaf et al., 2012) shows that lifetime substance use disorder was prevalent in 19.1% of the respondents, and substance use disorder in the twelve months before the interview in 5.6% of the respondents. Lifetime alcohol abuse was highly prevalent (14.3%), while as 12-months disorder it was considerably less (3.7%). This signifies that this disorder does not often have a chronic course. Further, NEMESIS-2 shows that both sexes did not differ in the prevalence of any disorder, but females more often had mood and anxiety disorders, while men more often had substance use disorders.

The age group of 18–24 showed high odds for substance use disorder. A trend toward a higher prevalence of mood, anxiety, substance use disorder and adult ADHD was found with lower educational level. In general, those living with a partner had lower odds of a disorder than those living alone or otherwise. Unemployed/disabled subjects had a much higher risk for all disorder categories than those in paid employment. Housewives/-men did not differ from those in paid employment. Sex differences were consistent across the different age groups, except for substance use disorder in the age group of 25–34 and 35–44 years, where the gender imbalance was much higher than that in the youngest and oldest age groups. The estimated prevalence of 12-month substance use disorder in NEMESIS-1 (de Graaf et al., 2000) and the direct measure in NEMESIS-2 (de Graaf et al., 2012) did not differ significantly. A decrease of substance use disorder was found among males compared to females.

When it comes to the **method of use**, injecting substances is very unusual among African minorities, which can be derived from their low presence in projects of injection needle exchange (Rassool, 2006; Sangster et al., 2002). South Asians and Black Caribbeans do seem to inject heroine and steroids. The aversion to intravenous use among the Chinese and the Vietnamese is mainly dictated by the feeling that it implies less risk to dependency, by the fear of losing control, by the fear of needles and HIV-infection, and because of the stigma of intravenous use (Nemoto et al., 1999). According to this research, the use of crack and the aversion of its intravenous use occurs more often in the Asian population that moved to America after birth compared to Asians born in America. A qualitative study in London on women from Bangladesh also reports that these women repulse injecting substances (Cottew & Oyefeso, 2005).

In **Belgium** only the current (as opposed to the former, or double) nationality of clients with a migration and / or ethnic background is registered in substance abuse treatment centers

(Antoin et al., 2012). Consequently, very few statistical material is available on substance use and treatment use in ethnic and cultural minorities. Moreover, the existing statistics are hard to interpret and thus provide few to no insight in substance use among these minorities in Belgium. Derluyn et al. (2008) report that there is a high heterogeneity in the nature of substances used in ethnic and cultural minorities. Furthermore, their quantitative analysis of substance abuse treatment services in Antwerp concludes that about 25% of service users are non-Belgian. This number is parallel to the amount of non-Belgians in de general population which might lead to conclude that there is no underrepresentation of the target group in substance abuse services. Derluyn et al. (2008) do note a large difference in the profile of these clients when compared to Belgians, most notable they have a lower socio-economic status. Sacré et al. (2010) confirm this statement in their study of 26 non-Belgian injection heroin users. These individuals are more vulnerable when it comes to their educational, housing and economic situation. The respondents in this study were interviewed in Charleroi and Liège and were mostly males of North-African (50%), Eastern and European origin. Noteworthy mentioning is that this study also mentions that in some cases the traffic of heroin and cocaine in linked to human trafficking which makes certain groups of migrants more vulnerable for the use of the latter substance.

A key figure in the field, who is of Moroccan descent and works at a project of injection needle exchange, states that substance users of Maghrebin origin rather inhale substances than inject it (Derluyn et al., 2008). This fact leads to less attention to the risks associated with injecting substances among those who do inject it, which makes it hard for projects of injection needle exchange to do their work with regard to these target groups. The fact that knowledge about the consequences of use is often minimal is confirmed in the study of Eurotox and Modus Vivendi mentioned above (Sacré et al., 2010). This is the case for prevention campaigns on diseases such as HIV/AIDS and hepatitis as well. In these campaigns, it is hard to reach ethnic and cultural minorities, especially because of the stigma and taboos associated with these diseases, as well as the unfamiliarity of some communities with this type of prevention campaigns.

Both Anglo-Saxon and French literature mainly refer to the migration process, but each emphasizes different side-effects. We will briefly describe these stances and deepen the scope in existing research by distinguishing between individual, service related and other social mechanisms. At the social level, we introduce the concepts of ethnic conformity pressure, urban contexts, social capital and ethnic density. At the individual level, we will review the state of the art concerning the topics of ethnic identity, acculturative stress and discrimination. The service level does not belong to the scope of the current research.

3.2 Social mechanisms[1]

The position of migrants in society is, to a large extent, defined by the degree of socio-economic inclusion, levels of xenophobia, political decision making and the discourse of the receiving society. Therefore, when studying the nature of substance use in ethnic and cultural minorities, we must also study the social mechanisms underlying problematic substance use and/or access to health care. Migration can for example result in poor living conditions, economic and intellectual poverty, unemployment, limited access to education, disruption of social and familial structures and discrimination. Several studies indeed show that ethnic and cultural minorities are overrepresented in lower socio-economic classes, which might result in higher unemployment rates, more poverty and worse housing; all elements associated with poor mental health (Lindert et al., 2008; Negi, 2011).

These socio-economic factors can contribute to substance use (Ashruf & van der Eijnden, 1996). Various authors add that ethnic-cultural minorities are often confronted with combined sources of acculturation stress, lack of familial support, racism and discrimination. These can all be (joint) causes of (higher) substance use (Coordinamento Veneto su alcol e immigrazione, 2005; Jung, 2002; Min, 1995; Panunzi-Roger, 2005). Ashruf & van der Eijnden (1996) also report the following predictive factors for substance use among ethnic-cultural minorities, i.e. cultural adaptability and attitude towards the society of the host country at the individual level and deprivation and discrimination at the social level.

Reid (2001) highlights following risk factors that raise the vulnerability for illegal substance use among ethnic-cultural minorities: high unemployment, poor knowledge of the host language, limited access to education and low degree of education, intergenerational conflicts, acculturation and peer pressure. In our analysis, we will focus on the interplay of these social and individual factors and complement them with ethnic conformity pressure, the urban context, ethnic density and social capital.

We wish to gain an in-depth understanding of how these documented determinants and risk factors are intertwined and interact with each other within the framework of social mechanisms. We therefore propose to present six sensitizing concepts (ethnic conformity pressure, social capital, urban context, ethnic density, acculturative stress and discrimination, ethnic identity) that may be off significance in uncovering the black boxes of the social mechanisms behind substance use and unequal access to treatment facilities. Furthermore we will be attentive for new concepts to arise during our contacts and fieldwork within the communities.

[1] Mechanism based research focusses on the properties, activities, relations and interests of entities that produce effects in a certain phenomenon. Contrary to covering-law accounts, it presupposes that higher level mechanisms ('low presence of ethnic and cultural minorities in treatment centers') are founded in lower level mechanisms (f.e. 'high degrees of social closure because of perceived discrimination result in knowledge gap about treatment possibilities'). Broadening the intersectional approach, it hypothesizes that the causal relation between A and B can only be explained by considering A and B not as opaque entities but as agents, properties, actions and relations in a time related framework. Mechanism based theory is based in opening the black box behind a macro-level observation. It is concerned with how situational mechanisms of social structures constrain individual actions and cultural environments (1), describing action mechanisms linking individuals desires, beliefs etc. to their actions (2) and specify the transformational mechanisms through which people create (un)intended social outcomes (3). This is what shapes the macro-level association in mechanism based theory (Hedström, 2010).

3.2.1 Ethnic conformity pressure

Members of ethnic groups sometimes choose opportunistically between the norms, values and practices of their ethnic groups and those of the host society or have to construct a flexible combination of both.. They are confronted with a choice between two cultures, while these cultures may conflict in specific situations. To preserve their ethnic background and remain specific as a group, immigrant communities often try to maintain ethno-cultural boundaries by exerting ethnic conformity pressure – pressure not to assimilate too much, but to conform to those norms, values and cultural practices that are deemed central to the ethnic group's identity (Van Kerckem et al., 2014: 277).

In her research on the Turkish community in Ghent, Van Kerckem et al. (2014) consider ethnic conformity pressure to shape the behavior of ethnic group members and associate this pressure to the maintenance of ethnic boundaries as well as familial and ethnic solidarity. This pressure is exerted by other group members, potentially shapes the individual behavior and is expressed through direct discourse and indirectly through social control and sanctions when norms and values are perverted. In groups with high social interactions, social control works through gossip, ridicule and social sanctions and can lead to blame and expulsion from the community.

In ethnic groups, this ethnic conformity pressure is differentiated gender wise, as women are generally more pressured, because they are considered as "the designated keepers of the culture", in charge of the cultural line, the ethnic boundary maintenance and ethnic symbols (Van Kerckem et al., 2014). In an interactionist approach, Van Kerckem et al. (2014) consider individuals to be rational and able to weigh the costs and the benefits of mainstream or ethnic behavior. Thus, according to Van Kerckem et al. (2014), it is important to focus on how individuals negotiate, trace and reinterpret symbolic boundaries, and how they deal with the mechanisms of boundary maintenance.

The concept of ethnic conformity pressure as well as the creation and recreation of ethnic boundaries[2] may influence views on substance use, individual expressions of substance dependence as well as treatment strategies. Furthermore, these concepts enable us to further explore the concept of double isolation and alternative treatment strategies as postulated by Derluyn et al. (2008).

3.2.2 Social capital

The embeddeddness in society of the ethnic and cultural minorities as well as its 'members' studied in the current research varies greatly due to different individual migration histories and specific reception policies. This implies that substance use at the individual level will occur and will be handled in different ways, both at the individual, society and community context. Social capital is defined as "the resources embedded in a social structure which are accessed and/or

[2] Zolberg and Woon (1999) consider three types of ethnic boundary change , i.e. "boundary blurring", "boundary shifting" and "boundary crossing". Boundary crossing refers to the individual-level process of moving from one group to another, without any real change to the boundary itself. Boundary blurring implies a process in which the social profile of a boundary becomes less distinct, where "the clarity of the social distinction involved has become clouded, and individuals' location with respect to the boundary may appear indeterminate" (Alba, 2005). Boundary shifting, finally, involves "the relocation of a boundary so that populations once situated on one side are now included on the other." (Van Kerckem et al, 2014 a, p. 282; Wimmer, 2013).

mobilized in purposive actions" (Lin, 2001 inKim et al., 2006). Recent work has mostly been inspired by Putnam (1993) who defined the concept as "those features of social organization, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated actions". It taps those "features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit." (Putnam, 1995: 66). Putnam & Goss (2002) later refined social capital by distinguishing between networks connecting people who are unlike one another (bridging) and people who are like one another in important respects (bonding).

Social capital has first been deployed to study potential development in deprived or disadvantaged groups. Woolcock et al. (2000) describe four streams of research in this domain. The communitarian view equates social capital with local level organizations and focusses on the positive effect of social ties within a community. It presupposes a homogenous community and therefore fails to capture the consequences of diversity, power mechanisms and structural disadvantage. Secondly, from the network perspective, theorists and practitioners try to identify the positive aspects of bonding social capital and simultaneously help building bridging capacity of disadvantaged communities. The problem with such a view is that it does not take into account the impact of macro-level institutions, such as the state (Woolcock et al., 2000). The third perspective is the institutional one and does take the former level into account, since it presupposes that community networks are a product of the institutional environment (Tendler, 1997; Skocpol, 1995 in Woolcock et al., 2000).

Woolcock et al. defend a forth, synergy view that defines the tasks for theorists, researchers and policy makers to study the nature and extent of social relationships, the development of institutional strategies based on an understanding of these social relations and to define positive manifestations of social capital that can offset its negative manifestations such as isolationism (2000: 14).

In analyzing disadvantaged communities, bonding capital has proven its protective effect through risk management and solidarity functions (Kozel & Parker, 1998 in Woolcock 2000). Most research measures, however, the impact of bonding versus bridging capital. Bridging capital, in this perspective, would outperform bonding capital when related to self-rated health (Kim, 2006), positive civic values (Geys & Murdoch, 2010) and subjective well-being (Hooghe & Vanhoutte, 2010).

More recently, researchers have used bonding and bridging social capital to specifically study increasingly diverse societies in many aspects, such as the relation between social capital and social cohesion (Chan et al., 2006; Laurence, 2009). However, the concepts of bonding and bridging capital are currently suffering a serious conceptual inflation due to their politization - bonding is negative, bridging is positive (Cheong et al., 2007), and due to the lack of conceptual clarity regarding the unit of analysis (individual, community, society at large) and its consequent use as an independent, dependent or mediating variable and its causal or consequential effect on communities and individuals.

The researches of Geys & Murdoch (2010) and Laurence (2011) offer insightful clarifications for that matter, although they draw very different conclusions. Geys & Murdoch (2010) propose to study bonding and bridging capital as tapping into each other and into external and internal dimensions of networks. This integrated analysis offers empirical support for the fact that membership in associations that are both bridging in the network itself and outside it have the

strongest relation with acceptance of non-conformist forms of behavior (in the case of UK and Flanders). This is their answer to the idea that two different ways to operationalize of social capital co-exist, more specifically, one based on interconnectedness between networks, and one based on within-network heterogeneity.

Laurence (2011) departs from a similar reading of the current study of social capital, but offers a different answer. In studying the relation between social capital and interethnic relations, he concludes that it is not social capital that most strongly correlates with tolerance and positive civic values, but the factor of disadvantage. He poses that simply using social capital for measuring social cohesion can and has created apprehending negative pictures of the relationship between diversity and social cohesion. While diversity does play a role in weakening social capital, there are significant benefits to the weakening of in-group boundaries that encourage super-ordinate identities. Furthermore, disadvantage has a much stronger eroding effect on social capital than diversity itself, and is associated with increasing tolerance. Diversity in fact improves tolerance when disadvantage is left out.

Cloud & Granfield (2008) have introduced the concept of 'recovery capital' in the context of substance abuse treatment. Based in the definition of social capital, they define recovery capital as the internal and external resources that can be drawn upon to initiate and sustain recovery from alcohol and other drug problems. Recovery in that sense can be subdivided in three categories, namely personal, social, and societal recovery capital. The idea behind it is that individuals with a larger compositional recovery capital would be more likely to recover from substance abuse problems.

The interaction and possible relation between health and substance use on the one hand and embeddedness in bonding and bridging networks, as well as disposing of recovery capital on the other will be useful concepts in the current study, specifically in understanding determinants of substance use and barriers to treatment services at society and community levels and to study the hypothesis that interventions and policies that leverage community bonding and bridging social capital might serve as means of population health improvement (Kim et al., 2006; Negi, 2011). We wish to also analyze how social capital with its protective factors interrelates with substance use and access to general health care and treatment facilities. Furthermore, social as well as recovery capital should be considered for assessing resources and resistance to prevention interventions (Burkhart et al., 2011).

3.2.3 The urban context

> *Although the use and abuse of drugs is not restricted to any sector of society, its high prevalence and associated social problems are particularly marked in areas and localities marked by social exclusion. We could therefore say that minority [ethnic] drug users are facing a position of double jeopardy: they carry the stigmata of racial exclusion and drug use.*
>
> (Khan et al., 2000: 9)

According to Caponio (2006), cities are the place were the first contact between migrants and the members of the host society take place. Since the Antiquity, cities are places of populations whom in search of better living conditions and try to escape poverty and tyrannical political regimes (Giband, 2011). Relationships between space and ethnicity are becoming increasingly complex due to the deep transformations of contemporary cities (Leloup & Radice, 2008). Links between nation and territory, community and neighborhood, region and local tradition are changing because of migration, mobility, globalization and new widespread communication technologies.

In early urban sociology, the city was associated with anonymity and the end of the community (Tonkiss, 2005). Louis Wirth (in Tonkiss, 2005: 15), defines the city by its size, its density and its social heterogeneity, and considers that physical proximity coexists with social distance. In 1967, Wirth wrote that "processes of segregation establish moral distances which make of the city a mosaic of little worlds which touch but do not interpenetrate. This makes it possible for individuals to pass quickly and easily from one moral milieu to another, and encourages the fascinating but dangerous experiment of living at the same time in several different contiguous, but otherwise highly separated worlds" (1967: 40-41).

The urban Chicago School of Sociology focusses on urban segregation and social differentiation in terms of racial relations within an evolving pattern of competition, reciprocal adaptation and assimilation. This model of ethnically homogeneous neighbourhoods located near the city center is progressively being replaced by variegated spaces including multi-ethnic neighborhoods and peripheral areas (Leloup & Radice, 2008: 4). Indeed, neighborhoods are the territory of ethnic and social diversity (Poirier, 2008), but sociability is also developing through an a-spatial base. The neighborhood is not the only place of living. An individual can identify with several places in relation to the different dimensions of his or her experience.

The use and sale of (illegal) substances have had important transformative effects on those who live in multi-ethnic neighbourhoods (Kokoreff, 2010). Cities are central places for the accumulation of wealth, but they are also areas of social inequalities. Cities concentrate social problems induced by the processes of marginalisation, social exclusion and many other urban social problems, such as racial tensions, crime, and substance use related problems. In addition, cities provide the contextual conditions and the infrastructure necessary for the functioning of the drug market (Kübler and Wälti, 2001).

The study of the urban framework is important for our research in several ways. First of all, the physical living conditions and locations of our respondents may influence their perception of substance use and access to treatment services. Furthermore this perception could differ substantially from those living outside urban neighbourhoods or cities for that matter. We intend

to study the role of the urban context in social mechanisms underlying substance use and access to treatment facilities.

3.2.4 Ethnic Density

Ethnic density is defined as the proportion of co-ethnics in a certain ward or neighborhood (Becares et al., 2009). High ethnic density has been associated to decreased interpersonal discrimination and increased social support through participation in ethnic and cultural minorities and enhanced social cohesion (Becares et al., 2009; Bhugra & Becker, 2005). Furthermore, lower neighbourhood SES in concert with fewer individuals from one's racial group is associated with increased reports of discrimination (Dailey et al., 2010 in Molina et al., 2012). Poorer health, such as higher levels of stress, anxiety and detrimental health-related behaviour, has in its turn been attributed to, among others, interpersonal racism and discrimination (Karlsen et al., 2002; Williams & Collins, 2001). Epidemiological research has therefore studied ethnic density as a protective moderating effect in health (Karlsen et al., 2002).

Although some studies have found no significant effect of ethnic density on health, more recent studies do affirm this effect. Veling et al. (2008) have proven a significant increased incidence of psychotic disorder and schizophrenia among individuals with migrant backgrounds living in low ethnic dense areas in Den Haag. Low ethnic density was identified as an element for elevated risk in these first and second generation immigrants for psychotic and schizophrenic disorders.

Becares et al. (2011) document the greater adherence to protective social norms in areas of high co-ethnic density in the UK. They study drinking patterns through a combined study of the UK Department of Health surveys from 1999 to 2004 and the UK Census that identifies the spatial concentration of ethnic and cultural minorities. Respondents living in non-white areas reported decreased odds of being current drinkers, when compared to people living in white areas. This study is the first one to link ethnic density to alcohol use in the UK.

The relationship between discrimination and health has been studied extensively (Chae et al., 2008). The link between health and ethnic density as a moderating factor is less documented. In their quantitative studies, Veling et al. (2007) and Bécares et al. (2011) have accounted that ethnic density may be a moderating factor in health. They do, however, also bring to attention some limitations that are particularly important for our qualitative research. The role of social selection (Veling et al., 2007: 6) or gentrification and individual levels of acculturation (Bécares et al. 2011: 24) may also be attributed a mediating role in the study of ethnic density. Furthermore, this research is based on respectively self-reported measures of alcohol use (Bécares et al. 2011) and DSM-IV definitions of psychotic disorder and schizophrenia (Veling et al., 2007). Both scholars recognize that these respective denominations are limitations to their studies, because they may cause biased outcomes and cross-cultural validity was lacking.

Ethnic density often coincides with ethnic segregation in poor neighborhoods (Verhaeghe et al., 2012b), that are often disadvantaged compared to neighborhoods with low density or neighborhoods with high ethnic-white density (Laurence, 2011). Consequently it should be noted that deprivation of a community has a strong relationship with lower self-reported well-

being (Hooghe & Vanhoutte, 2010), 2010). In this context, we should be cautious for reversed causation. Jamoulle (2010) for example notes in her qualitative study of Brussels neighbourhoods, that higher ethnic density often coincides with high levels of perceived discrimination that in their turn result in higher ethnic conformity pressure.

To the best of our knowledge, no studies related to neighborhood ethnic density to health and substance use have been conducted in the Belgian context so far. The protective ethnic density effect does demonstrate similarities to the characteristics and processes of ethnic conformity pressure as studied in the urban context by Van Kerckem (2013) (see supra 2.2.3.1). We expect that our research will create a better understanding as to how these two concepts relate to substance use and abuse, and how these could be refined.

3.2.5 Acculturative stress and discrimination

Some research directly links the migration process to acculturation stress (Berry, 1994; Berry & Ataca, 2007). This stress, at its turn, can negatively influence physical and mental health (Haasen et al., 2004; Lindert et al., 2008; Sam & Berry, 1995). Stress caused by acculturation could therefore lead to (elevated) substance use, serving as a coping mechanism (De La Rosa et al., 2000; Vega et al., 1998).

Then again, substance use can cause a more difficult acculturation process, at its turn, raising the accompanying stress. German research among migrants from former Soviet Union shows that substance dependence among migrants can seriously interfere with the process of acculturation in the host country (Grüsser et al., 2005). On the other hand, multiple studies on Hispanic women report that the stress connected with acculturation and the changes in the position of men and women and the relationship between them, raises the risk of alcohol and substance use (Amaro et al., 2006; Finch et al., 2001; Vega et al., 1998). However, the role of acculturation in the origination of substance use among ethnic-cultural minorities is not always clear (Vega et al., 1998).

Acculturation is defined as “complex processes and cultural contacts through which societies or social groups assimilate or are obliged to adopt the features from other societies” (Berry, 1994). Improvements in acculturation research have been made by giving a more specific definition to the concept of acculturation by adding items, such as the language skills, birth place, educational level, socio-economic status, relationship with peers etc.

Several hypotheses can be distinguished when it comes to associating acculturation and substance use. The assimilationist model demonstrates that substance use of migrants tends to progressively be similar to those of the members of the host society. This model is exemplified by the fact that larger degrees of acculturation in Hispanic American youth cause greater normative approval of substance use and higher rates of actual substance use (Epstein et al. in Kulis, 2009). Furthermore, acculturation may produce an acculturation gap between parents and children which undermines parental control over risk behaviour such as substance use (Escobar in Kulis, 2009). A third model is based on the fact that acculturation is a stressful process and considers substance use as a coping mechanism (Gibbons et al., 2012). Lastly, higher acculturation has been associated with a heightened awareness of disadvantaged ethnic minority status triggering coping mechanisms such as substance use (Vega & Gil in Kulis, 2009). Nieri et al. (2005), Ebin et al. (2001) and Finch et al. (2001) (in Kulis et al., 2009),

have concluded that higher acculturation (see infra) results in higher prevalence of substance use, while lower acculturation is recognised as a protective factor (in Latino adults). Kulis et al. (2009) contrarily have found no evidence for this conclusion and point out that lower accultured (see infra) Latino youth perceive higher levels of ethnic discrimination and might consequently be more prone to substance use. In the past, it was assumed that acculturation inevitably involves social and psychological problems but nowadays, studies report mixed results in regard to acculturation and mental health (Missinne & Bracke, 2012).

Recent research rules out that acculturative stress is the prominent and decisive risk factor for substance use. Kulis et al. (2009) have compared the relative impact of both acculturative stress and perceived discrimination, and have come to conclude that the latter factor is far more influential. Problematic, though, is the fact that in most research discrimination is considered an aspect of acculturative stress and not measured separately although there is no conceptual basis for this hierarchy. Recent studies on discrimination and substance use can be subdivided in studies that focus on the one hand on individually perceived discrimination identifying mediating factors such as self-control (Gibbons et al., 2012) and coping mechanisms, and on the other hand the impact of structural discrimination on health outcomes (Krieger, 2012).

Within the framework of a critical eco social approach (Krieger, 2012) to health and discrimination, we will explore how acculturative stress, structural and perceived discrimination interact and relate to substance use in our target groups. We will map the degree to which participants in our research feel exposed to perceived discrimination and how this relates to their ethnic identity as well as to the nature and patterns of their substance use.

3.2.6 Ethnic Identity

Ethnic identity refers to a sense of belonging to an ethnic group, the pride of belonging and the degree of involvement (Chédebois et al., 2009). In terms of the identification process of an individual, it is important to examine their social ties. Identification is closely related to social ties, i.e. not only those between the individual and the ethnic group, but also those between the individual and native persons. De vroome et al. (2011) demonstrate that having social ties with natives is positively related to national self-identification.

The development of one's identity must be seen along similar lines. The younger generation of ethnic and cultural minorities learn how to deal with their 'ethnic identity' in a new way, as part of the acculturation process of an individual. This can be very complex because of their life 'in' and 'between' two cultures. Further, certain features of the communities involved may additionally hinder the development of the identity (Rastogi & Wadhwa, 2006).

When it comes to measuring ethnic identity, it is important to introduce the concept of collective identity. Ashmore et al. (2004) and numerous other researchers consider collective identity as a multidimensional concept (Ashmore et al., 2001; Deaux, 2013; Jackson et al., 1997; Phinney, 1992). The most basic element of collective identity is *self-categorization* (Ashmore et al., 2004). In understanding ethnic identity we will base our research in the self-categorisation of the respondents (Phinney & Ong, 2007). In that sense, measurement of ethnic identity must begin with verifying that the individuals studied in fact self-identify as members of a particular group. This can be done either with open-ended questions. For example by asking questions

like: “In terms of my ethnic group, I consider myself to be …”. In this perspective, Phinney (1992) created the Multigroup Ethnic Identity Measure (MEIM).

Research linking ethnic identity to substance use is quite contradictory (Taïeb et al., 2008). Individuals with low self-identification towards both the receiving culture and the ‘home’ culture would be more vulnerable for substance use disorders (Oetting, 1994). A second hypothesis is that a low level of acculturation combined with a high level of ethnic self-identification serves as a protective factor towards substance use disorders. A third hypothesis is that low ethnic self-identification may result in higher identification with deviant sub-cultures (Beauvais & Oetting, 2002).

3.3 Barriers to care and treatment

3.3.1 Differences in care trajectories

Experts operating in Flemish services (outreaching services, drug treatment, etc.), support the assumption that substance users with a migration background are under-represented within (drug) treatment services (Derluyn et al., 2008). They account for the absence of African clients, ups and downs in presence of Eastern European clients, and the under-representation of individuals with Turkish and Moroccan roots. During the exploratory talks for the current research a stakeholder of a Flemish heroin substitution centre (MSOC, personal communication 14.07.2015) expressed concerns about accessibility towards Congolese, Bulgarian and Slovakian populations. Furthermore the stakeholder attested that their reach of users with Turkish and Roma roots, as well as undocumented migrants had improved during the last couple of years.

Lodewyckx et al. (2005) studied the differences between care trajectories among youngsters with native and immigrant background (concerning mental or behavior problems). They conclude that youngsters with an immigrant background find their way to care services in a very late stage. Earlier intervention would logically reduce the risk for escalation of the problem at hand.

Equal access to health care is a fundamental human right. Within this human rights perspective, substance users who feel they belong to an ethnic and / or cultural minority minorities seem to be confronted with various barriers when using those services (Scheppers et al., 2006). These barriers can be divided into different clusters of barriers. We use the threefold classification of Scheppers et al. (2006)[3]: barriers at the individual, provider and societal level. This cluster stems from a socio-ecological model which provides a community understanding of health and offers an overarching framework for examining individual, organizational and social factors in mental health and drug treatment services (Fleyry & Lee in Shattell et al., 2008). We agree with Scheppers et al. (2006) to complement this ecological approach by including potential barriers at the system level. This approach is in line with Martiniello’s approach to unequal social outcomes in ethnic groups at micro, meso and macro level (see supra 2.2).

[3] Equally used by Derluyn et al. (2008)

3.3.2 Barriers at the individual level

Within the category of individual barriers, we discern five barriers: socio-economic and judicial status, cultural perspectives, religious perspectives and collectivist perspectives on the individual within the family. Of course, individual barriers are intertwined with structural barriers.

First of all, there is a lack of *knowledge about* the diversity *of (addiction) care services* among some ethnic and cultural minorities. Some minorities are less informed about the existing diversity of care services, and about where they can go with a specific health problem.

Amaro et al. (2006) argue that a low *socioeconomic status (SES)* is a negative predictor of treatment results in the addiction care services. Furthermore, it is well established that poor living conditions of substance users can result in socioeconomic problems and a lack of attention towards health related problems (Piérart et al., 2008). *Judicial status* is another barrier at the individual level. The accessibility to general health care as well as treatment services is often extra problematic for those individuals without permanent resident permits (Haker et al., 2010; Shattell et al., 2008; Teunissen et al., 2014).

Among ethnic and cultural communities, (illicit) substance use is strongly *stigmatized*. A feeling of shame or the fear of being stigmatized by the own community may prevent substance users from seeking help and recognizing the problem (Ciftci et al., 2013; Clement et al., 2015; Sacré et al., 2010). Another barrier among ethnic and cultural minorities is the fact that individuals may be *less conscious* of the gravity of the substance use related problem. Even when these individuals are conscience of the problem, the step towards the *recognition of the problem* is often (too) big (Derluyn et al., 2008).

Another barrier within the cluster of individual barriers may consist of a *different cultural representation of the problem* of substance addiction. This problem is twofold. Individuals from ethnic and cultural minorities may adhere a purely medical approach to substance use (Derluyn et al., 2008). Furthermore different cultures have different concepts of health and disease (Lindert, 2008). This often creates a restraint towards Western, formal addiction care services and Western therapy based in empowerment and self-reflection.

Furthermore, substance users who feel they belong to an ethnic minority are said to seem to have a larger inclination to rely on religious or spiritual explanations for their addiction problems. They turn, for instance, to spiritual healers or shamans (Derluyn et al., 2008) to resolve substance related problems. Although some scholars argument that this inclination is similar to native populations resorting to alternative treatment methods (Knipscheer & Kleber, 2005).

3.3.3 Barriers at provider level

At the organizational level of treatment and general health care services, several barriers can be distinguished. Firstly, Fountain et al (2004) determine a *lack of cultural sensitiveness* or ‘cultural awareness’ within care services. If care givers and their clients share similar ethnic backgrounds, the sustainability of treatment may be influenced in a positive manner (Ellis, 1999 in Derluyn et al., 2008). Some research goes beyond the concept of cultural

sensitiveness and points at a *lack of competence or willingness* by administrative, medical, and social actors to adequately inform and reach ethnic-cultural minorities (Fassin, 2000; Picozzi, 2004 in Derluyn et al., 2008).

Furthermore, the *lack of cultural responsiveness* of the professional can be a reason why ethnic and cultural minorities are underrepresented in treatment services (Derluyn et al., 2008; Finn Ma Mat, 1994). An important element is the way the client perceives the empathy by the caregiver, because this influences the clients' involvement (Fiorentine et al., 1999 in Derluyn et al., 2008). Another determinant is *the lack of transcultural competence* of professionals. This competence takes account of the socio-cultural context and the familial context of the client. The presumptions of health care providers are of vital importance to the success of treatment. Stereotyped images and missing the context of marginalization, discrimination and poverty could lead to lower treatment completion rates (Quintero in Alegria et al., 2011).

At the organizational level, we can also distinguish a practical barrier. *Communication and language* may become significant barriers in both access to treatment and treatment itself. The lack of multilingual staff in the addiction care services and/or the non-availability of interpreters can be seen as important motives to quit treatment (Derluyn et al., 2008). However, the use of an interpreter is not always the solution for the language barrier. The intervention of an interpreter can create distrust for both the client and the caregiver (De Vylder, 2012).

3.3.4 Barriers at system and societal level

Stigmatization towards substance users does not only occur at the level of communities, but also among the authorities and society of the host land (Jung, 2004). Individuals from ethnic and cultural minorities might suffer *double stigma* meaning that they suffer from being stigmatised both by their ethnic identity and their substance use (Gary, 2005). This stigma has proven to have a negative effect on help-seeking behaviour, especially in ethnic minorities (Clement et al., 2015).

The *'nature' of care services* and their medical paradigm (Scheppers et al., 2006) can be seen as another potential barrier (Derluyn et al., 2008). Ethnic cultural minorities may feel uncomfortable or even threatened by the Western values, professional attitudes and scientific knowledge on which care services are based, for instance the concept of (medical) confidentiality (De Vylder, 2012).

Moreover, in many cultures, unlike the West, substance use related problems or dependence are n*ot seen as an illness* (Derluyn et al., 2008; Muys, 2010), but as a criminal fact. This means that the taboo in those countries of origin can take even bigger proportions than the taboo on substance use related problems in the Western countries.

Further, US based research mentions that health care policies and regulations at the city, state and federal level may result in health care access disparities (Alegria et al., 2011). Our personal communication with health care and treatment providers confirm that budget cuts often result in limiting outreach work and cutting in projects that promote broader access and diversity in treatment, health care and other relevant social facilities.

3.4 Good practices in dealing with ethnic minorities and substance use

Paradigms on health care for ethnic and cultural minorities are dominated by the culturalism / anti-differentialism debate. The main question is the extent to which facilities should recognize and incorporate 'the other's' differences in their services (Derluyn et al. 2008: 83). This question can be extended to question as to whether the risk factors and determinants for substance use in ethnic and cultural minorities differ substantially or, on the contrary, whether they demonstrate manifold similarities to risk factors when compared to native populations (Viruell-Fuentes et al., 2012).

Most scholars and professionals agree that an intermediate position is key to successful service delivery (Fountain & Hicks, 2010). In this context, Bhui et al. (2000) argue that the creation of partnerships with specialist providers, voluntary and independent workers should enhance the successful components of generalist treatment services for individuals from ethnic and cultural minorities.. Sangster et al. (2002) argue for a similar intermediate position where specialist services and practices should complement 'mainstream' services.

Noteworthy in this debate is that specialist services (Fountain & Hicks, 2010)as well as parallel networks (De Gendt, 2014; Verhaeghe et al., 2012a) have emerged because of the historic failure of generic services. Fountain (2004) discusses the fact that mainstream services could use the existence of independent specialist services as a justification for not developing their own service responses. Individuals who describe themselves as belonging to an ethnic and cultural minorities themselves rarely see the existence of specialist services as a solution to services' lack of cultural competence (De Vylder, 2012; Fountain & Hicks, 2010).

Derluyn et al. (2008) conclude that services should on the operational level introduce transcultural awareness, not by means of a single employee belonging to an ethnic and / or cultural minority, but by introducing processes at all levels of the facility. Further, the fact that individual determinants of problematic substance use often have a larger impact than cultural determinants should be taken in account in individual care trajectories (Derluyn et al., 2008; De Vylder, 2012). Treatment of individuals of ethnic and cultural minorities should not be an isolated action within treatment services, but need to form an integral part of 'interculturalising' (Van der Seypt, 2013) treatment services, prevention and harm reduction initiatives.

3.4.1 Cultural “responsiveness”

The degree to which service planning organizations and professionals in health care respond to the challenges posed by the diversification of the European population is discussed under many guises. Service providers do generally agree that cultural responsiveness, competence, sensitivity or appropriateness is necessary for meeting the needs of heterogeneous client groups. The diversity in naming this capacity results in a very varied way of putting it into practice.

The employment of staff with a migration background is one way of dealing with cultural diversity in services. This practice proves to be helpful in understanding some of the client’s culturally oriented or grounded needs, but also implies a fear for confidentiality breach and stigmatization (Fountain & Hicks, 2010). Further, this practice does not answer the cultural capacity needs in service planning of organizations at large. Culturally responsive organizations are dependent on the majority of staff who have the capacity to reach and support individual clients from all layers of society.

A greater affinity with and empathy for the situation of individuals who feel they belong to an ethnic and / or cultural minority is necessary to, on the one hand, fully understand the specific vulnerabilities of substance users who feel they belong to an ethnic and / or cultural minority and on the other hand, to organize prevention and harm reduction for this group. Cultural sensitivity should consist of basic knowledge of cultural backgrounds, intercultural communication, acculturation processes and cultural perceptions of substance dependence (Broers & Eland, 2000). However, cultural sensitivity does not only imply understanding specific cultural traces, such a pride, taboo and stigma. It also implies a greater understanding of the interconnectedness of socio-economic factors, psychosocial stress, discrimination and the migration background (Otiniano et al., 2014).

Increasing cultural sensitivity can in this perspective be seen in the context of creating more accessible drug treatment services at large (Jackson et al., 1997) and consequently implies some basic requirements at the structural and organizational level of the services. Creating culturally sensitive treatment facilities and interventions does not only imply a full optimization of the staff’s competences, it also requires 1) an integrated policy perspective of the facilities 2) an organizational environment that appreciates diversity and diversity in society at large 3) promoting equal opportunities for all staff members and 4) diversity in the staff members (Van der Seypt 2014: 101).

3.4.2 Dealing with the medical perspective

Some ethnic and cultural minorities appear to have a medically oriented view on substance use (Vandevelde et al., 2003). This implies that trajectories in treatment facilities are less often completed, when the client appears to have physically healed from his or her dependence, without taking into account the psycho-social aspects of dependence. The inclusion of this medical perspective (Verdurmen et al., 2004) as well as learning to incorporate the *somatising* reaction to dependence (Broers & Eland, 2000) may open pathways to more durable treatment solutions for individuals who feel they belong to an ethnic and / or cultural minority. In the target groups themselves, psycho-education has in some cases proven to increase self-reflection as an important instrument in the treatment process (Chow et al., 2010). Some

studies have also proven that a multidimensional family therapy (Litle et al. in Alegria et al., 2011) as well as multisystem therapy result in higher treatment completion rates.

3.4.3 Outreach work

3.4.3.1 General outreach work

Contact and networking with community members and organized ethnic and cultural minorities is beneficial at various levels of treatment, prevention and harm reduction. In this sense, outreach work responds to the observation that the needs of individuals who feel they belong to an ethnic and / or cultural minority all too often do not reach health services. Initiatives that lower both the symbolical and physical threshold are in these cases in place (Noens et al., 2010; Walleghem, 2013). Since the 1960s, this has been the general answer to the fact that a broad gamut of individuals does not have access to residential psychiatric care. The emphasis on low threshold initiatives may broaden the scope of prevention, treatment and harm reduction in ethnic and cultural minorities, taking into account that individuals who feel they belong to an ethnic and / or cultural minority find access to ambulant care more easily when compared to residential care (Derluyn et al., 2008). A key figure the out-client service of De Kiem vzw as well as a staff member of an in-client center of De Sleutel (personal communication 24.03.2015 & 01.04.2015) confirm that since they have dismissed the outreach worker in their center, the number of people with a migration background has been reduced to zero. A staff member of MSOC (personal communication 15.03.2015) working in a needle exchange program also confirms that since one of the key bridging organizations in the city of Ghent (vzw De Eenmaking) has seized to exist in the city's drug scene, the number of clients with a migration background in the program has reduced drastically.

The importance of outreach work should thus also be seen in the broader perspective of a presence oriented theory (Baart inBryssinck, 2013) in dealing with substance dependence and social isolation. In this theory, the focus lies on the creation of a connection by respecting and caring for the other in a Levinasian perspective, instead of just wanting to fix, heal or normalize the patients of society. The focus on what we have called cultural differences such as taboo and pride should in this perspective be shifted towards a priority in establishing a bond with substance users. Such a perspective does of course presuppose a specific setting, some principal requirements and can so far only help us deal with specific problems of substance abuse and it cannot be applied to all treatment services.

3.4.3.2 Networking

Studies broadly recognize that creating links with self-organizations and durable networks among treatment facilities, social services, families and communities are beneficial methods and can, in the long run, reduce some of the barriers (see 2.3) and difficulties mentioned above. Quantitative analysis in closely knit ethnic and / or cultural minority networks confirms that interventions and policies that leverage community bonding and bridging social capital might serve as a means of population health improvement (Kim et al., 2006), and that this is specifically true in community mental health services (Priebe et al., 2011). Professionals in treatment facilities affirm that closer contact with the communities might reduce communication difficulties by helping lift taboo and by creating more confidence towards services (Chow et al., 2010; Meys et al., 2014).

3.4.4 Local needs assessments

Local needs assessments in the tradition of rapid assessment or participatory action research prove to be useful in assessing and addressing specific needs in harm reduction and treatment (Castro et al. in Alegria et al., 2011). These methods have shown to pave the way for grounded and specific interventions that reach target groups trough the knowledge gained about specific needs in communities as well as the pitfalls in working with these communities. In assessing these needs and tailoring interventions, it should be underlined that not all ethnic and cultural minorities have the same needs and that tailored interventions might not have the same effect on all individual group members (Sloboda et al., 2012).

Using methods of involvement, consultation, participation and engagement of individuals of ethnic and cultural minorities (Fountain, 2012) and not only key figures (Fountain, 2003) offers a useful insight into the specific needs, supports capacity building and increases knowledge and consciousness about substance use.

3.4.5 Targeted Information initiatives

The lack of knowledge about drug treatment services and the effects of substance use may be one of the reasons why some ethnic and cultural minorities are underrepresented in drug treatment facilities (Derluyn et al., 2008). Further, the taboo about substance use in some ethnic and cultural minorities is characterized by the fact that there is no communication about the this theme. Facilitating targeted information initiatives thus remains an important aspect in effective prevention, treatment and harm reduction. Information initiatives should of course be integrated in a broader view on prevention, treatment and/or harm reduction; they should not stand alone or consist only of the distributions of leaflets or the random organization of information events.

3.5 Overall assessment of the state of the art

In our review of the existing literature, we depart from the idea that ethnicity is a dynamic concept, and therefore not unproblematic when used as a unit of analysis. Two main research traditions can be distinguished, i.e. research that departs from the Herderian concept of ethnicity, and research that refutes this unity of community, culture and identity, and therefore departs from individual variables in relation to substance use. The difference between these traditions often results in contradictory outcomes when the relation between ethnicity and substance use is studied. Nevertheless, lower health statuses and substance use have proven to be linked to lower socio economic statuses and discrimination (Marmot & Wilkinson, 2005; Otiniano Verissimo et al., 2014; Smedley et al., 2003; Warnecke et al., 2008), while many individuals self-categorized in ethnic and cultural minorities often have lower socio economic statuses (Manço, 2004; Van Kerckem et al., 2013). Furthermore, these individuals have shown to be underrepresented in drug treatment facilities. (Verdurmen et al., 2004; Vandevelde et al., 2003).

Anglo-Saxon research in psychology and epidemiology offers insights in substance preference, prevalence and methods of use in specific ethnic and cultural minorities. These studies allow us to identify the influence of accessibility of prescribed medication on the preference in substances (Argeriou, 1997), the influence of the country of origin on prevalence (Ramsey et al., 2001 in Rassool, 2006) and differences in prevalence between generations (Hjern, 2004) in specific ethnic and/or cultural minorities. Nevertheless, this research remains problematic because its basic assumption is a distinction between ethnic groups.

Consequently, other explanatory factors, such as discrimination remain subordinate to the impact of the ethnicity factor.

We strongly argue for the need to diversify the concept of ethnicity at three levels, i.e. individual identification, ethnic mobilization and social positioning (Martiniello, 2013). Consequently, we link substance use to the production and reconstruction of ethnic boundaries (Wimmer, 2013), and stress the importance of combining the analysis of non-ethnic social mechanisms as well as distinguishing ethnic processes from individual processes in social mechanisms. We will focus our qualitative research on the social dimensions of the urban context, ethnic density, conformity pressure and social capital. At the individual level, we will focus on acculturative stress, discrimination and the formation of ethnic identities.

We will explore how these social mechanisms influence the nature and patterns of substance use and access to treatment facilities. Recognizing the complexity of the concept of ethnicity, however, impels us to create a new framework for taking a variety of non-ethnic factors into account, to define and be aware of the heterogeneity within and between the ethnic and cultural minorities studied, and to place the aspect of ethnicity and migration in a wider context of non-ethnic influences at micro, meso and macro level.

We have reviewed grey literature and have supplemented this review with personal communication with key figures to address the barriers that individuals from ethnic and/or cultural minorities experience in their contact with the health care sector, and vice versa. We've clustered these barriers into individual, societal, and service-related barriers. In our qualitative fieldwork, we will test these sensitizing concepts in the narratives of community members and users and complement them with new concepts that emanate from our fieldwork.

The concepts that we put forth in this review (ethnic conformity pressure, social capital, the urban context, ethnic density, acculturative stress, discrimination and ethnic identity formation) are concepts that have proven to be productive analytical concepts in the study of ethnicity and health. Our research design does, however, imply that we work both inductively and deductively and do not depart only from specific hypotheses, and that we are open to new explanatory factors or contextual themes that will emanate from the research context, the community researchers, the stakeholders, other field workers and community researchers.

Because of the difficulties related to conducting research in the areas outlined above, we have decided to work within a community based participatory research design. We aim to improve the understanding of service planners and providers, build community capacity and most importantly, bridge academic knowledge with policy and practice.

4 COMMUNITY BASED PARTICIPATORY RESEARCH (CBPR)

CBPR is a research and engagement model developed to tackle health disparities in disadvantaged groups by installing equitable partnerships between academia and community-based partners (Belone et al., 2014; Bogart & Uyeda, 2009; Green et al., 1995; Israel et al., 2010; Israel et al., 2001; Krieger, 2014). It is a conceptual model for bridging evidence with policy-making (Cacari-Stone et al., 2014; Domenig et al., 2007; Minkler et al., 2008). When applying CBPR to the case of substance use in ethnic and cultural minorities, the underlying rationale is not only to study the nature and patterns of use and barriers to health and social service access, but also to increase the understanding of service planners, commissioners and providers about segments of the population they serve (Domenig et al., 2007; Fountain et al., 2004). Furthermore, community involvement builds upon community capacity, and increases the likelihood of future sustainable interventions through existing social organisations and community structures (Bogart & Uyeda, 2009; Wallerstein & Duran, 2010). This way, CBPR also allows to tackle health disparities at the fundamental levels of distributive and procedural injustice (Cacari-Stone, 2014). The engagement model is thus aimed at equality of access, equality of experience and equality of outcomes (Fountain et al., 2010).

In what follows we will elaborate upon (1) the history and goals of the research design, (2) the concept of empowerment in this research design, (3) the application of CBPR to our four case studies and collaboration between a) project assistants, b) community organisations, c) community researchers and d) community advisory boards. We conclude by pointing out some of the pitfalls we encountered during the implementation of this model.

4.1 History and goals of the research design

Participatory research is an umbrella term for various research methods including CBPR[4]. It can historically be traced back to Lewin's utilization-focused action research (1948), Paulo Freire's emancipatory research (1968), and the more recent self-determination and sovereignty movements of indigenous peoples and ethnic minorities in USA, New Zealand, Canada (Cargo & Mercer, 2008) and UK (Fountain, 2010). Participatory research aims at the formation of partnerships between academics and those who will utilize and benefit from the results of the research to effect change (Salsberg, 2015). Community-based participatory research increases the relevance of the research questions, creates a potential of effective knowledge translation, and leads to the faster uptake of evidence into practice. CBPR, fundamentally it is (Israel, 1998):

- participatory;
- cooperative, engaging community members and researchers in a joint process to which each contributes equally;
- a co-learning process;
- an empowering process through which participants can increase control of their lives;

[4] as well as action research, participatory rural appraisal, empowerment evaluation, participatory action research, community-partnered participatory research, cooperative inquiry, dialectical inquiry, appreciative inquiry, decolonizing methodologies, participatory and democratic evaluation, social reconnaissance, emancipatory research and participatory action research (Cargo & Mercer, 2008: 326).

- it involves system development and local capacity building and achieves a balance between research and action.

These principles translate into five practices that characterise CBPR (Salsberg et al., 2015):

- the creation of an advisory board;
- the development of a research agreement;
- the use of group facilitation techniques;
- hiring from the community;
- having frequent meetings.

An extensive literature review on CBPR projects by Cargo & Mercer (2008) reveals that participatory research designs have significantly contributed to closing the gap between scientific standards on the one hand and social as well as cultural validity on the other hand. Participatory research has proven its value specifically in 1) illuminating prevalence rates of health problems 2) identifying needs and priorities of diverse communities of interest; and 3) establishing causal associations between behavioral risk factors, social and environmental risk conditions, and the health status of vulnerable populations. (Cargo & Mercer, 2008).

4.2 Empowerment

We considered the participative factor of our research not only as a means to collect data and to easily reach substance users in the respective ethnic and cultural minorities, but also as a means to increase expertise in those communities. This concept of empowerment first arose in the Anglo-Saxon literature, where the ideas of community and individual agency (capacity of doing) are strongly embedded in social values and leave minor space for state intervention in the social sector. In the European and specifically the Belgian context, on the contrary, the intervention of the state is considerably larger in the social sector. The notion of empowerment and voluntary participation were recently reintroduced both by the state within the context of financial crises, as by social actors in reaction to the latter (ref. toevoegen). We will elaborate upon the consequences of this evolution in our description of the CBPR process.

The concept of empowerment has been used in very different contexts since the 1970s. The feminist local movements in the USA and South Asia, popular education movements and black movements only to name some (Biewener & Bacqué, 2014). For US-battered women associations, empowerment focuses on egalitarian, participatory and local processes in which women develop social conscience (Biewener & Bacqué, 2014) to strengthen their inside power and gain the capacity to individually and collectively act in a perspective of social change.

More recently, the concept of empowerment has been added to the international vocabulary of expertise and public policy of international organisations such as the UN and the World Bank (Biewener & Bacqué, 2014).The notion highlights the relationship between knowledge and power within a knowledge society. In other words, acting consciously and rationally for community organisations presupposes being knowledgeable about community issues both to represent and advocate when being the target of public policies. In the context of health research, empowerment and agency have been quoted to resolve the mystery of the health gradient by Syme (2004). Syme poses that only poverty and lower education cannot be the determinants of worse health, and that control over one's destiny - agency, may have a larger impact on health statuses. In this line of thinking Piérart and colleagues (2008) state that in

diagnosing a health situation in close collaboration with deprived communities, not only do communities form the basis for resolution of the situation, but they already start the resolution process by tackling one of the possible determinants of unequal health statuses: empowerment and agency.

Scholars have alerted the fact that a conceptual framework is still missing to consolidate the benefit of this type of research in academic as well as community capacity. Consequently no association can be made between this capacity and actual empowerment and ownership (Cargo & Mercer, 2008). Noteworthy is the research of Cacari-Stone et al. (2014) in measuring the degree in which CBPR designs lead to increased partners brokerage of research findings to reach a policy audience.

The most recent *Reliability Tested Guidelines for Participatory Research* (Cargo & Mercer, 2008) are an extended version of Green's (Green et al., 1995) five review criteria intended for research partners to evaluate and gain perspective in designing, implementing and evaluating community-based participatory research projects. These guidelines do however not address issues of power dynamics, centralised power and equity of resources nor the issue of adding or replacing new members through the project (Salsberg et al. 2015).

Taking into account that clarity concerning the scope of our design is paramount, we chose to limit our implementation and evaluation criteria to these five criteria during the project design, implementation and evaluation. We will use these criteria in describing our CBPR process.

1. Participants and the nature of their involvement

- ✓ Is the community of interest clearly described or defined?
- ✓ Do members have concern or experience with the issue?
- ✓ Are interested members provided with opportunities to participate in the process?
- ✓ Has attention been given to establishing an understanding of the researchers' commitment to the issue?

2. Origin of the research Question

- ✓ Did the impetus for the research come from the community?
- ✓ Is an effort to research the issue supported by the members?

3. Purpose of the research

- ✓ Can the research facilitate learning among participants about individual and collective resources for self-determination?
- ✓ Is the purpose of the research to empower the community to address determinants of health?

4. Process and methodological implications

- ✓ Does the research process apply the knowledge of community participants in the phases of planning, implementing and evaluating?
- ✓ Does the process allow for learning about research methods (community participants)?
- ✓ Does the process allow for learning about the community health issues (researchers)?
- ✓ Are community participants involved in analytics issues: interpretation, synthesis, verification of conclusions?

5. Nature of the research outcomes

- ✓ Do community participants benefit from the research outcomes?
- ✓ Is there an agreement about the ownership of the research data?
- ✓ Is there an agreement about the dissemination of the research results?

Green et al., 1995

4.3 The CBPR model in this study

> *'The simultaneous and multifaceted engagement of supported and adequately resourced communities and relevant agencies around an issue, or set of issues, in order to raise awareness, assess and articulate need and achieve sustained and equitable provision of appropriate services'*
>
> (Fountain et al., 2004)

The Centre for Ethnicity and Health (UK) has developed a CBPR model based on following key principles (Fountain, 2007) that are in line with the accepted principles in CBPR literature (Cacari-Stone et al., 2014; Israel et al., 2010; Israel et al., 1998, 2001; Lantz et al., 2001):

- raising awareness of community members;
- reducing the community's stigma;
- capacity building within the community;
- increasing the trust of the community;
- involving local service planners.

These principles were part of a research project on substance use in ethnic minorities in UK (Fountain & Hicks, 2010). This model was the blueprint for our research design. Rather than employing 'external' people to conduct research, this approach involved forming a relationship with relevant 'host' organisations (community organisations) who have helped us to recruit a team of researchers from the community, and to provide training to support the work. Four researchers (project assistants) from the involved universities provided ongoing support and mentoring (see infra). Training was provided to build the capacity of the community researchers alongside help with managing the project and quality assurance.

The four sub-studies each consisted of:

- One academic project assistant (see § 4.3.1);
- a community organisation (CO) (see § 4.3.2);
- at least ten community researchers (CRs) (see § 4.3.3);
- a community advisory board (CAB) (see § 4.3.4).

Although we used the Center for Ethnicity and Health's model as a blueprint for our research design, the execution of the projects differs substantially. First and most importantly the scale of the projects differ: the UK project reached over 2,000 substance users in 30 ethnic groups in 47 geographical locations (Fountain et al., 2004) whereas the Belgian project reached about 200 substance users in 4 ethnic communities in 3 urban areas. Secondly, UK and Belgium differ substantially in their societal organisation and mobilisation of ethnic minorities. UK has long established community organisations as the backbone of the British model of multiculturalism (Vertovec, 2007: 28) whereas ethnic organisations in Belgium and more specifically in Flanders are less structurally embedded, less organised and are not recognised as liaisons between specific ethnic minorities and local or other governments.

4.3.1 The project assistants

The four project assistants, scientific staff members that work for Ghent University (3) and Université Libre de Bruxelles (1) were responsible for monitoring the project and each one was responsible for one of the target groups. The preparatory literature review, the organisation of information sessions and the training and follow-up of the community researchers, monitoring the community researchers and organising the meetings of the community advisory board were the main tasks of the project assistant. The project assistants also went in search of new respondents when community researchers appeared not to reach any participants or certain sub target groups. This was the case in all sub-studies (see infra).

Three of the project assistants work at Ghent University and the fourth one works at ULB (Université Libre de Bruxelles). Also, two of the case studies were Ghent-based (The Turkish and the Eastern European communities) while the third target group could not be pinned down to a region (asylum applicants, refugees and undocumented migrants). Consequently, some of the efforts were joined, such as the regular dissemination of the call for participants, the organisation of an info evening as well as the joint community advisory board for the Turkish and Eastern European communities (see infra).

The project was presented by the project assistants in a heroin substitution center in Ghent (Medisch Sociaal Opvangcentrum Gewad (MSOC), during three municipal welfare meetings in Ghent (*Welzijnsoverleg*: Tolhuis, Brugse Poort, Bloemekeswijk, Sluizeken-Ham), a neighbourhood team meeting in Ghent (Brugse Poort), in a center for double diagnosed clients (Villa Voortman), to staff members of a refugee center (Wingene) and in a youth organisation in Ghent (vzw Jong). The project assistants conducted exploratory interviews with staff members of in-client, out-client and outreach substance abuse treatment centers, municipal health centers (*wijkgezondheidscentra*), youth organisations, other municipal services and key figures in the respective communities. The goal of these preliminary talks was to gain insight into the phenomenon of substance use in the four target groups and during the writing of the literature review. Furthermore, these contacts were made to create a network for dissemination.

4.4 Community Organisations (COs)

Ethnic minority civil society organisations were considered to be important stakeholders in this project. Early on in the project we noticed that this pillar of the CBPR model could not be easily established in the Belgian context. This is mainly due to the fact that the CBPR model was developed and refined in US and UK. In these Anglo-Saxon countries, the multicultural societal model consists of the recognition of ethnic groups through the establishment of subsidised ethnic organisations parallel to other 'native' socio-cultural organisations. In Belgium, these organisations also exist, but enjoy less funding. Furthermore community and neighbourhood-based (mental) health care systems are well developed in Anglo-Saxon countries whereas they are –despite recent efforts and reforms, more centralised in the Belgian context. Lastly, both the socio-cultural and the mental health care sector in Flanders are undergoing far-reaching governmental reforms[5], putting pressure on their organisational structures.

[5] New Flemish decrees for respectively socio-cultural work and mental health care implying a restructuring of the municipal, provincial and community organization of these sectors.

The first stage of the project was essentially focused on finding support in ethnic communities and finding suitable community organisations. In each of the four communities, we identified community organisations through personal contacts, stakeholders, professionals from treatment and prevention services, and platforms, academics and professionals with expertise on ethnic and cultural minorities. Once the partnership with community organisations was established they received a (rather limited) financial restitution for their collaboration.

We applied the following criteria in selecting the respective community organisations:

- An ethnic and / or cultural minority-based organisation or a community-based organisation that demonstrates that it undertakes a substantial amount of work with, and on behalf of the ethnic and / or cultural minority;
- able to identify at least 10 people from within their community who would be willing to be trained, supported and paid to conduct interviews;
- able to access members from ethnic and cultural minorities;
- able to secure the support of, and engage with, key service planners and providers.

4.4.1 The Turkish community in Ghent

Over 100 self-organisations represent persons with a Turkish migration background in Ghent. These organisations are usually one-man organisations run on a voluntary basis. They bring Turkish people together for leisure and socio-cultural activities. Many of these organisations initially brought people together originating from a same region in Turkey. Also, some of these organisations are indirectly linked to political or religious movements. They offer services that people of Turkish origin initially could not find in 'regular' municipal or governmental services (e.g. educational support, language lessons, administrative support etc.). Over the years several federations were installed to strengthen these and other ethnic organisations. VOEM, the Turkish Union, CDF (Federation for progressive associations) and FZO-VL (Federation of Self-organisations Flanders) are examples of these federations with multiple paid staff in Brussels and Flanders.

Because these federations reach a large number of organisations and individuals of Turkish origin, we chose to work with two of these federations instead of partnering directly with one single self-organisation. Because of personal and well established professional contact we partnered with **CDF** and **FZO-VL**. These organizations focus on a broad range of political and religious ideologies to reach people from various regions of Turkey. They unify 16 and 15 Turkish self-organisations respectively. A symbolic commitment agreement was signed in May 2015 and is the reflection of a mutual commitment between the Institute for Social Drug Research and the organisations respectively.

We chose those two federations to minimize the risk of abstinence and to reach the widest possible audience, both for finding community researchers and for finding research participants. The community organisations have actively collaborated in order to find community researchers and later on in the organisation of a meeting with potential community researchers, and its delegates participated in the four meetings of the community advisory board. The premises of these two organisations were used alternately for the training of community researchers and peer intervision moments.

4.4.2 The Eastern European communities in Ghent

The Eastern European community in Ghent stems from a rather recent migration flux (see infra). Therefore it is not as organised as for example Turkish and African communities in Ghent. Of the 82 recognised self-organisations in Ghent, no more than 10 organisations represent the Eastern European communities. Therefore we choose to work with an organisation that could help us the most to reach an Eastern European subgroup, namely Roma migrants. The community organisation **Opre Roma** is a one-man organisation that is ran by volunteers. In January 2012 the first Bulgarian organization in Ghent was founded and announced at Kom-Pas Ghent. The main aim of this organization is to tackle the issues the Bulgarian community is dealing with and to spread positive signals to the whole community. They want to fight the persistent prejudices and be a point of contact for the community as well as the local authorities.

Also in 2012 the Bulgarian Cultural Centre awlp (member of FZO-VL, the Turkish community organisations) was officially opened. Its main goal is to advise people of Bulgarian origin of all ages and to offer tutoring for students, classes Bulgarian and Belgian language and culture, etc, so that their integration in the community of Ghent is optimized. In 2013 awlp De Magische Stem was founded by about ten Bulgarians from Ghent. It's a Bulgarian cultural organization that wants to discern the image of the Bulgarian community, emphasizing the wide variety of Bulgarian migrants. They want to be a platform for the creative, working and enterprising Bulgarian people who want to keep the Bulgarian culture alive and pass it on to their children. Further, they want to support charity in Bulgaria by organizing charity events in Ghent and surroundings.

Finally, in XXXX Opre Roma awlp was founded. Opre Roma is an organization that focuses on the current situation of Roma in Belgium, more specifically in Ghent. It wants to change the Roma-problemacy into a Roma-theme. They want to provide honest and correct information on the culture and life situation of the Roma. In that regard they are organizing informative, cultural and sport related activities by and for Roma and non-Roma. Opre Roma awlp is recognized by the Ministry of Welfare and named to be the only awlp working on Roma in Ghent. Other than these there are no significant community organizations within the Eastern-European community in Ghent. Furthermore, all of these organizations are driven by volunteers and fully dependent on funding. We contacted every organization more than once. Some we could get hold of, others we couldn't reach or weren't willing to cooperate as our community organization. Opre Roma was willing to participate though and act as the community organization of this substudy.

4.4.3 Asylum applicants, refugees and undocumented migrants

In our search for community organisations we sent out a call to experts and policy makers with a focus on asylum applicants, refugees or undocumented migrants, and to professionals who work for organisations in the field. Eventually we worked with 2 community organisations. The first community organisation is **Free Clinic vzw** located in Antwerp. Free Clinic vzw offers out-client services to people with a serious addiction problem to illegal substances. It operates within a harm reduction perspective and they help users with addiction problems. Many undocumented migrants find their way to these low threshold services.

The second community organisation is the **Mind-Spring** project (embedded in Agentschap Integratie & Inburgering). It is located in East-Flanders, Ghent. Mind-Spring is a psycho-educational program for asylum seekers and refugees. The program is guided by qualified trainers who have had experiences that are characteristic to refugees and asylum applicants. A symbolic commitment agreement has been signed and is the reflection of a mutual commitment between the department of 'social work and social pedagogy' of the Ghent University and the community organisations just presented.

Free Clinic vzw reaches the group of undocumented migrants, the Mind-Spring project reaches the group of asylum seekers and refugees. The community organisations actively collaborated in finding community researchers and in participating in the meetings of the community advisory board. The premises of Free Clinic vzw were used for training community researchers and other meetings.

4.4.4 The Congolese community

Finding a suitable community organisation to conduct the research in the Congolese community in Brussels turned out to be quite hard, because of the weak professionalization of the Congolese associative structure in Belgium (Rea & Sacco, 2006; Demart, 2013; Manço et al. 2013). However there are more than 600 Congolese associations (Thys, forthcoming), only a few of them are really working and receiving public subsidies. The present situation of the Congolese associations translates the social exclusion and the ethnic discrimination of the Congolese Community in Belgium.

Before finding a community partner, many contacts with key figures from Congolese origins (priests, doctors, and Belgian officials) directed our interest towards various organisations such as Observatoire Bayaya, l'amicale Lipopo, Change and Mémoires coloniales and with associative (Maison Africaine, Free Clinic) and public agents (Service de prévention de la Commune d'Ixelles, Stewards de rue de la Commune d'Ixelles, et Police d'Ixelles) acting in Matonge, the meeting point of the Congolese community in Belgium, but not a residential center for the Congolese community (Schoonvaere, 2012). Some organisations expected a larger financial restitution for the partnership than what we offered, others considered that their actions were too far from the subject of the research.

Eventually a partnership was officialised with the organisation 'Change in Congo'. Since this partnership was initiated when data collection had already started in the other case studies, the relationship with the organisation was not easy: the agreement for the partnership has been really long and slow at the beginning, the bottom line of most communication was their financial restitution for the project. Despite the difficulties, the partner organisation did help promote the project to find respondents and community researchers. The project assistant announced the search for community researchers four times on a Congolese radio station. But the majority of the community researchers were found thanks to a student job advertisement on the website of the ULB and Infor Jeunes. During the research process, contacts with other Congolese representatives and associations (le Manguier à Fleurs, Carrefours Jeunes Africains) helped us find Congolese drug or alcohol users.

4.5 The community researchers (CRs)

Initially the project assistant aimed at reaching a minimum of 10 community researchers per sub-study via the community organisations. Potential community researchers were invited for a personal interview with the academic researchers and were screened on their communication skills, potential research skills, empathic attitude, social engagement and leadership capacities.

Once recruited, the community researchers in each sub-study were asked to attend a nine-hour training, in order to conduct in-depth semi-structured interviews on issues surrounding drug use in ethnic and cultural minorities. A nine-hour training was developed, with particular emphasis on qualitative techniques; basic awareness of drugs, with the emphasis on drug types and effects, Belgian legislation, and on the study's conceptual framework, aims and design. During these training sessions we also discussed ethical dilemmas, research methods and interview skills with the community researchers. Furthermore we discussed how to deal with requests for help, how to deal with questions about anonymity and how to approach the sensitive subject of substance use. Participants who had finished the entire training were awarded a certificate in Community Research and Drugs by Ghent University and Université Libre de Bruxelles. Furthermore they received a financial restitution for their voluntary work in the research project, namely conducting semi-structured interviews with substance users.

4.5.1 The Turkish community

In our search for community researchers we used an information leaflet and contacted the community organisations and other organisations in the socio-cultural field. Posters for an info moment in Ghent were distributed to community centers and small Turkish entrepreneurs in the city center, the Brugse Poort and Dampoort neighbourhoods. During the info moment we received about 30 people who wanted to volunteer as a community researcher. Seventeen of these people eventually participated in the nine-hour training program which was organised three times.

The research team developed an interview guide that was discussed with the community researchers at the end of the training (see Annex interview guide). This guide was adjusted based on the community researchers' feedback. Thirteen out of the 17 community researchers conducted a total of 57 interviews over a period of seven months (May to November 2015). Four interviewers did not conduct any interviews. Eight of the interviews turned out to be invalid[6]. The project assistant conducted 13 interviews with an audience that could not be reached by the community researchers, more specifically heroin and methadone users.

During the period of data collection, 8 intervision sessions were organised and the project assistant visited the community researchers at their homes about four times for supervision. During these meetings, specific questions, doubts and pitfalls were discussed. In addition, these moments allowed the project assistant to establish a relationship with the community

[6] One of the community researchers lost three audio files because his recording device broke down. Five interviews could not be analysed because of several reasons. The quality of the audio file of one interview was too low. One participant retracted his permission for the use of the interview afterwards. One interview was not transcribed in time. One interview was not recorded. One participant was interviewed twice by two different community researchers.

researchers to keep abreast of their motivation, the quality and quantity of the interviews and the type of participants.

Our group of research participants is largely influenced by the profiles of our community researchers. Therefore we give a short overview of the profile of these researchers.

Age	Average: 37, youngest: 19; oldest: 54
Gender	7 women, 6 men
Education	7 high-educated / 6 have attained secondary education[7]
Profession	6 regular employment 2 temporary employment, 3 unemployed, 2 students
Motivation	7 professional and personal motivation, 3 experience with use in the family, 3 want to empower the Turkish community in dealing with substance use
Generation	10 second generation, 2 third generation, 1 first generation[8]
Origin	Emirdag, Eskisehir, Izmir, Posof, Black sea
Location of residence	Boroughs of Ghent (5), Ghent: Brugse Poort (2), Ghent: centre (2), Ghent: Tolpoort (1), Ghent: Bloemekeswijk (1), Ghent: port (1), outside Ghent (1)

4.5.2 The Eastern European communities in Ghent

Our goal was to find ten motivated community researchers who would each do ten interviews with users of Bulgarian or Slovakian origin. During the info moment we received about eight interested people who wanted to volunteer as a community researcher. Seven of these people participated in a nine-hour training in Dutch which was organized two times. Another three interested people turned up as the project got along. Two of them were trained during a 6 hour training in English and one of them was trained during a one day training in Dutch. During this training, participants were introduced to qualitative research methods emphasizing on semi-structured interviews. Also, we discussed ethical dilemmas and interview skills. Furthermore we discussed how to deal with requests for help, how to deal with questions about anonymity and how to approach the sensitive subject of substance use. The research team developed an interview guide that was discussed at the end of the training with the community researchers (cfr. Annex interview guide). The guide was adjusted based on the community researchers' feedback.

This report was also presented to the community researchers and their feedback was incorporated. The advantages and disadvantages of working with community researchers are described in Chapter 6 of this report considering they are very similar in the four sub studies.

Eight out of ten community researchers conducted a total of 63 interviews over a period of seven months (May to December). Two trained community researchers did not conduct any interviews. One interview turned out to be unusable[9]. The project assistant conducted three interviews with an audience that wasn't reached by the community researchers, more specifically heroin and methadone users. During the period of data collection three intervision sessions were organized and each community researcher had about three supervisions at

[7] We perceived low educated as not having attained secondary educated and hight educated as having attained higher education (bachelor or master degree).
[8] See 3.3 'Generations' in chapter 5 for the definition of these generations.
[9] One interview was not transcribed in time.

various places (e.g. their home, the office of the project assistant, a cafeteria). During these meetings specific feedback was given on their interviews, and questions, doubts and pitfalls were discussed. In addition, these moments allowed the project assistant to build up a relationship with the community researchers to keep abreast of their motivation, the quality and quantity of the interviews and the type of participants.

Our group of research participants is largely influenced by the profiles of our community researchers. Therefore we give a short overview of the profile of these researchers.

Age	Average: 31, youngest: 26; oldest: 36
Gender	6 women, 2 men
Eduction	7 high-educated / 1 has attained secondary education
Profession	3 regular employment, 4 alternatively temporary employment and unemployed, 1 part-time student – part-time fixed employment
Motivation	5 professional and personal motivation, 3 financial motivation
Generation	8 first generation[10]
Origin	6 are from Bulgaria and 2 are from Slovakia
Location of residence	Eeklo (2), Ghent: Ledeberg (1), Ghent: Sint-Amandsberg (1), Ghent: Elisabethbegijnhof-Papegaai (1), Ghent: Macharius-Heirnis (1), Ghent: Rabot-Blaisantvest (1), Ghent: Muide-Meulestede (1)

4.5.3 Asylum seekers, refugees and undocumented migrants

In our search for community researchers we used an info leaflet and sent out a call to our community organisations. Our goal was to find 10 motivated community researchers who would each conduct 10 interviews with asylum seekers, refugees or undocumented migrants who use substances. Together with the other project assistants, an info moment was organised and 3 different nine-hour trainings were organised in May and June – 2 in Dutch and 1 in English. An extra training session in French was given for 2 French-speaking community researchers. Finally 1 more training in Dutch was given in September. In total, 14 community researchers were trained.

The research team developed an interview guide that was discussed at the end of the training with the community researchers of each sub-study separately (see Annex interview guide). This guide was adjusted based on the community researchers' feedback.

Twelve out of 14 community researchers conducted a total of 71 interviews over a period of seven months (May to November). During the period of the data collection, 7 intervision sessions were organised and the project assistant supervised the community researchers through telephone calls, individual meetings and email. During these meetings specific questions, doubts and pitfalls were discussed. In addition, these moments allowed the project assistant to build up a relationship with the community researchers to keep them motivated and to make progress with them, to keep control of the quality and quantity of the interviews, and to give them the support and feedback they needed to succeed in their task as a community researcher.

[10] See 3.3 'Generations' for the definition of those generations.

Our group of research participants is largely influenced by the profiles of our community researchers. Therefore we give a short overview of the profile of these researchers.

Age	Average: 39, youngest: 26; oldest: 57
Gender	women (2), men (9)
Education	higher education (7), secondary education (1), unknown (3)
Profession	employment (3), unemployment (5), student (3)
Origin	Afghanistan (3), Iraq (2), Rwanda (1), Ghana (1), Morocco (1), Syria (1), Iran (1), United Kingdom (1)
Location of residence	Ghent (3), Antwerp (2), Gentbrugge (1), Dendermonde (1), Deinze (1), Anderlecht (1), Vilvoorde (1), Genk (1)
Type of residence permit	definitive residence document (8), undocumented migrants (3)

4.5.4 The Congolese community

The Congolese community researchers were recruited through various channels. Posters were distributed via student houses and community organisations, the project assistant advertised the project in four radio shows (Radio Panik, RADIO Air Libre, Radio Campus), in a treatment service and the project was advertised at the student job site of the University. This last source resulted in most community researchers, while the former had only resulted in 6 community researchers. Through this channel 22 community researchers were found and trained during a one-day training session. Since most community researchers were students and the training was organised on campus, there was not a lot of interaction nor debate about the research questions or the interview guide. Unfortunately only 7 of these student community researchers conducted interviews.

Maintaining regular contacts with the CRs has been quite hard. In the beginning of the data collection period (June 2015 – January 2016) some of the CRs got demotivated. First of all, because of technical issues the financial restitution promised to the respondents could not be handed over at the time of the interview. A second constraint was linked to the weak level of awareness of the drug and alcohol use of the community researchers. During the training in June 2015, it was obvious that the majority of the community researchers were not informed on drug and alcohol use.

Thirdly, the community researchers were unable to find users within their own circles. This is related to the high level of suspicion and paranoia in the Congolese community when someone is interested in socially taboo topics. There is a fear to add to the bad image of the Congolese and to encourage a bad reputation. This kind of reaction is typical of people who have had bad experiences with police officers and structures like authoritarian regimes.

The female CRs were the most productive. By the end of the data collections period, despite the efforts of the project assistant to find users, all the CRs were inactive. At his moment, the project assistant started conducting interviews herself together with an intern of sub-Saharan origin.

4.6 Community advisory boards (CABs)

Each project assistant mobilised, in collaboration with the community organisation, a large group of stakeholders. These stakeholders included the primary beneficiaries (the communities or groups), commissioners of drug services at regional and local level, and a range of other agencies including health, housing, outreach workers and local academic institutions. In each sub-study, these stakeholders were invited to participate in a Community Advisory Board (CAB), which met every two to three months and had decisive input on each key moment in the project. These community advisory boards were a valuable way of gaining feedback on the progress of the sub-studies, as well as a way to involve those who have a vested interest in the results of the research and could ensure the sustainability of the work.

4.6.1 The Turkish and Eastern European community in Ghent

The community advisory board initially consisted of a delegate of FZO-VL and CDF (the Turkish community organisations), a representative of InGent vzw, a staff member of vzw Jong, the municipal drug officer, a staff member of the municipal outreach service, the president of Moslim Adviespunt & vzw Avroes, the coordinator of the Institute for Social Drug Research, the project assistant and a member of the Centre for Turkish Studies of Ghent University. After our first meeting the group was supplemented with an experience expert and a staff member of the municipal Integration Service.

For practical and contentual reasons we decided to join the community advisory boards for the Turkish and the Eastern European communities in Ghent. It offered the project assistants the advantage of comparing pitfalls and successes in the two target groups and to adjust the research process accordingly. Furthermore it reduced the demanded time investment of members of the community advisory boards employed in municipal services. The community advisory board was consequently extended with a representative of the Roma organisation Opre Roma and with the coordinator of a homeless shelter (Huize Triest).

The main goal of our two-monthly meetings was to systematically verify and adapt our research goals to the needs of the target groups and professionals in addiction care and the socio-cultural field. Moreover, the members of the community advisory board were regularly contacted on an individual basis for specific questions. Following items were discussed at length in the community advisory board:

- The timing of the project;
- The content of the training of the community researchers;
- The interview guide;
- Supplementing the participant pool;
- Reporting and disseminating the research results;
- Keeping the topic of this research on the municipal policy agenda.

This report was also presented to the community advisory board, and their feedback was incorporated in this text. The board mainly reflected an interest in successful referral systems which resulted in a small subchapter about this topic in chapter 5.5.4. Additionally, the concerns of the community advisory board were included in the ‘recommendation’ chapter. Furthermore, the work plan of the project was discussed with the community researchers. We adapted our planning because of the fact that many people with Turkish roots go to Turkey during the summer holidays. We decided to prolong the period of data collection with two

months. The research outcomes were also discussed with all actors in the project (see supra) and their feedback was incorporated in this report. This report, as well as the expertise created in the community organisations and community researchers allowed the research design to be refined and introduced in other fields of research or in new research on local need assessments. The dissemination of the research outcomes was also conducted in close collaboration with all actors in the project..

4.6.2 Asylum applications, refugees and undocumented migrants

The community advisory board consisted of a delegate of the 2 community organisations (Free Clinic vzw and the Mind-Spring project), a representative of Fedasil, a retired professional from the Red Cross asylum center in Wingene, a representative of Stedelijk Opvanginitiatief (SOI) for asylum seekers in Ghent, a representative of MSOC Ghent, a researcher of the International Centre for Reproductive Health (ICRH), a physician of the Fedasil asylum center in Poelkapelle, the project assistant from the Turkish sub-study, the project assistant and the promotor of the sub-study for asylum seekers, refugees and undocumented migrants.

The goal of our CAB-meetings was mainly to systematically verify and adapt our research goals to the needs of the target group and professionals in addiction care and the field organisations. Following items were discussed at length in the community advisory board:

- Input from professionals/experts (sharing expertise)
- Building bridges between different organisations
- Reporting and disseminating the research results
- Converting the research results into action

This report was also presented to the community advisory board and its feedback was incorporated in this text. The Board for example advised to subdivide user groups in users that started using substance in their home countries, during the flight or in Belgium.

4.6.3 The Congolese community

The creation of a CAB for the Congolese community was not really successful. The first meeting was set late in the data collection period (instead of before the data collection period, or the training of the CRs for that matter). This meeting was postponed. A month later the meeting was reorganised. Part of the CAB were researchers, local associations, user services and community researchers but only a few of them actually attended the meeting and none of the CRs were present.

Many people were contacted as potential members of the CAB: Congolese doctors, pastors, musicians, associates, police officers in Matonge, prevention workers and a mother who belongs to a Congolese association for drug prevention among Congolese young people in Uccle. The discussion with these people was really interesting and showed the link between prevention and policing services. This association received funds, collaborated with the police, and diffused its know-how and methodology even in Canada, but recently, they were judged unprofessional and no longer receive subsidies

4.7 Data collection: interviews

Upon completion of the training workshops, community researchers were asked by the project assistant to consider the various points from which they could begin to access members from their community to participate in the research. In collaboration with the community organisation and the Community Advisory Board, they contributed to the wordings of the interview guide. The project assistant prepared an introduction that explained the nature and purpose of the research, and stressed that interviews were confidential and reported anonymously. This document was discussed with the community researchers and adapted accordingly (see annex).

The interviews focused on several themes from international literature that appeared to be relevant (Bashford et al., 2003; Fountain et al., 2003), namely: ethnic identity, structural and perceived discrimination, ethnic density, social capital, ethnic conformity pressure, and the individual, organisational and structural barriers to substance abuse treatment care.

Community researchers were asked to conduct 10 to 12 interviews (in order to reach a preliminary goal of about 100 interviews per sub-study) with participants meeting the following inclusion criteria: they describe themselves as belonging to the particular community or target group under study, they were between 15 and 65 years old, and had last-year experience with illegal drug use or episodes of excessive drinking. Respondents were recruited using Respondent Driven Sampling, a recruitment strategy specifically designed to research hidden networks of at risk populations in precarious situations (Heckathorn, 2011; Bangdiwala et al., 2012). The participants were encouraged to identify and access a sample of the community under study, as representative as possible, but we did expect that some community researchers would have some difficulty in accessing participants outside their own peer groups (Salganik & Heckathorn, 2004; Schonlau & Liebau, 2012). Because of the risk not to reach certain subgroups via this 'insider' sampling technique (Simon & Mosavel, 2010), we supplemented it with 'purposive sampling'.

During the fieldwork, it turned out that the initial aim of reaching 100 interviews per sub-study was overly ambitious, and had to be downscaled. Instead of artificially intending to reach this initial goal and lose quality in the process of making short cuts to reach the original ambitions, we decided to stick to a similar in-depth procedure throughout the data-collection phase, which however did result in a smaller obtained number of respondents. Over a course of six months we conducted 71 semi-structured interviews in the Eastern European communities in Ghent, 71 on undocumented migrants in Flanders, 70 in the Turkish community in Ghent, 49 in the Congolese community in Brussels. Most of these interviews were conducted by the community researchers (n=229). Some of the interviews were conducted by the project assistants (n=32), these interviews mostly concerned problematic heroin users and hard-to-reach Congolese users.

About half of the interviews was carried out in mother tongue languages, and some in Dutch, English or French. These interviews were audio recorded. Researchers were asked to conduct interviews in settings where not only their interviewees felt comfortable, but the safety of both parties could be ensured. Information about the study aims and confidentiality was given to all participants prior to the interview (King & Horrocks, 2010). Community researchers were asked to inform their project assistants in case specific questions for help arose during the interviews. The researchers were largely supported by the project participants guiding the sub-studies. This guidance mainly consisted of peer group sessions and individual guiding.

All interview tapes were transcribed as soon as possible after the interview (Silverman, 2000). This allowed the project assistants to examine the data in detail, and remain aware of data collection saturation. Where translation of interview recordings was needed, this was done by the community researchers and in some cases by the project assistants.

4.8 Data analysis and dissemination

The period of data analysis took about seven months. Interviews were considered valid when we received the audio transcripts (including oral informed consent), the interview guide with (anonymised) personal information about the participants and ad verbim transcripts. These research proceedings were approved by the Ethical Committee of the Ghent University Faculty of Law. Most of the interviews were transcribed by the community researchers and some by the project assistants.

After having received the first interviews of the community researchers, the interview guide was slightly modified and simplified. This was mainly because most community researchers had interpreted the interview guide as a questionnaire. They read out the questions literally which prevented the participants from speaking openly about the topics. This in turn led to difficulty to obtain rich, in-depth data.

A first phase of grounded coding in the qualitative data software Nvivo 9 was conducted by one of the project assistants in the interviews of participants in the Turkish community in Ghent during the data collection period. During this first phase, an initial coding list was used notwithstanding the fact that new emerging themes were identified (Hesse-Biber & Leavy, 2010).This procedure was carried out in all interviews with Turkish participants and resulted in a proposal on main coding categories and procedures for all sub-studies. During a shorter period each project assistant applied this coding list on some interviews in each target group. This way, the coding list was further refined and categories specific to a target group were identified. After checking for intercoder reliability by means of having one interview in each target group analysed by all project assistants, each assistant adapted the coding list to match the respective target groups.

A report was created for each sub-study / target group based on the analysis of the interviews, field notes, reports of meetings with the community advisory board and community researchers and literature on the target group at hand. This report was presented to the respective community advisory boards and community researchers. Their feedback and considerations were included in the current report. The members of the Turkish and Eastern European CAB for example asked to refine the recommendations as well as to put the emphasis on referral systems in substance abuse treatment care.

In each of the sub-studies, the preliminary results were discussed in a one-day small-scale seminar with the community researchers, the project support workers (the academic staff), the project manager and other representatives from the community organisation, and the Community Advisory Board (stakeholders), and we jointly agreed on the final conclusions and on the policy, practice and research implications of the findings. In these seminars we also discussed how the findings and recommendations could be disseminated and advocated (among the communities under study, among the community researchers networks, and to

policy makers, relevant professionals, organisations, civil society and academics). (aanvullen op het eind van het project)

4.9 Pitfalls in CBPR

Collecting data in ethnic and cultural minorities is often experienced as a difficult task for the WEIRD[11] academic (Van buren, 2010). We anticipated these risks primarily by means of the proper CBPR design and by working with community researchers. This design does however not eliminate all possible difficulties. Some of them are proper to the target group, others to the researchers and still others to the research context and setting.

4.9.1 The participants

As mentioned above participants were recruited using Respondent Driven Sampling, a recruitment strategy specifically designed to research hidden networks of at risk populations in precarious situations (Heckathorn, 2011). The construction of the waves was decided upon by the community researchers themselves. Participants were given a 30 euro gift voucher for a supermarket as an incentive for participation. Community researchers did have some difficulty accessing interviewees outside their own peer groups (Salganik & Heckathorn, 2004; Schonlau & Liebau, 2012). In the Turkish community for example this lead to not reaching heroin or cocaine users although this sub target group exists. This led project assistants to supplement the sample by means of purposive sampling (see case studies) for these target groups.

An experienced researcher realises that it is sometimes hard to meet participants and do an interview. It entails remaining in close contact, arranging an unequivocal appointment at a proper date, hour and location. Furthermore the target group of substance users is an extra hard population to reach. These difficulties were discussed with all community researchers during their training. Nevertheless, many of our community researchers got demotivated after several experiences of not being able to do the interview because of a problem in communication.

The search for substance users in the group of asylum applicants was another difficult mission for community researchers. While it was already difficult to convince substance users to do an interview, it was even harder to convince them if the person was an asylum applicant. They were often very suspicious, especially to talk about their substance use. They couldn't believe – if they should talk about their substance use – this should not have consequences for their application for asylum. The word "interview" had also a bad connotation for many of them. These potential reasons made it probably very hard for the community researchers to find asylum applicants. Moreover, as we could not count on any active community researcher who was an asylum applicant during the period of the research project, was probably another potential reason why we did not reach a lot of asylum applicants.

Another difficulty that affected different community researchers – no matter if they had a background as (ex) substance user or not – was the state of some respondents who were under influence of a substance while the interview would take place. Some interviews took place anyway, other interviews were cancelled or delayed to another moment.

The fact that our participants belong to an ethnic minority was an extra difficulty for the data collection. Ethnographic researchers such as Deutsch (2008) and Hagendorn (2008) point out

[11] Western, educated, and from industrialized, rich, and democratic countries. (Henrich et al., 2010)

that persons with an ethnic background, certainly those involved in gangs or substance use, are very sensitive as to how they are perceived by others and are easily hurt by discrimination or stigmatisation. This resulted in the fact that many of the respondents put up 'politically correct' images of their substance use. Furthermore some of the community researchers did not succeed in putting their own normative systems and beliefs aside while interviewing which of course influenced the scope of the answer of the participants.

Finally, for some respondents, the question of the financial retribution was the main incentive to agree to do an interview. Before the CR's had the time to explain the goal and the process of the research, they were asking for a monetary compensation. Some respondents considered that the gift voucher worth 30 euros wasn't enough money, respect to the entrance in their intimacy.

4.9.2 Positionality of co-ethnic community researchers

Having interviews conducted by co-ethnics has several advantages, nevertheless, most come with considerable disadvantages and ethical issues. First, co-ethnics have easier access to co-ethnic participants but on the other hand some participants feel more at ease talking to someone neutral who can guarantee not to spread information within the respective communities. In intimate communities such as the Turkish community in Ghent, the subject of privacy and confidentiality cannot be guaranteed by semi-professional community researchers (Simon & Mosavel, 2010).

Co-ethnic researchers who do not use substances have also shown to have limited access to users within their communities. As a part of the respective communities, co-ethnic researchers cannot guarantee they are value-free when it comes to the taboo subject of substance use. In other words, when community researchers unconsciously uphold this taboo and possibly stigmatise substance users, this has a large influence on their ability to find participants as well as their ability to have an open conversation about it with co-ethnic participants. This is particularly true for the Turkish community researchers.

Secondly, co-ethnics have the advantage of conducting the interview in the mother tongue but this in its turn has the disadvantage of the need for back-translation (Mosavel et al., 2005) which seriously jeopardizes ad verbatim transcription as well as rich linguistic description (Winchatz, 2006). Certain sentences in the interviews for instance lead us to believe that some concepts or shared beliefs are not explained explicitly during the interview and consequently are not always understandable to the person analysing the data (f.e. "you know how these things go", "you know what they say about that" etc.).

Furthermore, the shared feeling of belongingness to a community by researcher and participant easily implies a misbalance in the communication because the researcher is not a substance user, possibly has a better socio-economic status within the community, or lives more conform shared religious norms (aanvullen met andere voorbeelden).

For community researchers with a background as (ex) substance user it was more easy to find respondents in their network (cf. the method of Respondent Driven Sampling). While community researchers who were not familiar with substance use experienced more difficulties in finding respondents. However, the community researchers who know substance users in their network encountered another difficulty. The peers they have interviewed were not always honest in giving their answer, or the community researchers received very short answers by

their peers – they argued. Perhaps the relationship between the community researcher and the respondent was too close in this situation. So probably the advantage of the CBPR design became here a disadvantage.

These considerations bring us to the very core of ethnographic fieldwork. Whereas ethnographers in classic anthropological studies have generally defended the idea of getting as much in touch with participants as possible while safeguarding an outsider research position (see f.e. Malinowski), current ethnographic researchers question the degree in which these insider / outsider and in-group / out-group perspectives influence the quality of data. Both being an insider and being an outsider has its advantages in specific research contexts. Bucerius (2013) for example has, as a young female German researcher, been capable of getting quite close into the lives and beliefs of a set of male Turkish German drug dealers. Berlin (2008) in his turn doubts if his being male jeopardizes data collection in female samples. Each research setting should be assessed specifically for the influences of the researcher on the participants. In some cases over-identification, value conflict, behavioural norms or power relations will jeopardize quality and objectivity while in other settings these issues will be of no value or could turn into advantages. To nuance the insider-outsider debate Carling et al. (2014) identify five types of 'third positions' that deviate from the archetypal insider–outsider dichotomy in migration research: explicit third party, honorary insider, insider by proxy, hybrid insider-outsider, and apparent insider. We could describe Bucerius as a 'proxy' insider (a researcher that acquires an insider position during fieldwork) whereas our community researchers are better described as apparent insiders because they belong to the same group or ethnic community but do not use substances.

4.9.3 The relation community researcher – project assistant

The main task of the project assistant during the data collection period was to keep the community researchers motivated as well as to guide them in optimising their interview skills and dealing with problems they encountered. In doing so we acknowledge that "researchers need to be aware of their own personal investments, interests, and frustrations; 'accept rather than defend against healthy tensions in fieldwork'; and be attuned to 'questions of relationships, position, social complexities, and how to turn resulting tensions into data" (Lutrell in Muhammad et al., 2014: 6). This entails a reflexive research identity both within academic staff and community researchers and implies the active exploration of how identity and perceived power within identity status may influence data collection and analysis processes.

Each community researcher had his or her own 'learning curve' as well as different preferences on how to deal with these issues. Some were always present in group sessions, others preferred face-to-face supervision and still others avoided contact because they did not feel the need for guidance or because they had lost the motivation to participate in the research. The community researchers received a financial restitution per interview they conducted and transcribed. During the process we noticed that a significant number of researchers underestimated the transcriptions of the interview. Consequently we instituted a new arrangement for financial restitution for those who did not want to transcribe the interviews. During the process of data collection we lost track of x community researchers of a total of x researchers in the four target groups who had attended the training. (reasons for drop out)

The contact moments between community researchers and participants were also meant to keep track of the quality of the interviews and possible saturation of data collection. Because

some researchers had a very fast pace while others were rather slow or had changing paces, it was quite hard to keep track of the amount and quality of the interviews during the data collection. When reaching the proposed ending of the data collection process we decided to extend the period because the amount of interviews gathered was not sufficient. This was mainly due to the fact that the data collection period took place during the summer holidays and because community researchers had difficulties in finding participants.

5 SUBSTANCE USE IN THE TURKISH COMMUNITY IN GHENT

5.1 The Turkish community in Ghent

The Turkish community in Ghent originates in the sixties. Foreign workers were attracted by firms as well as the Belgian government because of a lack in work forces during these years. The foreign workers originated from Tunesia, Morocco, Italy, Portugal and also from Turkey, among other countries. They worked in sectors such as mining, textile and metal industries as well as in abattoirs. The Belgian government decided to install a migration stop in 1974, because of the relapse in the Belgian economy in the 70's. Most of the Turkish 'Ghentians' originated from Emirdag, Peribeyli and Posof in those days. The group of Turkish and North African foreign workers mainly consisted of men between 25 and 40 years old (Verhaeghe, 2013: 15). Many of them left their wives and children in Turkey, because they thought they would return to their home countries. After 1974 the Turkish community kept growing, because men made their family come over through using the legal system of family reunion. This migration was supplemented with marital migration, because of a lack of suitable partners in Ghent.

In 2010, about 152,000 people with a Turkish or double nationality were living in Belgium. This group made up about 1.4% of the Belgian population, and thereby became the fifth largest ethnic minority in Belgium (Schoonvaere, 2013). Most people with Turkish origins live in the Brussels region, followed by East-Flanders (16%). Migrants from the provinces of Afyon and Eshikishir mostly live in Brussels and Ghent, while people originating from other regions live more widespread in the regions of Limburg and Antwerp (Schoonvaere, 2013; Van Kerckem et al., 2013).

Between 2001 and 2005, the Turkish-Belgian migration flux was mostly directed towards Ghent (Schoonvaere, 2013: 50). In 2014, about 42.2% of the Ghent population consisted of people with an ethnic background[12] of which about 12.8% did not possess the Belgian nationality (Studiedienst van de Vlaamse Overheid: 2015). This part of the Ghent population consists of 156 different nationalities. 10.5% of the Ghent population is of Turkish origin of which 1.7% only possesses the Turkish nationality (Studiedienst van de Vlaamse Overheid, 2015). The remainder of these people have both Belgian and Turkish or only the Belgian nationality.

5.1.1 Spatial distribution in the city of Ghent

The participants in the sample of this study (n=62) mainly originate from the regions of Istanbul, Afyon (Emirdag and Eskisehir) and Ankara. When we ask participants[13] what the Turkish community in Ghent means to them, we get a wide array of answers.

We based the general description of the Turkish community in Ghent on the opinion of 56 participants that answered this question. One in six participants state that there are different Turkish communities in Ghent. One in five finds the spatial segregation the most characteristic element of the Turkish community. This is only partially confirmed in literature. Many authors refer to the fact that Ghent neighbourhoods would correspond to certain regions and cities in

[12] Current or first nationality is not Belgian or the first nationality of one of the parents is not the Belgian one.
[13] For a comprehensive overview of the profile of the participants see chapter 5.3

Turkey (De Gendt, 2014; Verhaeghe et al., 2012a). Nevertheless, the participants in this study live quite dispersed in the city. We should however notice that some of the participants consciously moved to another neighbourhood to avoid contact with family and acquaintances (see infra). Moreover, a large majority of our participants lives in the nineteenth century belt of the city[14]. One fifth lives in the suburban periphery of Ghent and one in ten in the city center. This seems to confirm the research of Verhaeghe et al. (2013) that states that the spatial segregation of the Turkish community in Ghent had been in decline between 2001 and 2011. The fact that a substantial share of the participants lives in the suburban periphery seems to confirm this thesis[15].

5.1.2 Characteristics of the community

"Vandaag de dag betekent de Turkse gemeenschap heel veel. Vroeger was dat zo niet… dan bestond er geen Turkse gemeenschap maar vandaag de dag wel. Er zijn handelaars, winkeliers, kappers, politieagenten, advocaten, dokters, politici, … We zijn langzaamaan geïntegreerd aan het geraken in de maatschappij hier he. Terwijl dat in de periode van onze ouders niet zo was.. Als mijn vader achter eieren ging in de winkel dan moest hij gelijk een kieken staan kakelen om uit te leggen wat eieren waren." (Fatih, male, 50 years old, heroin and methadon)

"Nowadays the Turkish Community has a lot of meaning. It was not like this before… back then, the Turkish Community did not exist, but now it does. There are merchants, tradespeople, hairdressers, police officers, lawyers, doctors, politicians… We have gradually integrated into this society. This was not the case during the time of our parents.. When my father went to buy eggs in the shop, he had to cackle like a chicken to explain what eggs were." (Fatih, male, 50 years old, heroin and methadone)

When we ask about the characteristics of the Turkish community in Ghent, we often got the response that Turkish people mostly originate from Emirdag and that this creates a bond. About half of the participants originates from Emirdag but it is not only them who made this statement. Additionally, participants note that the shared migration history is a characteristic of the community. Cultural and sociological characteristics are mentioned as well. Participants mention Turkish bars, marriages and going to the mosque. Many participants link belonging to the community to social cohesion ("Ghent is small and everybody knows each other" is mentioned at least four times in the interviews) or more pejoratively to social control.

As mentioned before, the feeling of social control has in some cases resulted in moving to other neighbourhoods or even other cities. This practice is confirmed in other studies on the Turkish community in Ghent (Van Kerckem et al., 2014). Other characteristics mentioned are pride, entrepreneurship and identification with the historical Ataturk leadership. All participants mention in one way or another that the Turkish community nowadays is quite divided be it in terms of generations, religious beliefs or political controversies.

"Heel wat mensen hebben hun visies en gedachten bijgesteld. Zij die eerst korte kleren droegen, dragen nu langere kleren en omgekeerd. Vroeger lette ik daar niet op, maar nu weet ik in welke situaties ik moet opletten. Vroeger nam ik nooit een hoofddoek mee als ik de Koran ging beluisteren bij iemand huis. Ik zei dat ik zo was. Maar naarmate de tijd vorderde, en waarschijnlijk

[14] Mainly Tolpoort, Sleepstraat, Dampoort and Brugse Poort
[15] Mainly Gentbrugge, Sint-Amandsberg, Sint-Denijs, Wondelgem and Oostakker

ook door de leeftijd, probeer ik nu toch te letten op mijn kleding." (Berna, female, 46 years old, prescribed medication)

"A lot of people have changed their vision and thoughts. Those who wore short clothing at first, now wear longer clothing and vice versa. I didn't really pay attention to it before, but now I know which situations I should pay attention to. I never brought a headdress when I went to someone's house to listen to the Koran. I said that that's who I was. But as time progressed, and probably because of my age as well, I now try to pay more attention to my clothing." (Berna, female, 46 years old, prescribed medication)

5.1.3 Relatedness to the community

When we ask participants about the way they relate to the Turkish community, they never answer completely negatively. However, more than half of the participants state to have mixed feelings concerning this relation. In some situations, they feel more or less bound to the community. This ties in with Lamont and colleagues' (2001) notion of actively refining the symbolic boundaries of the perceived community. When participants answer positively to the question of feeling related to the Turkish community, they refer to a feeling of mutual respect and relatedness in the domains of language, migration history and traditions (mostly referring to marriage and death).

One in three participants states to be 'different' than other members of the community. They report that they do not feel part of the community, because they are not from a village, are higher educated, have different cultural values (less materialist, more modern, other living habits or other familial circumstances) or because of their (mostly problematic) substance use (see infra). Some of them also note that they don't seek contact with the community to escape the social control of the community or because they find the community too conservative.

"Er zijn café's, en vzw's waar de Turken naartoe gaan en gans de dag op hun leeg gat zitten. En roddelen achter een ander zijn dingen en ditten en datten. Dus ik hoor daar niet bij. Ik ben een junkie en ze bekijken mij als stront, terwijl dat ze zelf bijvoorbeeld alcoholieker zijn. Ze zitten gans de dag te zuipen en te drinken en ditten en datten, nee ik voel mij daar niet thuis." (Ekrem, male, 47 years old, heroin)

There are bars and non-profit organizations that Turks visit and sit on their asses all day. And gossiping about someone else's business and this and that. So I don't belong there. I am a junkie and they look at me like I'm dirt, while they themselves are alcoholics, for example. They sit there boozing and drinking and this and that, no, I don't feel at home there." (Ekrem, male, 47 years old, heroin)

5.1.4 Religion and community

Almost all Turkish Ghent people describe themselves as muslims. Today, Ghent has about 15 islamic houses of prayer. In 2002 (Kanmaz, 2007) about two thirds of the mosques was exploited by the Diyanet, the Turkish state service for religious matters. These mosques are directly supported by the Turkish government, and imams preaching in these mosques are sent from Turkey. Not all Turkish Ghentians agree with this interference of the Turkish state or simply adhere another islamic branch, such as the ones preached by Milli Görüş, Süleymanci or Fethullah Gulen (Kanmaz, 2007). Furthermore, a small minority is Alevite and sufi associations also exist. Most mosques are more than what we would expect from catholic

churches for example. A mosque in Belgium is a place where all sorts of activities take place, and it serves as a community center (De Gendt, 2014; Kanmaz, 2007). This is also reflected in its architecture: a mosque is often not recognized from the outside, and consists of many rooms to host a wide range of activities, such as guest lectures, religious schooling, educational support and other socio-cultural activities.

5.2 The participants

First of all, we stress that the sample of this qualitative study is not representative for the whole Turkish community in Ghent. In total, we interviewed 70 people. In our analysis we include 62 interviews, seven of which were interviews with family members of users. These were family members of problematic alcohol, cannabis and polydrug users. When we report on the use of substances we only use the own description of problematic or non-problematic use of the participant. When we take the opinions of family members into account, we mention this specifically. Participants were mostly contacted because of the use of one specific product, but during the interviews, other products were mentioned in almost all cases. A small number of the participants are ex-users, but most participants did not report on current or former use in a consequent way during the interview. Consequently, we only make this distinction if the type of nature of the given information requires this distinction.

5.2.1 Socio-demographic characteristics

Three in four participants in our sample were males and one fourth was female. About three in four participants mention that the use of the main product is problematic. Four in five participants have not entered higher education, and half of these participants did not attain secondary education. Those who describe their use as problematic belong exclusively to this group. Only a small minority (about one in ten) of participants has attained higher education and none of these participants indicate their use as problematic. The majority of the self-described problematic users (39) are singles (29) of which 6 participants are divorced and live alone and 11 participants live with their parents. The remaining participants are married (8), cohabiting or widowed (2). Half of the group of problematic users is unemployed, 9 of which have been categorized as disabled in the social security system.

As regard ages the sample looks as follows:

Age category	Non-problematic	Problematic use
18-25	8	4
26-35	6	14
36-45	2	14
46-55	-	6
60	-	1

5.2.2 Substance use

"Als gij psychisch problemen hebt, ga jij gemakkelijk geneigd zijn om iets te gebruiken. Begrijp je? Als gij sociale problemen hebt, ga jij gemakkelijker iets misbruiken. Dat kan eten zijn, dat kan middelen zijn, dat kan gokken zijn. Dat kan vrouwen zijn. Het kan van alles zijn." (Arda, male, 36 years old, ex-heroin user)

"If you have psychological problems, you will feel more inclined to use something. Do you understand? If you have social problems, you will feel more inclined to abuse something. That can be food, it can be medication, it can be gambling. It can be women. It can be anything." (Arda, male, 36 years old, ex-heroin user)

As mentioned above, participants have been contacted for the use of one main substance. Participants did mention several other substances as well as gambling during the interview. Therefore the list below does not correspond with the total number of participants. Further, it should be noted that the actual use is probably higher, because participants may, consciously or unconsciously, not have mentioned the use of certain substances. Noteworthy to mention in this respect is the fact that the three main substances participants were contacted for (alcohol, cannabis, heroine), do not coincide with the three main substances mentioned during the interview (alcohol, cannabis, cocaine). The project assistant maintained a good relationship with the Medisch Sociaal Opvang Centrum Gewad (MSOC) which is why there is an overrepresentation of heroin and methadone users in the sample. The project assistant started purposive sampling in this group when it became clear that community researchers did not reach this type of users. All other participants were found by the community researchers.

Substance	Total	Not problematic	Age category	Male	Female	Problematic	Age category	Male	Female
Alcohol	27	17	18-42	7	4	10	25-55	8	5
Cannabis	27	16	18-41	12	4	11	21-55	10	4
Cocaïne	19	10	25-42	9	1	9	33-55	8	1
Heroïne	13	2	28-32	1	1	11	33-55	11	-
XTC	11	9	21-44	8	1	2	33-34	2	-
Methadon	11	4	33-42	4	-	7	35-50	7	-
Sedative (prescribed) medication[16]	7	-	-	-	-	7	19-45	4	3
Speed	6	3	22-35	3	-	3	32-36	3	-
Gambling	5	-	-	-	-	5	35-55	5	-
Anti-depressants[17]	4	2	21-33	-	2	2	34-42	-	2
Antipsychotica[18]	4	2	33-41	2	-	2	38-42	1	1
Anabols	1	-	-	-	-	1	35	1	-

[16] Including mostly benzodiazepines

[17] This was not specified in all cases. Participants did speak of Seroquel and Tranxene.

[18] This was not specified in all cases. Most participants spoke of Trazanol, Dominalfort en Cloxipol.

LSD	1	1	22	1	-	-	-	-	-

More than half of the participants consumes **alcohol** and about one in five of the total participants describes this use as problematic. Further, three interviews with family members were about problematic alcohol use. The data corresponds with the available data about the total Belgian population. Half of the Belgian population above 15 years old does not use alcohol daily or ever, and one in four Belgians has a tendency to be a problematic drinker (Drieskens & Gisle, 2015: 48). The general acceptance of alcohol use in the Turkish community was confirmed by key figures from the community and municipal outreach work (personal communication respectively 09/03/2015 and 01/04/2015).

The trends concerning the use of both alcohol and **cannabis** are comparable in our sample. Still, the use of cannabis in our sample is a bit higher than the use in the general Belgian population, which is estimated at 14% (De Donder, 2014). We also point out that the age categories and the representation of men and women are similar to alcohol and cannabis in the target group. Problematic use is more prevalent among men when compared to women. More than half of the participants report having already used these substances and half of these users describe their use as problematic. For non-problematic cannabis use, the use is mostly described as 'sporadic experimental use'. Problematic use of both products is only acknowledged by participants above the age of 20.

The use of **cocaine** in our sample is somehow remarkable. None of our participants were contacted for the use of this substance. This could indicate that the consciousness about the use of this product is low in the Turkish community or that it remains in a taboo sphere. More than one in three participants reports to have used cocaine. Half of these participants describe this use as problematic. These participants are mostly persons using heroin and cocaine alternately or together (*snowball use*). One of the heroin users who was double diagnosed with addiction and schizophrenia mentioned he uses cocaine in order 'not to hear voices'. Further, in half of the cases, cocaine is used in a recreative way in nightlife.

Problematic **heroin** use occurs in a considerably older age category than other substances (33-55). Users are mostly low educated single or divorced men. Two participants report one time experimental and non-problematic use. The remaining participants use heroin on a regular basis and usually in combination with methadone, cocaine and cannabis respectively. The life story of these participants is quite similar (see infra).

More than one in five participants has used **XTC**. Only in two cases, this use is described as problematic. These two cases concern a short period of intensive and daily use. Participants who do not describe their use as problematic report to have used it experimentally and on a sporadic basis in nightlife. Six participants have used **speed,** and three participants report this use to have been problematic. The nature of this problematic use is similar to the problematic use of XTC: a short phase of intensive and daily use.

We included an interview with a problematic gambler, because **gambling** was mentioned both by community researchers as well as at least one key figure (personal communication 09/03/2015) and in literature as a specific phenomenon in the Turkish Community (Laudens, 2013). In four of the interviews with problematic heroin users, gambling is reported as having caused large amounts of debt. Gambling in these cases means playing poker and other card

games in bars. Moreover, two participants report on the problematic gambling of their fathers and one about her husband. Three other participants mention on the side that gambling is a specific problem in the Turkish community in Ghent.

Finally, about one in four participants (n=13) mentioned the use of **sedative (prescribed) medicine**, i.e. benzodiazepines, sleeping pills, valium, antidepressants, antipsychotics and codeine. Usually this medication is used in combination, but not in all cases. The mentioned codeine use concerns a stand-alone case of heavy use (2g/day). Noteworthy to mention is that even when the use of this medication is therapeutically supported, participants experience this use as problematic. The problematic aspect of the use of antidepressants is mostly linked to the physical dependence to the substance as well as to the stigma linked to use. Seven participants report they have experienced at least one psychotic phase, 3 of these participants were double diagnosed with addiction and schizophrenia. In our sample, the use of antipsychotic medication is mentioned four times but the actual use might be a little higher. The problematic use of all prescribed medicines is to be situated in a higher age category than other substances (35-46) with the exception of sleeping medication (19-45).

5.2.3 Ethnic identity

We talked about ethnic identity with 61 users and family members. When we ask participants if they rather feel Belgian/Flemish or Turkish, 52 participants answered that they feel they are in between cultures and that they feel Belgian in Turkey and Turkish in Belgium. Half feels more Turkish, because:

- they have another mentality (6);
- they are muslim (5);
- because of their language and culture (5);
- they have another skin color and / or do not feel accepted (5);
- they spend more time with Turkish people, don't have the nationality or have lived in Turkey for a long time (3).

Two participants note explicitly that they feel Turkish because as ethnic Bulgarians in Belgium, they feel stigmatized, but have been educated in the Turkish culture in Turkey. Five participants report they feel human, not Belgian nor Turkish. Two other participants report they feel they are Ghentians and two others report they feel Belgian because they are not typical Turks.

The question as to what it actually means to be Turkish puts the answers mentioned above in perspective. Being Turkish means for most participants to be proud and to live Turkish traditions, education, religion and language and attend family get-togethers. To a lesser extent, participants mention the shared history, army service, fraternity, Turkish TV, being a migrant and that being Turkish 'is in the blood'. Being Belgian and to a lesser extent being Flemish is in the first place associated to being born in Belgium, living in Belgium and having the Belgian nationality. Further, freedom, equality and thinking about the future of the country are mentioned. However, when asking if participants feel Belgian, participants most often answer negatively, because they do not speak the language, do not have the nationality or because they have another religion and do not feel accepted.

When we compare the answers of the self-described non-problematic (n=16) to problematic users (n=39), there are no significant differences between their answers (whether they feel

rather Belgian/Flemish or Turkish). We should however note that the reasons given for not feeling Belgian are more specified in problematic users. They more often report not feeling Belgian while they would in fact like to feel more Belgian. Four of them have difficulties acquiring the Belgian nationality and six note that the fact that Belgians do not accept them is a reason not to feel Belgian. We will specify these answers in chapter 4.2 on discrimination.

5.2.4 Generations

In literature, a distinction is made between four Turkish generations on the one hand (Lievens, 1999; Van Kerckem et al., 2014) and four migration fluxes on the other hand (Manço, 2012). The first migration flux consists of Turkish guest workers who came to Belgium in the sixties. The second migration wave consists of the children of these workers who have migrated to Belgium at a young age, mainly during the eighties. The third migration wave consists of marriage migrants and was mainly situated between the eighties and the year 2000. A fourth migration wave consists of elderly who have grown old in Turkey and join their Belgian-Turkish children in Belgium today (Manço, 2012). This first and second migration fluxes constitute what we call respectively the first and second generation, in layman terms. The third generation consists of the children of second generation migrants. A fourth group in our sample is made up of newly arrived marriage migrants who arrived in Belgium after the migration stop of 1974.

The majority of our sample (n=26) belongs to the second generation Turkish. Their ages vary between the ages of 19 and 46 years old. The third generation Turkish are represented by 16 participants born in Belgium between the ages of 18 and 35 years old. Eight of our participants are marriage migrants, five men and three women between the ages of 35 and 55. We only interviewed 1 participant belonging to the first generation (60). Furthermore, some participants cannot be properly categorized in generations as defined above: two came to work in Belgium in the eighties and nineties and one has migrated to Belgium more recently to study. Most of the participants who describe their use as problematic belong to the second generation and to the group of marriage migrants. Most participants who do not describe their use as problematic belong to the third generation.

5.2.5 Language

We asked participants to report on their language knowledge (understanding, speaking, reading) on a scale from 1 to 5. For third generation migrants Dutch is the first or second mother tongue. Consequently, this group scores an average of 4.9. For the second generation, an average of 4.3 is attained and only three participants report to barely speak Dutch. We cannot report on the first generation, because we only interviewed one person belonging to this group. The average for the category of marriage migrants is 2.3. The interviews with these participants were consequently conveyed in Turkish.

When we ask participants which language they prefer to speak, we unanimously get the answer that they prefer Turkish because it is their mother tongue. Second and third generation Turkish as well as marriage migrants speak both Turkish and Dutch with friends and family. In the third generation Turkish, we hear of some families who only speak Dutch with their family. In conclusion, it is noteworthy to mention that the average knowledge skills of non-problematic users is 4.8, whereas the average for problematic users is 3.8.

5.2.6 Religion

Only three participants in our sample report not being muslim. When we ask participants if they practice their beliefs only one in seven answers affirmative. This is significantly less when compared to the general Turkish population in which about 40% confirms to practice their beliefs (Manço, 2012). Practicing islam means for our participants to pray five times a day, to read the Koran and to participate in the Ramadan. Our participants declare that they do not practice because they do not have enough time, because they do not know how to pray or because they do not feel pure enough. Only a small minority of our participants (one in ten) goes to a house of prayer regularly. We get quite a lot of reasons why participants do not frequent a mosque or other house of prayer. These reasons are mostly of a social nature: too much slander, no good contacts or not feeling accepted. Further, participants report to learning quite a bit about islam via TV and the internet.

Participants describe a very personal way of experiencing the islam. Many note that religion is something between the individual and god and that it is about being a good person and to find support in your belief. We elaborate on how participants experience support of imams and hodjas in chapter 6.2 about help seeking behaviour.

5.3 Nature and patterns of substance use

5.3.1 First time use

First time cannabis use of problematic and unproblematic users is mostly reported at the age of 16 in our study, although a considerable number reports to have started smoking cannabis between the ages of 12 and 16. This use can be characterized as experimental and usually takes place in a school context or in parks with friends, nephews or brothers. Participants state that this use occurred because of peer pressure (wanting to belong to the group, behaving tough), boredom and curiosity. This is in line with a recent participative study on Turkish youngsters in Ghent (Laudens, 2013). Two participants mention that one of the influences on their first time use was their fathers' use. 11 participants report that their use occurred for the first time between the ages of 16 and 23. This later use is mostly linked to student life. Regular users attest to use to calm down and relax.

Alcohol use is reported to occur for the first time at an average age of 15.8. The participants report that this first use happens in social contexts, such as nightlife, weddings and with friends. Intensified alcohol use is reported often times to occur because of relationship difficulties. Three participants report that they were used to drinking in Turkey, but that their use intensified after their migration to Belgium. Two other participants state that they started drinking because of their father's drinking behavior.

The first use of XTC and cocaine mostly occurs during nightlife around the age of 20 and is motivated by curiosity and the influence of friends. First time use of XTC occurs at the age of 20 and exclusively during nightlife. The use of speed occurs at an average age of 23 and is motivated by combating fatigue during nightlife.

First time use of heroin is at the average age of 20. Participants report to have started using because of the lack of cocaine in two cases. In two other cases participants report on using because of the use of other family members. In two other cases participants started because of being involved in dealing. The remainder of heroin users started out using with friends. Users mention that they did not know the drug and its consequences during their first use.

First time use of all medicines is at 27.5 years and is usually accompanied by therapeutic treatment. The reasons for this use are familial problems, marital problems and in one case the feeling of insecurity because of the lack of a residence permit. Three participants attest to have started using respectively cannabis, cocaine and heroin when incarcerated.

"En ook vooral in de gevangenis, als ge zo in 6 vierkante meter zit, dan heb ik de behoefte gehad om te gebruiken, vooral cannabis. Om op mijn gemak te zijn, da maakt het verdragelijker" (Demir, male, 33 years old, cannabis)

"And especially in prison as well, when you are sitting in a space of 6 square meters, then I felt the need to use, especially cannabis. To feel at ease, that makes it more bearable." (Demir, male, 33 years old, cannabis)

5.3.2 Reasons for continued problematic use

When non-problematic users are asked why they use substances, they refer to the circumstances of their use rather than intrinsic motivations for their use. They refer to acting tough at school or using at social events with family and friends such as marriages and during nightlife. Users who do describe their use as problematic display a larger awareness for their reasons to use. The most common reason for current use and peak use are marital hazards and the consequences of divorce such as not seeing their children. The second most given reason for continued use is difficulties in the family such as the death of a family member or discordance within the family. We also heard several times that participants use substances such as medicines and cannabis to be less aggressive and to remain calm, for example, but not exclusively, when incarcerated. There is no distinction between the reasons for use and the type of substance used.

When asked if and why participants see their use as problematic, they first and foremost refer to the physical dependence they experience from the used substance. Moreover, participants refer to the fact that it has a big impact on their lives. The general upside of their use is that it makes them forget difficulties and that it makes them feel calmer. In the case of heroin use, participants additionally refer to the loss of family and being incarcerated in prison. In the case of problematic cannabis use, participants also refer to the fact that it makes them too lazy, resulting in not evolving in life.

The life stories of our participants put these seemingly isolated reasons in perspective. They allow us to dig a little deeper into the given reasons. A significant number of our participants married at a fairly young age and express that the marriage was not exactly their own decision (8). Half mentions mental and physical abuse in a family and marital context. Three participants mention to have put off wedding plans because of their use. In this context, we need to mention that some participants note that parents have tried to arrange marriage for their children to get out of the drug scene. This partly ties in with Bucerius' (2014: 145) observation of German Turkish dealers who see marriage as a way to find a place outside of the drug market and to

find an ultimate goal in life. Some participants refer to their stay in prison and involvement in drug circuits as a reason for continued use.

"ik kwam na vier maanden buiten en was nog 10 keer erger dan ervoor" (Demir, male, 33 years old, cannabis)

"I was released after 4 months and was 10 times worse than before" (Demir, male, 33 years old, cannabis)

"ik kwam buiten en iedereen was weg: getrouwd, kinderen gekregen enzo" (Can, male, 33 jaar, heroin)

"I was released and everyone was gone: married, kids and stuff" (Can, male, 33 years old, heroin)

5.3.2.1 Early life experiences

Although this was not a specific topic in our interview guide 24 problematic users (out of 39) talked to us about their youth as one of the influences on their use. 14 participants attest to not have been able to finish their secondary education, most of them started working at the age of 16. Most of these participants belong to the group of classic second generation migrants.

"Maar nee ja… de meeste komen naar hier, werken, vestigen ulder hier en die blijven hier. Maar die ouders hebben altijd gedacht, wij gaan terug, maar zij gaan niet terug, versta je. Daarmee… dat was niet leren of… zoveel mogelijk geld verdienen… maar zij zagen dat zo, het is niet omdat zij dat zo zagen dat wij (tweede generatie) dat ook zo zagen. Versta je.." (Hikmet, male 42 years old, heroin)

"But no yes… most of them come here, work, get settled and stay here. But those parents have always thought, we're going back, but they're not going back, you see. That's why… it wasn't learning or… making as much money as possible… but that's how they saw it, it's not because they saw it that way that we (second generation) had the same opinion. You see.." (Hikmet, male, 42 years old, heroin)

We discern a group of 11 men between the ages of 32 and 50 because of their similar situation. These men belong to the group of migrants that came to Belgium at a very young age. In several cases their fathers had left Turkey some years before the migration of the mother and the children. Some of these children had barely known their fathers at a young age. The migration to Belgium meant a rupture in the living patterns of these children as well as their upbringing. Additionally, the educational context of the village in Turkey suddenly fell away completely (De Gendt, 2014: 136). This generation of Turkish growing up in the 80s in Ghent is oftentimes referred to as 'a lost generation' (De Gendt, 2014: 186). They lived in politically turbulent times of growing racism, economic instability and growing conservatism of their parents. Many of these participants' parents did not at all expect their children to study. Some of the parents did not have the means to pay for further education, but most of them wanted their children to work as early as possible because this was the initial goal of their migration.

"Hij was de beste van de klas, hij wou hier dierenarts worden en zijn euhm, zijn schooldirecteur is komen smeken thuis of hij ASO mocht doen en ze vonden het nodig dat hij TSO deed. En dat interesseerde hem geen bal, beginnen spijbelen. Vroeger was de leerplicht tot 16 he. Dus van zodra dat hij kon, was hij weg he." (Eser, 46 years old, wife of heroin user)

"He was at the top of his class, he wanted to become a veterinarian here and his uhm, his principal came begging for him to be in General Secondary Education (ASO) and they thought it was necessary

for him to be in Technical Secondary Education (TSO). And it didn't interest him at all, started skipping school. Education used to be compulsory till the age of 16 eh. So as soon as he could, he left eh." (Eser, 46 years old, wife of heroin user)

Most of these 11 participants note that they did not feel good in the school context mostly because of their migrant background. Four of these men's parents arranged a marriage for them at the age of 18, mainly to get them on the right track. All except one have divorced. Three have spent a large part of their youth in a youth center. Six of these men were incarcerated in prison for the first time around the age of 19, which seriously jeopardized their chances in the labor market. Ten people within this group started using substances between the age of 12 and 15. Three attest to have been beaten up severely by their fathers because of their use.

"18. ik was juist 18 geworden. Ik was 's nachts 18 geworden. En 's morgens zat ik in de gevangenis. Zat ik bij de onderzoeksrechter en 's avonds zat ik er al in. Ik had gevochten in een dancing. (…) Dat was de allereerste keer. Ik weet nog hoe dat ik geweend heb. Ja, dat is de eerste keer dat ge zo tussen al die gangsters zit. Ge zijt pas achttien geworden. Pas. Nog maar een dag. En ge zit al in de gevangenis, aleja, dat is niet… en ja… dat was mijn eerste kennismaking met de criminaliteit zal ik maar zeggen." (Hikmet, male, 45 years old, heroin)

"18. I had just become 18. I had become 18 that night. And in the morning I was in prison. I was led to the examining magistrate and in the evening I was already there (in prison). I had a fight in a dance hall. (…) That was the first time. I remember crying back then. Yes, that's the first time you are put together with all these gangsters. You just turned 18. Just. Just a day. And you're already in prison, well, that's not… and yes… I'd say that was my first experience with delinquency." (Hikmet, male, 45 years old, heroin)

We discern a second smaller group of three participants who attest that having been married at an early age was the main cause of their current substance use. These are individuals between the age of 39 and 45. Elíf (female, 45 years old) ventilates the story of her father dying at a young age followed by her mother sending her to Belgium to engage in a marriage with a Turkish-Belgian man. She suffered an abusive marriage and describes herself as a problematic alcohol user. Tarkan (male, 39 years old) narrates having married at the age of 13 in Turkey. He divorced and came to Belgium to marry a Turkish-Belgian woman[19]. This marriage is not what he had expected, which is why he has been treated for depression. A third female participant narrates a similar story in which her parents had a Turkish man come over from Turkey. She suffered an abusive marriage and has been treated for severe depression over the past ten years.

"Ik trouwde op mijn dertiende toen ik nog kind was. Eigenlijk wou ik niet trouwen. Ik leerde in het leven dat niemand beslissingen voor jou mag nemen. Ik beslis zelf over wat ik wil. Uiteindelijk besloot ik dus om te scheiden van mijn vrouw. (Tarkan, male, 39 years old, prescribed medication)
"I got married when I was 13 when I was still a child. I didn't really want to get married. I learned that in life no one can make decisions for you. I decide what I want. Eventually I decided to divorce my wife. (Tarkan, male, 39 years old, prescribed medication)

[19] A small scale qualitative research in Turkish women (De Kock, 2012) confirms that in the years 2000 some Turkish women voluntarily choose to marry a young man originating from Turkey. It could be hypothesized that this type of marriage was a social emancipatory practice for some second generation Turkish women. This specific choice enables these women to create more distance between themselves and their families by means of marriage (Lievens, 2000 in Schoonvaere, 2013). Furthermore they could in part protect themselves from male dominance because their husbands did initially not speak the Dutch languages nor did they have jobs.

"Ik wilde niet trouwen. (Maar) omdat mijn moeder ziek was, moest er iemand zijn om haar te verzorgen. Ik was zelf jong. Ik wist ni. Ik was zelf kind, ik had kinderen. Dan ben ik beginnen gebruiken eh." (Engin, male, 40 years old, heroin)

"I didn't want to get married. (But) because my mother was ill, someone had to be there to take care of her. I was young myself. I didn't know. I was a child myself, I had children. That's when I started using eh." (Engin, male, 40 years old, heroin)

For the younger generations, it is harder to describe how participants feel about early life choices and youth. As mentioned in the introduction, most third generation participants describe their use as non-problematic. Still, most of the second generation problematic users mention problems at school and with parents when referring to reasons for their use. Consequently, it is indispensable to note that a recent participatory study in Ghent reports that the three most prominent problems of Turkish third generation youngsters include problems at school and racism (Laudens, 2013).

We will shortly account three stories of youngsters who describe their use as problematic. Unfortunately, we have no further in-depth information about the course of use of these youngsters. Burcu (19 years old) repeatedly notes that he has no hope nor goals in life. He has not been able to finish secondary education and is not able to find a job. He smokes cannabis out of boredom. Kadriye (28 years old) explicitly repeats that she has been left alone, that nobody accepts her for what she is (a user). Her father is a heavy cannabis smoker and so is she. She moved to the city to avoid the social control in her extended family. She has been in in-patient treatment several times, but does not seem to be able to shake her habit off. Ebru (25 years old) explains she had a good youth. Her parents have always treated her well, but for a couple of years she is addicted to alcohol. She drinks large amounts of alcohol in her room at her parents' house on a daily basis. She has joined AA (Anonymous Alcohol users) but has not been able to shake her habit off yet. She gives no further reasons for her use.

5.3.2.2 Marital problems

A significant number of the problematic users (13) refers to marital problems as a cause for their problematic substance use. Half of these participants mention that the marriage their parents had arranged was a bad choice in their lives. One man and two women mention a non-voluntary marriage[20] at the ages of respectively 13 and 18. Three of these participants mention that if they could do it all over again, they would not have moved to Belgium for this marriage. The women in our sample resort to medication and alcohol to overcome the trouble they experience because of these marriages. The excessive use of prescribed medication was confirmed by a general practitioner and a social worker (personal communication 27/03/2015 & 07/09/2015). This trend is similar in men, although heroin also appears only in the case of men. Additionally, three men attest to have divorced due to their problematic use.

[20] It is important to distinguish between arranged marriages and non-voluntary arranged marriages. Most arranged marriages in the Turkish community are voluntary.

5.3.2.3 Racism, perceived and structural ethnic discrimination

"Zij beginnen van nul de vlamingen. Ze beginnen van nul. En euh allochtoonse gemeenschap begint van -3." (Ender, female, 23 years old, cannabis)

"They start from 0, the Flemish. They start from 0. And uhm, the foreign community starts from -3." (Ender, female, 23 years old, cannabis)

Recently, the amount of literature on the detrimental impact of perceived and structural discrimination on mental health has grown extensively (Krieger, 2014). Several questions in our interview guide, such as 'are you often confronted with your migration background?' or 'how do you feel about Belgians?' and 'how do you think Belgians see you?', led participants to talk about their experiences with racism and discrimination. Although we should consider that our questions were formulated quite directly (possibly triggering an affirmative answer), almost all participants have experienced racism and half comes up with concrete examples. The determinants of differences in these answers seem to lay mostly in the generation participants belong to, their views towards new migrants, and their description of use as problematic or non-problematic.

Over half of the 39 problematic users in our study exemplify specific cases of discrimination in the educational, housing, health care and/or in the labor context.

"Toen ik mijn naam zei, was er opeens een stilte. Ze zeiden dan dat ze op dat moment niet zochten naar een nieuwe werknemer. Als ze nu horen dat ik vreemdeling ben, dan zeggen ze: 'nee je bent niet zo gelijk de anderen, je bent anders.' Dan zeg ik altijd dat ik ook turk ben en niet anders ben, maar ze blijven zeggen dat ik wel anders ben. Soms willen ze het eigenlijk niet geloven of aanvaarden dat ik turk ben (lacht)." (Berna, female, 46 years old, prescribed medication)

"When I said my name, there was a sudden silence. They said that they weren't looking for a new employee at the moment. If they now hear that I'm a foreigner, they say: 'No you're not like the others, you're different.' Then I always say that I'm Turkish as well and that I'm not different, but they keep saying that I am different. Sometimes they don't want to believe or accept that I'm a Turk (laughs). (Berna, female, 46 years old, prescribed medication)

"t' Is zeer moeilijk. En tis ook beetje wederzijds. Gelijk vroeger als ik werkte, was er doorgroei mogelijkheden. Maar echt de Belgische mensen kregen de voorrang. En dat maakt je psychisch kapot. Ja sorry dat ik dat moet zeggen maar allochtonen worden nog altijd gediscrimineerd." (Abdullah, male, 28 years old, cannabis)

"It's very difficult. And it's also a little reciprocal. Like when I worked in the past, there were career opportunities. But the Belgian people were put first. And that's what psychologically destroys you. Yes, sorry I have to say this but foreigners are still discriminated." (Abdullah, male, 28 years old, cannabis)

First generation migrants and marital migrants did not make statements about discrimination or stated not to have been confronted with discrimination because of their ethnic background. Second generation migrants on the other hand are less likely to interpret experiences of discrimination as isolated incidents. On the contrary, they perceive it as processes of discrimination, marginalization, disempowerment and social exclusion (Bucerius, 2014: 44).

Most of our participants are quite positive about Belgians in general. Many participants note that there are good and bad Belgians, racists and non-racists. They mention the socio-political climate that creates a fearful image of muslims, and that they partially understand racist reflexes. This is also mentioned in a study on Turkish dealers in Germany (Bucerius, 2014: 126). Tarkan (39 years old) puts it as follows:

"Als ik denk aan al die terreurorganisaties (...), dan stel ik mijzelf in de schoenen van de Belgen en vind ik het normaal als ze mij ook bijvoorbeeld terrorist zouden noemen. Als ik ooit geconfronteerd zou worden (met racisme), dan zou ik daar respect voor hebben."
"When I think about all these terrorist organizations (…), than I put myself in the Belgians' shoes and I find it normal that they would call me a terrorist too for example. If I would ever be confronted (with racism), I would respect it."

Many accept the fact that they are seen as foreigners and the racist encounters that sometimes originate from that perspective. Moreover, they narrate that when it comes to prejudices and stigma, racism goes both ways: "the Turks" also have their restrictions towards 'the Belgians'.

"*Ik voel mij ni uitgesloten. Nee, nee. Ze mogen zeggen van : 'Vuilen Turk' ik zal er mee lachen"*
(Demir, male, 33 years old, cannabis)

"I don't feel excluded. No, no. They can say: 'Vuilen Turk' and I will laugh about it. (Demir, male, 33 years old, cannabis)

"Van ja 'die zijn toch racist (Turken over Belgen). Wij worden ni aanvaard. Dat zijn toch klootzakken. Dat zijn smeerlappen, dat zijn schijnheiligen.' Wij hadden ook veel vooroordelen. (...) Er is een stuk waarheid aan dat. Maar niet zo in ons hoofd echt zo vergroot. Der is zeker een waarheid over da. Wij worden ni aanvaard dit dat. Maar tis ni voor te zeggen dat dat over het algemeen zo is." (Arda, male, 36 years old, ex-heroin user)

"Like yes 'they are racist (Turks about Belgians). We are not accepted. They are assholes. They are bastards, they are hypocrites.' We had a lot of prejudices as well. (…) Part of that is true. But not this blown up in our heads. There's definitely some truth about it. We are not accepted and this and that. But you can't say that that's the case in general." (Arda, male, 36 years old, ex-heroin user)

Similar to those participants who describe their use a problematic, half of the non-problematic users report on having experienced discrimination in the areas mentioned above. Yet, in the stories of these non-problematic users, we do perceive a different narrative on racism and discrimination. Most importantly, there seems to be a greater insight and stamina in going around with these issues. As most of the non-problematic users have enjoyed higher education, they often refer to this as a weapon against discriminatory practices. They also mention more often than problematic users to have reacted upon these practices.

"Ik heb ene keer meegemaakt. Da was toen, wij willen iets huren. Wij hebben een huisbezoek gehad. En toen ik begin Nederlands te spreken, dat ze tussen elkaar spreken, te zeggen das een buitenlander wat kan doen enzo… Vandaar dat ze hebben gehoord dat ik in de universiteit werkt heb, da was een beetje minder. Maar ik vind da toch discriminatie." (Cemil, male, 31 years old, occasional alcohol user)
"I have experienced it once. That was when, we want to rent something. We had a house visit. And when I start speaking Dutch, which they speak to one another, to say that's a foreigner and what I can do and stuff… That's why they heard that I worked at the university, it was a bit less. But I still think that's discrimination." (Cemil, male, 31 years old, occasional alcohol user)

"Kennissen die mij niet echt kennen kunnen soms scherp uit hun bocht komen. 'het zijn weer de turken' enzo, van die rare opmerkingen die ik hoor. Ik reageer daar niet op. Domme mensen." (Deníz, male, 34 years old, occasional cannabis user)

"Acquaintances who don't know me very well can be mean sometimes. 'It's the Turks again' and stuff, those weird remarks I hear. I don't react to it. Stupid people. (Deníz, male, 34 years old, occasional cannabis user)

"Ik? Ik voel mij Belg. Dat zij me niet graag hebben betekent niet dat ik mij niet belg voel hé. Ik ben hier geboren. Da's hier ook mijn land hé. Ik heb hier gewerkt, mijn ouders, mijn familie ook. Zij hebben veel gedaan voor belgie. Wij hebben ook belastingen betaald, wij hebben evenveel rechten zoals hen." (Tarik, male, 32 years old, occasional cannabis user)

"Me? I feel Belgian. The fact that they don't like me doesn't mean that I don't feel Belgian eh. I was born here. It's my country too eh. I have worked here and so have my parents, my family. They have done a lot for Belgium. We have also paid our taxes, we have just as many rights as they do. (Tarik, male, 32 years old, occasional cannabis user)

Finally, it is noteworthy to mention that in some cases the feeling of being discriminated and not 'belonging' in the Belgian society is directly linked to racist feelings towards other groups of new European migrants. Four of our participants report having encountered discrimination, but immediately change the subject towards the consequences of new European migration. They talk about challenges with new migrants and that these migrants are 'far worse' than the Turks. Two of our Turkish participants with a Bulgarian background in their turn attest of discrimination by the Turkish in the labor and housing market respectively.

5.3.2.4 Social networks

26 out of 39 participants who describe their use as problematic are unemployed. One third is financially supported by the social security system because of depression or schizophrenia. One in three has full employment. All participants gave us an insight in how they live their daily lives. We will give a short overview and compare those describing their use as problematic and those who don't. What those groups have in common is that most of them describe their best friends as persons with a migrant background (as opposed to 'Belgians').

"Ik kan niet meer functioneren op de arbeidsmarkt ik kan gewoonweg niet bedenken dat ik ooit terug kan gaan werken. Dit is een groot probleem ik weet niet hoe ik mijn dagen kan vullen. Geen inkomen, geen verwachtingen meer." (Derya, female, 38 years old, prescribed medication)
"I can no longer function on the job market, I simply cannot imagine ever being able to go back to work. This is a big problem I don't know how to pass the time. No income, no more expectations." (Derya, female, 38 years old, prescribed medication)

Users who describe their use as problematic are generally quite negative about their social lives. Some of them literally state 'I don't have a social life' when asked about what they do in their leisure time. Many mention that they used to go out, but that because of their use, they have lost friends and family or have chosen to distance themselves from these friends because of their use. One participant describes a double life: when he relapses in heroin use he stops contacting non-using friends until the moment he gets back on his feet. His non-using friends

are unaware of these episodes. Three participants describe moving neighbourhoods in order to change their social environment.

The participants using heroin and methadone describe a very isolated life. They mention that they only have acquaintances and no real friends they can trust.

"Voila, heroïne is geen jointje dat je rondgeeft. Heroïne wil je met niemand delen (lacht) want dat is een zware uitgave. Dat is elke dag minimum 20 euro (...). Minimum eh. (...) Tis zeer moeilijk om te vinden, hier in Gent. Je gaat ni springen van ja ik ga het delen met mijn vrienden. Want bij heroïnegebruik is er geen vriendschap. Het is ieder voor zijn eigen. 't Is nie alleen bij mij. Bij elke zware verslaafde is zo. Het is voor ieder zijn eigen." (Arda, male, 36 years old, ex-heroin user)

"Voilà, heroin is not a joint you pass around. Heroin is something you don't want to share with anyone (laughs) because that's very expensive. That's a minimum of 20 euros every day (…). Minimum eh. (…) It's very hard to find, here in Ghent. You're not going to say that yes, I'm going to share it with my friends. Because there is no friendship when it comes to heroin use. It's every man for himself. It's not only me. This is the case for every serious addict. It's every man for himself." (Arda, male, 36 years old, ex-heroin user)

To avoid problems, most of those users remain at home and have a monotonous daily routine of getting methadone in the pharmacy or local drug substitution center (MSOC), watching TV, sleeping and using heroin when they have money (mostly in the beginning of the month). Four of them visit a local initiative for double diagnosed persons (Villa Voortman) on a daily basis and account that it is the only social activity they participate in.

Alcohol users do in general appear to dispose of a larger network of friends. The stories of arts and music lovers lead us to assume that in this scene the consumption of alcohol by both men and women is generally well accepted. Problematic alcohol and cannabis users often times state that they prefer to stay at home and that they mostly use alone at home.

"Dat gaat niet! Vrienden overdrijven. Ze gebruiken 1 of 2 (joints) en zitten al te zeuren voor een 5e. da ga niet. Da stoort mij. Drugs is privé. Je moet niet delen met iemands anders. Vanaf dat je deelt ben je een junkie. Waarom? Ge gaat alles weggeven, je gaat steeds meer gebruiken. Als je af en toe eentje gebruikt, moet je zeggen "ik heb geen geld meer" en loopt ge weg. Dat zijn verstandige mensen." (Tarik, male, 32 years old, cannabis)

"That doesn't work! Friends exaggerate. They use one or two (joints) and they're already whining for a fifth one. That doesn't work. This bothers me. Drugs is something private. You don't have to share with others. From the moment you share, you're a junkie. Why? You'll be giving everything away and start using more. If you use one once in a while, you should say "I don't have any money left" and walk away. Those are smart people." (Tarik, male, 32 years old, cannabis)

Although Ghent consists of a rich scene of Turkish associations, only a few of our participants, both problematic and non-problematic users join activities in these or other associations. The only activities in associations we heard of were membership in a football association (6), a fitness club (6) and a basketball team (2). Further, there are singular accounts of being active in a charity organization of a mosque, a boxing club and a karate club. Users describing their use as non-problematic seem to have a larger array of leisure activities, including visiting bars in the city center (as opposed to bars in the own neighbourhood), playing instruments and going out for dinner and concerts.

5.4 Help-seeking behavior

5.4.1 Perceptions of use and seeking help

"Ik denk dat de grootste oorzaak daarvan (taboe) ego is. Niemand wil aan anderen vertellen dat zijn of haar familielid zich in zo'n situatie bevindt. Ze proberen dat gewoon te verbergen. Ze zeggen dan: 'oké, die gebruikt drugs, maar niemand mag dat weten." (Aydan, female, 21 years old, prescribed medication)

"I think the main cause of this (taboo) is ego. No one wants to tell other people that his or her family member is in this situation. They just try to hide it. They say: "Okay, he/she uses drugs, but no one should know about it." (Aydan, female, 21 years old, prescribed medication)

When participants are asked how they feel the Turkish community deals with substance use and problems caused by it, we unanimously get the answer that it is a taboo subject. A large individual responsibility is expected from problematic users and their families. Abdullah (28 years old) puts it as follows:

"Kijk moslims die aan drugs zitten, weten perfect dat ze dat niet mogen."

"Look, muslims that are using drugs, perfectly know that they're not allowed to do so."

The feeling of responsibility for one's own behavior is quite far-reaching. Users themselves often refer to it when rejecting help and explaining continued problematic use. Further, participants use individual responsibility as a defense strategy for their feeling of being stigmatized, excluded or having become the shame of the family. They note that persons stigmatizing them, have their own things to be ashamed of (responsibilities) in their families. Taboo, shame, stigma and individual responsibility are closely intertwined, and result in avoiding to talk about the topic of problematic substance use and not sharing experiences outside the own household.

Beings able to talk about the topic is also hard within the households. Our younger participants note that their mothers are probably aware of their use, but avoid to talk about it. When the topic is discussable with mothers, users do not benefit from these conversations as its main topic is to stop using. Fathers do not seem to be in the picture, when it comes to discussing substance use. Married men do talk to their spouses about their use. Women on the other hand seem to find less hearing in their close family, especially when it comes to problematic use of cannabis and alcohol. Women using antidepressants and other medication do feel comfortable talking about it with sisters and female friends.

5.4.2 Religion and use

Our interviews demonstrate a close intertwinement of being muslim, using substances and the belongingness to the Turkish community in Ghent. Some research asserts that being religious may function as a protective factor for problematic substance use. In this context, it is indispensable to take a closer look at the intertwinement of substance use, belief system and belonging to the community.

First of all, the notion of *haram* (opposite of *hallal* and literally: forbidden) was brought up by about one out of three participants when asked how they see their use from a religious perspective. This question was however in many cases posed in a way that unveiled the

opinions of the community researchers themselves towards the desired answer. The participants consequently note that gambling and the use of substances is *haram*. When we take a closer look at what this 'forbidden' means to them, we get a wide array of interpretations and participants note that there is discussion about its interpretation and consequently which use is to be interpreted as *haram*. Participants mostly refer to the fact that the use of anaesthetizing substances is forbidden. Further, mistreating the body is also considered *haram*. The use of medication however is considered *less haram*. Overall, participants seem to struggle actively as how to match their use with their beliefs.

"Het is eigenlijk heel moeilijk weet je, je struikelt met je geloof en je geweten: je weet dat het niet mag (middelen gebruik) en toch doe je het! In plaats van te denken wat de anderen over jou denken zit je te vechten met je eigen geweten want je weet dat je verkeerd doet door alcohol te gebruiken bv. je wilt het niet maar doet het toch, je hebt dat niet in handen!" (Elíf, female, 45 years old, alcohol)

"It's actually really difficult you know, you struggle with your faith and your conscience: you know that you're not allowed to do it (substance use) and you still do it anyway! Instead of thinking about what the others might think about you, you're fighting your own conscience because you know you're doing the wrong thing by using alcohol e.g. you don't want it, but you still do it, you have no control over it!" (Elíf, female, 45 years old, alcohol)

"Ik ben getatoeëerd ook. Ik heb daar altijd zin voor gehad maar ik heb dat nooit niet laten doen omdat ik altijd hoorde dat dat volgens onze godsdienst verboden was. Haram noemen we dat, en uiteindelijk ben ik er op uitgekomen dat dat niet zo is maar dat dat niet graag wordt gezien. (...) en de gemeenschap waar ik woon nu, (...) ze hebben gezegd ge zijt ne zondaar. En ik heb gewoon een vraag gesteld (stilte). (...) Ja dus het reinigingsritueel heb ik gevraagd van, ben je daarmee in orde als je uw onderhuid wast of uw bovenhuid? en iedereen heeft gezegd uw bovenhuid. Dus ik heb gezegd awel dat zit in mijn onderhuid. En ze zijn er nog niet mee gestopt van mij daarmee te ambeteren. En ik heb toen een vraag gesteld. Ik heb gezegd, hier ietske verder is er een klein parkske; ik heb gezegd uw kinderen zitten dar allemaal, ja hebben ze gezegd. Ga eerst eens gaan kijken naar al die drugsgebruik dat ze daar doen, toen hebben ze gezwegen en is er niets meer gezegd geweest tegen mij." (Kaan, male, 35 years old, ex-anabol user)

"I have tattoos as well. I always wanted them but I never did it because I always heard that it was forbidden in our religion. Haram is what we call that, and eventually I discovered that that's not the case, but that they just don't like it. (…) and the community I live in now, (…) they said you are a sinner. And I just asked a question (silence). (…) Yes, so the cleansing ritual I asked, is it all right if you wash your epidermis or your dermis? And everyone said your upper skin. So I said well that's in my epidermis. And they still haven't stopped pestering me about it. And then I asked a question. I said, a little further down the road here there's a park; I said all your children are over there, they said yes. Go take a look over there first at all the drug use, then they kept silent and they haven't said a word to me ever since." (Kaan, male, 35 years old, ex-anabol user)

We pointed out earlier that the majority of our participants find strength in their belief. Some note that prayer has been of great help when incarcerated or during rehab. Only three participants note they often go to a mosque or house of prayer. The others say they do not, and half of them explains that they cannot go because substance use is forbidden or because they feel they are not accepted in the religious community. When asked if it is possible to talk to imams or hodjas about problematic substance use, a large majority answers negatively because mosques are not the place for this kind of help, and because an imam is not the person to help with such problems nor do they possess the competences to help in such

cases[21]. Many participants say that they feel guilty towards their belief and that they are quite sure that the imam might be able to refer to other services, but that they would judge their behavior in the first place.

"CR: Is er niemand in de moskee die je kan helpen, aan wie je kan vertellen over je problematiek? R: Neen. Want ik ben degene die het eerst uit zijn hoofd moet het gebruiken zetten. En dan pas hulp zoeken van de omgeving.
CR: Maar als je dat niet kunt, kan je niet gewoon bij iemand hulp gaan vragen? Is er niemand die dat doet in de moskee?
R: Ik denk niet dat ze hulp kunnen bieden." (Haluk, male, 39 years old, alcohol)
"CR: Is there no one in the mosque that can help you, you can tell your story about your problems to? R: No. Because I'm the one who needs to get the use out of my head. Only then can I search for help.
CR: But if you can't, can't you just ask someone for help? Is there no one that does this at the mosque?
R: I don't think they can offer me any help." (Haluk, male, 39 years old, alcohol)

Problematic users do go in search of religious help and support outside of what they perceive as their own religious communities. Two users account that they feel more comfortable in Moroccan religious communities.

"Maar als ge naar de moskee al komt, dan zijt ge al aanvaard, dan zeggen ze oh hij heeft zijn verstand gekregen. versta ja, hij is niet meer die persoon die hij geweest is maar hij probeert iets anders te zijn, het rechte pad ik zal het zo zeggen en dan word je wel aanvaard bij de Turken. Ze zijn wel vergevend he. Als ze zien van ja, ik wil het terug goed doen, dan wordt je wel aanvaard he. Maar ik ga toch liever bij de Marokkaanse gemeenschap gewoon omdat ze geen vooroordelen zouden hebben. Want als ik bij de Turken ga, heel Gent kent mij versta ja. Dan gaan ze zeggen, oei den diene, versta je. Dat heb ik niet bij de Marokkaanse gemeenschap, die kennen mij niet, die kennen mij gewoon als ne moslim, that's it." (Hikmet, male, 45 years old, heroin and methadone)

"But if you go to the mosque, you are already accepted, then they say oh he's finally using his common sense. You see, he's not the person he used to be but he's trying to be something else, on the straight and narrow path I'd say and then you are accepted by the Turkish people. They are forgiving eh. If they see yes, I want to do the right thing again, you are accepted eh. But I prefer going to the Morrocan community because they wouldn't have any prejudice. Because if I go to the Turks, everyone in Ghent knows me, you see. Then they will say, oh no him, you see. That doesn't happen to me at the Moroccan community, they don't know me, they just know me as a muslim, that's it. (Hikmet, male, 45 years old, heroin and methadone)

Two family members report to have visited imams in Turkey to deal with psychotic sons. They account that it was a kind of 'last resort' solution after or parallel with therapeutic treatment and medication. They also report to have paid a lot of money for these treatments, but that it has not paid off. One participant reports that a Turkish imam has visited him several times and has performed non-harmful rituals on him to help him stop hearing voices. This is partly in line with Oliemeulen's (2007: 121) observation concerning the fact that it is usually the family that initiates contact for religious help.

[21] An imam is a person who leads prayers in a mosque in Sunni islam. Further, the imam can be seen as a community leader and a person who provides religious guidance. In shia islam imams have a more weighty position because they are believed to be appointed by god himself. Some say that hodjas are persons who have performed the 'hadj' (pilgrimage to Mekka) but in popular speech and in our interviews, we hear that hodjas are wise people in some way or another (f.e. by having studied qu'ran or having enjoyed higher education) and are called upon for religious and other guidance. In some studies, hodjas are called faith healers (Edirne et al., 2010).

Additionally, several participants report on regular personal contact with an imam or hodja to talk about islam, and that this is of great help for their emotional stability. Two women report that they would like to talk to a hodja, but that there are few female hodjas.

In conclusion, we stress that islam consists of many religious branches and contains some popular beliefs that are not interpreted or picked up by all muslims. When inquiring about the consultation of hodjas our community researchers unanimously state that 'charlatans' making money out of expelling ghosts, neutralizing the spell of djins (a popular cultural belief), or the protection of the 'evil eye' do exist, but that they do not make up the majority of imams and hodjas (communication during intervision 14/09/2015). The participants seem to confirm this statement. This is consistent with previous research that postulates that alternative treatment use in ethnic minorities is comparable to this use in the general population (Derluyn et al., 2008: 298; Knipscheer & Kleber, 2005).

Further, participants note that they are aware of lectures in mosque associations about substance use and how to go around with the substance use in children. Still, none of our participants has found true support in their own religious community. On the contrary, we should note that they are ashamed and feel excluded from these communities because of their use.

"We (respondent and wife) zijn dus voorstander van een Europees centrum voor de islam met een Europese opleiding. (...) Turkije is een zeer progressief land. (...) De erkende Turkse moskeeën hier die door Turkije gesubsidieerd worden die dan imams naar hier sturen, theologen, die zeven jaar unief gedaan hebben. Ze komen naar hier voor vijf jaar en ze gaan terug. En hier (in de buurt) was er ne keer een jonge gast, met een jong gezin, begin de dertig. En die kwam uit een grote stad. Hij voelde zich hier niet goed want dat is hier nog getto mentaliteit. Ze zitten hier eigenlijk op Turkije achter, de oudere mensen. In Turkije ging hij met zijn vrienden naar het strand, zelfs met zijn vrouw en kinderen, en ze gingen ne keer op een terrasje gaan zitten, dat is hier dus not done. Zeker hier met de Peribeyli's. En dan de laatste die ik gezien heb die is blijkbaar nu ook alweer weg. Dat was het andere extreme, ik wou met hem babbelen en ik stelde die een vraag maar die antwoorde aan mijn man. en die keek niet naar mij. Dat je denkt van dat is mogelijk in Iran, of in Afghanistan maar toch nie… in Turkije zelfs niet denkbaar. En dan nog zeker niet in Vlaanderen, wat voor mensen sturen ze naar hier, weet wel." (Eser, 46 years old, wife of heroin user)

"We (respondent and wife) are all for a European centre for islam with a European education. (…) Turkey is a very progressive country. (…) The accredited Turkish mosques here that are subsidized by Turkey and send imams to come here, theologists, that have studied at university for seven years. They come here for five years and then return. And here (in the neighborhood) there was a youngster once, with a young family, early thirties. And they came from a large city. He didn't feel good here because here there's still a ghetto mentality. In fact, they are behind on Turkey here, the elderly. In Turkey he would go to the beach with his friends, even with his wife and children, and they would sit in an outdoor café, that's not done here. Especially here with the Peribeyli's. and then the last one I saw has apparently left again as well. That was the other extreme, I wanted to talk to him and I asked him a question, but he replied to my husband. And he would not look at me. Then you think this is possible in Iran, or in Afghanistan but not… In Turkey this is unimaginable. And especially not in Flanders, the type of people they send here, you know." (Eser, 46 years old, wife of heroin user)"Ja, de imam geeft toch regelmatig preken hé. Dan leest hij verzen uit de Koran en daar staan natuurlijk een paar dingen over verslaving en hoe dat dat is, maar ik heb eerder het gevoel dat er gewoon verteld wordt dat het strafbaar is en waarom het verboden is, wat ik ook wel belangrijk vind. Dan krijg je ook inzicht over waarom het verboden is en wat het met een mens doet. Dus er wordt wel over gepraat, maar meer over waarom het verboden is en hoeverre je dan zondigt." (Evren, woman, 18 years old, alcohol)

"Yes, the imam often preaches eh. Then he reads verses from the Koran and there are obviously a few things in there about addiction and what it's like, but I feel like it just tells that it's punishable and why it's forbidden, which I find important as well. That also gives you an insight into why it's forbidden and what it can do to a person. So they do talk about it, but it's more about why it's forbidden and how much of a sin it is." (Evren, woman, 18 years old, alcohol)

5.4.3 Visiting Turkey

Five participants account to have travelled to Turkey to get clean and two other participants report secondhand on this practice. When the problematic use concerns heroin, users usually take a large amount of methadone to Turkey and stay there with family or friends. One participant accounts to have tried to enter a treatment center in Turkey, but that he was not allowed to stay. This practice seems to be in line with the general habit of many Turkish Belgians of going to Turkey at least some months a year.

"Zeker mensen van de eerste migratie, die zoveel maanden per jaar naar ginder gaan. (...) van ja dat is mijn antidepressivum, zoveel maand per jaar naar Turkije gaan." (Fatih, male, 50 years old, heroin)

"Especially people from the first migration, that go there several months a year. (…) like yes those are my antidepressants, going to Turkey this number of months a year." (Fatih, male, 50 years old, heroin)

Three participants report on having used their mandatory army service in Turkey to get clean. As Fatih (male, 50 years old, heroin) puts it: "Je moet zware fysieke inspanningen doen en euh… de afkickverschijnselen voel je niet …" "You have to do severe physical effort and uhm… you don't feel the withdrawal symptoms…". Most of the participants report to having bought off or will buy off their mandatory army service. The three participants who have carried out their army service have continued their use after returning to Belgium.

"Ja want je kan dat afkopen he (legerdienst). Normaal gezien is het 15 maanden. Maar de mensen die in het buitenland leven die kunnen dat euh… in mijn tijd was het 5700 euro dat je moest betalen en dan moest je maar een maand meer gaan. Nu kan je dat nog afkopen maar het is 6700 euro ofzo. Het is wat duurder geworden." (Fatih, male, 50 years old, heroin)

"Yes, because you can buy it off eh (army service). Normally it's 15 months. But the people who live abroad can do that uhm… When I was young, you had to pay 5700 euros and then you only had to go for a month. Now you can buy it off as well but it's 6700 euros or something. It has become a bit more expensive." (Fatih, male, 50 years old, heroin)

5.5 Experience with services

One in three problematic users account to have appealed to general and mental health care services for dealing with their use. Half of them have resided in several in-patient treatment centers.

5.5.1 In-patient Care

11 participants have resided in in-patient center De Sleutel. All these participants feel that this in-patient center is very much disciplined when compared to other centers. Four participants account that they have not stayed longer than a week to three weeks because of this. Four other participants account that this discipline was useful to them. Two heroin users state that they have been clean for respectively five and seven years after their stay in De Sleutel, but only one in eleven is clean to this day. Some of the participants note that the principle of

“breaking down and building up” is not the way they want to, or can stop using. Most of these participants are persistent heroin users and two are cannabis users.

Ten participants have resided in specialized psychiatric centers within hospitals (PAAZ). They were hospitalized for problems with a wide array of substances (alcohol, cannabis, heroin, codeine and because of acute psychosis). Most of them were referred to a hospital by their GPs or psychiatrist. Half of these participants discontinued their stay. Two family members and one participant state that they were given too much anaesthetizing medication, and two participants state that not speaking Dutch was the main problem in the hospital. Two other participants note they have presented themselves at UPSIE-UZ (crisis care) and did not understand why they were rejected for a short stay in this crisis center (respectively alcohol and heroin users).

Eight participants have regular contact with a psychiatrist or psychologist outside in-patient care. More than half of these participants are treated for depression, two for psychosis disorders and one for alcohol use. Participants note that it was not easy for them to initialize the contact with these professionals because as Derya (38 years old, female, prescribed medication) puts it: “Het is algemeen geweten dat een psychiater alleen gekken behandelt” “It’s general knowledge that a psychiatrist only treats madmen”.

Generally, they are quite positive about the support of psychiatrists and psychologists, although two note having had problems because of language and cultural differences (mainly concerning family issues). This is in line with Acherrat-Stitou’s (2009) and Knipscheer’s (2005) assertion that psychiatrists and psychologists should be wary of cultural countertransference in the therapeutic relation with clients with an ethnic background. At least three participants state that their psychiatrist or psychologist is of Turkish descent.

> *“Mijn problemen waren vooral gebaseerd op familiale kwesties. Er waren grote ruzies tussen mij en de familie van mijn man. Ik had problemen met mijn schoonmoeder. Ik heb erdoor afgezien. Omdat de psycholoog deze culturele waarden niet begreep, heb ik niet echt de hulp gekregen die ik zelf wou. Maar na een tijd ben ik veranderd van psycholoog. Die psycholoog had opleiding gekregen over verschillende culturen en die bekeken mijn problemen anders en snapten me ook meer.” (Berna, female, 46 years old, prescribed medication)*

> *“My problems were mostly based on family matters. There were big fights between me and my husband’s family. I had problems with my mother-in-law. I had a hard time because of it. Because the psychologist didn’t understand these cultural values, I didn’t really get the help I wanted. But after a while I switched to a different psychologist. That psychologist was educated in different cultures and they looked at my problems in a different way and they understood me better.” (Berna, female, 46 years old, prescribed medication)*

We heard eight accounts of six participants who went through a long stay in in-patient center VITA (PC Sint-Jan Baptist) (5) and De Pelgrim (3). These centers are conceived as less strict because of visiting regulations and participants report to have stayed longer periods of time in these centers (compared to De Sleutel). Several of these participants note they have worked through some personal issues in these centers. But also for these centers it should be noted that all participants relapsed after a maximum of 3 months outside the center.

Furthermore we have heard singular accounts of in-patient stays at Ghuislain, K13, Sint-Camillus. Generally speaking participant’s experiences in these centers were positive because they succeeded in staying clean.

5.5.2 Outreaching, out-patient and crisis care

Only heroin users report to make use of outreaching and crisis care as well as the heroin substitution center (MSOC). Seven users account for their experiences in the MSOC. For many, MSOC is the main activity in their daily routine. They greatly appreciate the comprehension the GPs in this center demonstrate for their general situation and are positive about the flexibility shown concerning their substitution therapy.

"Toen ik daar (in MSOC) mijn levensverhaal in het kort moest samenvatten merkte ik dat die onder de indruk was van hetgeen er allemaal gebeurd was. In zijn beleving was dat, of die indruk kreeg ik althans, was dat een logisch gevolg, mijn gebruik. Hij bekeek mij niet als een junk of een crimineel, hij had eerder medeleven met mij. Waardoor dat hij mij dan ook meteen euh… oprecht geholpen heeft met een opname te zoeken." (Ismail, male, 35 years old, heroin)

"When I had to tell my life story over there (in MSOC) I noticed that he was impressed with everything that happened. To his way of thinking, or at least that's what I thought, my substance use was a logical result. He didn't see me as a junkie or a criminal, he felt sorry for me. That's why he immediately uhm… sincerely helped me with finding an admission." (Ismail, male, 35 years old, heroin)

Two of these users account of the monthly visits of the mobile teams to support them in their mental well-being. Two other users account not going to the MSOC for methadone because they do not want to be confronted with ex-users. Three participants report about the helpful support of employees of the former 'De Eenmaking'. We mention this service explicitly because professionals also referred to it. This organization was meant to form a bridge between Turkish and Moroccan communities and treatment centers, but ceased to exist in 2012, when it was incorporated in Centrum Algemeen Welzijn (CAW).

Consistent with the accounts of substance abuse center use described above, none of the cannabis, alcohol or medication users have reported contact with outreach services. These individuals seem to be easier inclined to appeal to hospitals, GPs and individual psychiatrists and psychologists. Moreover, it is noteworthy to mention that only mental health care and medical outreach work is mentioned in our interviews, we have no record of contacts with socio-cultural outreach work of other social services (f.e. *straathoekwerk*).

5.5.3 After care and continuing care

Three issues have caught our attention in the life stories of our participants: waiting lists, being expelled from treatment centers and the period following in-patient stays. Five participants mention their frustration about the fact that in-patient treatment centers have waiting lists which requires patience at a moment they are least up for patience. The discouraging effect this has is confirmed in a small-scale study on psychiatric disorders in elderly with an ethnic background in Ghent (De Neef, 2011).

"Ik kon nergens niet terecht. Dan heb ik mijzelf laten colloqueren bij wijze van spreken. Dan heb ik mij veertig dagen laten opnemen om mijn medicatie… en om alles op punt te laten stellen, en dan heb ik dat op punt gesteld. En na veertig dagen was't in orde kon ik weer weg." (Fatih, male, 50 years old, heroin)

"I couldn't get help from anybody. That's when I had myself institutionalized so to speak. That's when I was admitted for 40 days for my medication… and to finalize everything, and that's when I finalized

that. And after 40 days, everything was okay and I could leave again." (Fatih, male, 50 years old, heroin)

One participant was placed in in-patient care with the help of a community researcher shortly after their interview.

"'t'is allemaal vers. Nog maar 4-5 maanden hervallen. Van 7 jaar clean te zijn. Tis nog vers. Ik wil geholpen worden. Snap je? Het hoeft ni 8-9 maanden te wachten eh. Ik heb nu nu nu. Laat mij daar (ziekenhuis) binnen geraken." (Can, male, 33 years old, heroin)

"It's all fresh. I relapsed only 4-5 months ago. After being clean for 7 years. It's still fresh. I want to be helped. You see? It shouldn't be postponed for 8-9 months eh. I have now now now. Let me be admitted there (hospital)." (Can, male, 33 years old, heroin)

At least four participants account being expelled from treatment centers for what they describe to be minor offences. Being expelled from a center often implies being included on a black list which impedes problematic users from reentering other treatment centers in the future. This in turn contributes to the further societal isolation and a lack of therapeutic monitoring.

"Ge moet altijd zo'n beetje uw verhaal opschrijven en dan wordt dat geanalyseerd door die mensen om u aan te nemen of niet. En bij mij was het altijd negatief. Als ze mijn verhaal lazen van ja, inbreken en diefstallen en euh.. gebruik en, aleja, ik heb alles gedaan behalve moord en pedofilie." (Fatih, male, 50 years old, heroin)

"You always have to write down your story and it's all analyzed by these people whether to accept you or not. And the response was always negative for me. If they read my story about yes, burglaries and thefts and uhm.. using and, yeah, I've done everything but murder and paedophilia." (Fatih, male, 50 years old, heroin)

"Ewel, tis iets heel simpel. Een pak sigaretten wordt gestolen. Ik gaat gaan zeggen. 'k Vind mijn pak sigaretten. Ik riep tegen die jongen. Ik word uit de instelling gezet." (Can, male, 33 years old, heroin)

"Well, it's something very simple. A packet of cigarettes is stolen. I'm going over to tell them. I find my packet of cigarettes. I yelled at that boy. I get expelled from the center." (Can, male, 33 years old, heroin)

"Ik heb niet geslaan. Hij heeft ook niet geslaan, maar hij is beginnen brullen tegen mij. Maar hij zat daar al acht, negen maanden, snap je. En die nieuwe groep… waarin ik geïntegreerd was, ze hebben dat gezien en ze hebben moeten getuigen en ze hebben gezegd dat ik hem een kopstoot gegeven had. Maar ze zitten al met die gast acht negen maanden, ze gaan niet de nieuwkomer…. verdedigen of de waarheid zeggen snap je." (Ismail, male, 35 years old, heroin)

"I didn't hit him. He didn't hit me either, but he started shouting at me. But he was there for eight, nine months already, you see. And the new group… the one I was integrated in, they saw it and they had to testify and they said I butt him with my head. But they have been with this guy for eight, nine months, they're not going to… defend the new guy or tell the truth, you see." (Ismail, male, 35 years old, heroin)

Noteworthy to mention is that four participants who are in this situation find great comfort in visiting day center Villa Voortman, an open center for doubled diagnosed clients.

A last striking fact is that at least 8 of our participants report to have restarted using, less than three months after successful treatment. They report having a hard time to take care of their housing situation and easily come back into contact with befriended users. This problem

becomes even more prominent when incarcerated, because participants have then often lost family and friends and their position in the labor market is seriously jeopardized. This is partly in line with Oliemeulen's observation that clients with an ethnic background are more likely not to receive follow-up after treatment (Oliemeulen & Thung, 2007: 147).

"die zes maanden en het leven tegemoet, de eerste drie vier weken spreekte weer met jan en alleman. Uw tijdsbesteding is vol maar naar verloop van tijd wordt alles weer normaal en verveelde u weer en het vlot niet gelijk of dat je wilt en dan was ik weer vertrokken." (Ismail, male, 35 years old, heroin)

"Those six months and back towards life, the first three to four weeks you talk to everyone and anyone again. You have a busy schedule but after a while everything returns to normal and you're bored and it doesn't go as easy as you want and then I started again." (Ismail, male, 35 years old, heroin)

"Maar op een dag moet gij terug beginnen met de echte dagelijkse leven eh. de kans dat je gaat hervallen is 95-99% eh. daar in het afkickcentrum, ze zeiden dat ik daar ging stoppen eh, maar dat de kans op herval zeer groot was. Dat is de waarheid. Ge moet voor u eigen uitmaken, ge moet voor u eigen die klik zetten. Ik ken veel mensen die gestopt zijn. maar ik ken ook veel mensen die ni kunnen stoppen." (Arda, male, 36 years old, ex-heroin user)

"But one day you have to get back to your normal life eh. There's a 95-99% chance of a relapse eh. Back there in the rehabilitation center, they said I would stop there eh, but that the relapse chances were very high. That's the truth. You have to decide that on your own, you have to flip the switch. I know a lot of people that quit, but I also know a lot of people who can't." (Arda, male, 36 years old, ex-heroin user)

"Toen ik naar afkickcentrum ging moest ik mijn appartement leegmaken. En achteraf kwam daar terug, en moest ik opnieuw op zoek naar een nieuw appartement. Terug nieuwe meubels kopen. Allez tis zeer moeilijk." (Abdullah, male, 28 years old, cannabis)

"When I went to the rehabilitation center, I had to empty my appartment. And when I returned afterwards, I had to look for a new appartment again. Buy new furniture, again. Well, it's very difficult. (Abdullah, male, 28 years old, cannabis)

5.5.4 Referral systems

"Die mensen proberen het meestal op te lossen binnen hun eigen kring. Ze willen niet dat de buitenwereld dat ook te weten komt. Dus als ze een probleem hebben houden ze dat liever geheim." (Ilhan, male, 22 years old, son of alcohol user)

"Those people usually try to fix things within their own circle. They don't want the outside world to discover it as well. So if they have a problem, they'd rather keep it a secret." (Ilhan, male, 22 years old, son of alcohol user)

At least seven participants report that they have gone to a rehabilitation center because of the direct action of a family member. This does seem to imply that when the urge for action becomes imminent, family members do find access to the health care system. Other referees we heard of are the heroin substitution center (MSOC), the police for compulsory intake, judicial interventions (*drugbehandelingskamer* in case of heroine) and to a lesser degree general practitioners, psychiatrists and psychologists. We note that in many cases the proactive intervention of a professional or volunteer makes the difference in referring problematic users to rehabilitation or the social services they need. Many note that

rehabilitation is a very personal process. The fact that treatment models differ substantially across treatment centers should be taken into account when being placed in one of them. Further, some participants note that general practitioners, as first line workers, should be more aware of the possibilities for rehabilitation.

5.6 Discussion

This exploratory study is based on interviews with 39 self-described problematic users, 16 self-described non-problematic users and 7 family members of problematic users. In our literature review we suggested several sensitizing concepts which we will elaborate upon in what follows. The general balance of executing this study by means of a community based participatory research design is positive because it allows us to gain an insight in use from the perspective of the Turkish community itself, as opposed to an outsider academic perspective. The pitfalls we encountered relate to reaching participants by means of respondent-driven sampling, the quality of the interviews and the time intensity for guiding and motivating the community researchers. We will describe these and other pitfalls in depth in chapter x to inspire future research. (verplaatsen naar algemene discussie)

The top three use of substances in the Turkish community as encountered in our relatively small sample seems **quite similar to use in the general Belgian population**. Alcohol and cannabis are the main substances used (taking into account that we did not include the use of tobacco in this study). The third most used substance is cocaine. Furthermore we point out that gambling and the prevalence of prescribed medication use is quite high. It is striking that our community researchers did not directly reach out to cocaine and heroin users which could imply that awareness or willingness to talk about the use of these substances is quite low in the Turkish population in Ghent. The fact that continued and problematic use is often imputed by familial problems is also comparable to the general population although marital migration brings in a specific risk factor (see infra).

The fact that most of our participants feel more Turkish than they feel Belgian is in line with research on the general Turkish population in Belgium that states that 78% of the Turkish feel exclusively Turkish (Manço, 2012). Most of our participants feel as if they are in between cultures and this is also in line with literature on **ethnic identity** (Rastogi & Wadhwa, 2006). We do however note that to problematic users, not feeling Belgian is experienced as a more negative issue than to non-problematic users and more often results in feeling exclusively Turkish. These users do not feel Belgian because they cannot attain the nationality or because of feeling discriminated against. This could contradict the thesis that a high level of ethnic self-identification combined with a low level of acculturation serves as a protective factor towards problematic substance use (Taïeb et al., 2008). Further, it could confirm the theory of 'reactive ethnicity' (Hagedorn, 2008) meaning that individuals feeling discriminated or excluded are more inclined to fall back on a perceived ethnic identity, as exemplified in Flemish Turkish youngsters by Ersanilli (2009: 56) as well as by Jamoulle (2010) in her study on Turkish youngsters in Brussels neighborhoods.

We note large differences when accounting for the **generations** participants belong to. Self-described problematic users are mostly second generation Turkish. We should however note that the amount of participants belonging to this generation is also higher in our sample which might distort this conclusion. Manço (2004) characterizes second generation migrants as having less ties with the Turkish identity, having fewer social support and possibilities of social valorization. Bucerius (2014) in turn notes in her study on German Turkish dealers that second generation migrants demonstrate a general lack of a consciously decided immigration experience. Escobar (in Kulis, 2009) raises the hypothesis that the acculturation gap between second generation Turkish and their parents elevates risk behavior such as problematic substance use.

Third generation migrants are least inclined to describe their use as problematic. This may be partly due to their low age and awareness. The larger amount of high educated participants within this group when compared to first and second generation migrants could possibly be a protective factor as well. Nevertheless, third generation Turkish descendants also remain a group at risk, mainly because of ongoing discriminatory practice in education, housing and the labor market (see infra).

Further, a significant number of **marriage migrants** is faced with problematic substance use. Taking into account that intercommunal marriages are the most prevalent type of marriage in the Turkish community (93%) (Manço, 2012) and that marriage migration is common practice in the Turkish community (Schoonvaere, 2013) special attention should be given to this target group. Further, recent research in the UK (Finney et al., 2015) confirms that the marital status of being separated or divorced are strong predictors of poverty status and consequent detrimental mental health.

Concerning **Language** there seems to be a significant difference between problematic and non-problematic users. On a scale of 1 to 5, non-problematic users score 4,8 while problematic users score 3,8. The fact that problematic users more often belong to the group of classic second generation as well as marital migrants partly explains this discrepancy. Furthermore it could imply that not speaking the language is a risk factor for problematic use, but further research on this topic is necessary.

Second and third generation Turkish describe feelings of **perceived discrimination.** Additionally, problematic users seem to demonstrate less flexibility in coping with these feelings when compared to non-problematic users. In line with Goffman's (1975) assertion that first generation migrants often accept the stigma associated with being outsiders and construct their lives around this stigma (in Bucerius, 2014: 67), first generation Turkish as well as marriage migrants attest less of discrimination. A recent quantitative study in Kurdish, Somali and Russian migrants in Finland confirms that unemployment and poor economic situation are significant risk factors for detrimental mental health in these groups (Rask et al., 2015). The feelings of perceived discrimination as reported upon in this study align with recent studies on **structural discrimination** in Flanders and Ghent:

- One in three persons with a foreign sounding name will be discriminated against in the housing market (Verhaeghe et al., 2015);
- Students with an ethnic background more often leave education without a diploma and are more often referred to vocational training (Agirdag et al., 2011; Boone & Vanhoutte, 2014);
- Only 10% of Turkish youngsters between the ages of 20 and 24 enter higher education (Manço, 2012: 4);
- Etno-stratification in the labor market implies that Turks and Moroccans close the ranks in the labor market because they are less likely to find a job and have the lowest paying jobs (Verhaeghe et al., 2012a);
- Four in ten Turkish youngsters are unemployed (Manço, 2012).

For marriage migrants, we can conclude that acculturative stress can be a risk factor for problematic substance use both in men and women. For all generations and marriage migrants we stress the impact of perceived and structural discrimination on mental health as confirmed in recent research (Kulis et al., 2009).

Social isolation has also been called to our attention as a risk factor. Several participants note that they feel relieved after the interview, because they have few people to talk about their situation. Individually migrated participants account to have had large difficulties in creating a social network in Ghent. Furthermore participants who have been incarcerated as well as problematic users feel isolated from and stigmatized by the Turkish community in Ghent.

The phenomenon of **ethnic conformity pressure** (Van Kerckem et al., 2014) within the Turkish community in Ghent as well as religious views on substance use play an important role in this isolation. Social isolation is closely intertwined with the personal conception of what is forbidden / *haram* in islam. Problematic users find strength in their belief but feel excluded from their religious communities because of their use. This results in self-exclusion from these communities.

Social capital and belonging to different networks has proven to increase mental health and stamina. However, our study demonstrates that belonging to the Turkish community in Ghent is rather detrimental for dealing with problematic substance use. Many of our participants lead isolated lives and do not engage in varying networks, and many do not have friends to count on. Additionally most problematic users do not have leisure activities although having leisure activities outside the therapeutic environment has proven to reduce risk of relapse (Linas in Favril et al., 2015). Furthermore, when users have been incarcerated in prison they become extra vulnerable because they are not prepared for life outside prison and usually do no longer dispose of networks of friends and family, generally live in precarious conditions due to housing difficulties and their position in the labor market (Tieberghien et al., 2008).

Perceptions on substance use influence help-seeking behavior in the community. Problems concerning use are often only dealt with within the household while it is a taboo subject in the extended family and in the Turkish community at large. Also within the household there is a close intertwinement of taboo, shame, stigma and the perceived individual responsibility which jeopardizes early intervention in the family context. We notice that ethnic conformity pressure has a large influence on help-seeking behavior (Van Kerckem et al., 2013). Label avoidance (of being a substance user) results in not seeking help when needed and is a direct result of stigmatization of substance use in this specific Muslim community (Ciftci, 2013). The fact that stigmatization is an extra risk factor in migrant communities (Sacré et al., 2010) is confirmed in the Turkish community in Ghent.

In line with Fountain's observations in Turkish communities in London (2010) substance use in the Turkish community in Ghent is considered *haram* / forbidden / unaccepted. This jeopardizes help-seeking behavior. The notion of ***haram*** seems highly problematic within the Turkish community. For many Turks islam is a moral compass. By analyzing the perspective of problematic users we put forth the thesis that the concept of *haram* / forbidden is too static in the Turkish community in Ghent and is directly related to exclusion from religious communities. We therefore plead to open discussion in mosque associations and islam education as to the interpretation and use of the dynamic concept of *haram* in muslims' lives. The successful collaboration between vzw Moslim Adviespunt and municipal services for parental support could be a starting point for those means.

When use becomes an acute problem close family members do go in search of help by means of in-patient treatment centers. Problematic alcohol, cannabis and prescribed medication use is more often dealt with by reaching for help in **hospitals, GP's and via psychiatrists** and

psychologist. Nevertheless, **stigma and taboo** do form a barrier towards seeking that help. Outreaching mental health care providers have rarely been mentioned and only in the case of heroin use. Taking into account the large prevalence of social isolation as a reason for and result of problematic substance use as well as the degree of relapse it could be interesting for social **outreaching** services to seek better access to these individuals.

Users generally describe their use as problematic because of their **physical dependence** to the substance. This is confirmed in the reasons participants give for seeing intake in in-patient care as successful or not and by the large amount of participants resorting to hospitals in case of problematic use. This could imply that looking at addiction only from a medical and physical perspective (as opposed to taking into account social factors) jeopardizes successful treatment.

At the service level a larger awareness and insight is needed towards the additional risk factors clients with a Turkish background are faced with (marital hazards, the construction of ethnic identity, the notion of *haram*, exclusion in the Turkish community, structural and perceived discrimination). Part of this culturally sensitive care may include opening up the conversation of religion as a protective factor. Furthermore, it could include the intensified use of the 'trialogue' including family members in the treatment of clients (Jamoulle, 2010). But most importantly it implies creating culturally sensitive organizational structures and dealing with structural discrimination at the service and policy level.

5.7 Recommendations

We conclude by pointing out that treatment for problematic use in the Turkish community in Ghent would likely benefit from focusing on following aspects:

- The construction of (reactive) ethnic identity;
- Generations (and marriage migration);
- Language acquisition;
- Marital problems;
- The perception of addiction in terms of physical dependence;
- Social isolation;
- Perceived and structural discrimination;
- Perception of use within the community;
- The role of social outreach work.

However, we stress the fact that characteristics of users and barriers to treatment as mentioned in this chapter could well be identified in other user groups (Derluyn et al., 2008; Scheppers et al., 2006). To this end we will focus on specific needs of the Turkish community in Ghent but also on some generalizable characteristics and the general need for a holistic approach in treatment.

Social mental health determinants (Kamperman et al., 2003; Knipscheer & Kleber, 2005; Marmot et al., 2008) seem to be underestimated both at client, community and institutional levels. Turkish substance users seem to be inclined to define their use as problematic only when they experience physical dependence. Sensitizing for social health determinants in the Turkish community will be a necessary step for successful intervention in problematic situations. This entails that fora should be sought to discuss the issues of perceived and structural discrimination, as well as marital hazards, and social isolation. These fora could include:

- The mosque associations;
- Female discussion groups, possibly to the example of the successful Tupperware formula (Laudens, 2013);
- Secondary schools: taking into account that accurate risk-assessment is a protective factor for problematic substance use in youngsters (Lombaert, 2005).

In the life stories of our participants we understand that the general socio-economic status is more influential than the fact that they are muslim or Turkish when it comes to perceived barriers in treatment. This is in line with Bekker's (2008) assertion that ethnic and culture specific client factors have a limited influence on the course of treatment. He discerns that only cultural traditionalism and nationality have a significant impact. Furthermore it ties in with a UK-based study of the National Drug Treatment Monitoring System (Fountain & Hicks, 2010) that states that there is no ethnicity-related differential impact when it comes to drug treatment.

The configuration of residential care as well as the professional attitude of care providers could consequently be dealt with in intercultural policy measures within the institutions to the example of elderly care and educational centers. Such projects have been initiated by for example in-patient and out-patient center De Kiem. We hereby echo the call we have heard several times in the field to create supported platforms, networks and policies for transcultural awareness

within treatment and other mental health care center by means of team training and explicit all-encompassing policy measures within the center.

As established in national and international literature, holistic interventions and co-operation between social and mental health services in urban areas are acutely needed (Laudens, 2013; Rask et al., 2015). We have encountered several initiatives to that means. Especially the recent collaboration between Ghent's social outreach service and OCMW (OpStap) aiming at reactivating ex-users, former vzw De Eenmaking linking Turkish and Moroccan communities to treatment centers and Villa Voortman offering day activities for double diagnosed users. Concerning vzw De Eenmaking an employee of a treatment center notes that since the organization seized to exist there has been a significant decrease of registration of individuals with an ethnic background (personal communication, 24/03/2015). Enlarging the work force with persons with an ethnic background could also enhance its work. Furthermore, such a holistic approach could, at the local level include:

- Collaboration between substitution centers (MSOC) and outreach social services;
- Collaboration between mental health services and social outreach services;
- Collaboration between integration, social and mental health care services;
- More intensive follow-up of users after incarceration and treatment;
- Creation of a platform for transcultural / culturally sensitive mental health care for knowledge sharing and dissemination and possibly a contact point for family members and users.

At the local level we point out that the harm reduction initiative MSOC reaches a large amount of clients with an ethnic background. Besides being very accessible we should take into account that such an initiative is referred to as a low-cost and high-impact intervention (HRI in Favril et al., 2015). Nevertheless this organization is faced with a serious reduction of employees (personal communication 28/08/2015). Therefore we plead for further investment in these low threshold harm reduction interventions.

At the macro institutional level we should repeat that structural discrimination as identified in the Flemish educational system (Boone & Vanhoutte, 2014), in the Ghent housing market (Verhaeghe et al., 2015) and in the labor market remain issues that are highly detrimental to mental health of among other ethnic minorities, the Turkish community in Ghent. Including these factors in dealing with substance use in ethnic minorities ties in with the health model of Dalghren & Whitehead (Dahlgren & Whitehead, 1991) who propose that education, culture, employment, community play an important role in (mental) health.

The community advisory board of the Turkish and the Eastern European communities furthermore stress the importance of:

- Intensifying collaboration between social and health outreach work;
- Diversifying the staff of outreach services;
- Existence of 'bridging' services such as 'De Eenmaking' (see supra);
- Psycho-education within the communities.

The execution of this study by means of a community based participatory research design has proven successful at various levels. It has enabled us to include the perspective of the communities themselves as well as experts in the field and to discuss this taboo topic and raise awareness about the issue in the community researchers. Parallel to the conclusions in

previous collaborative research projects on substance use and mental health (Favril et al., 2015; Laudens, 2013; Piérart et al., 2008) we plead to favor this engagement and research method in future project and research calls as well as in local government and social and health care service practice.

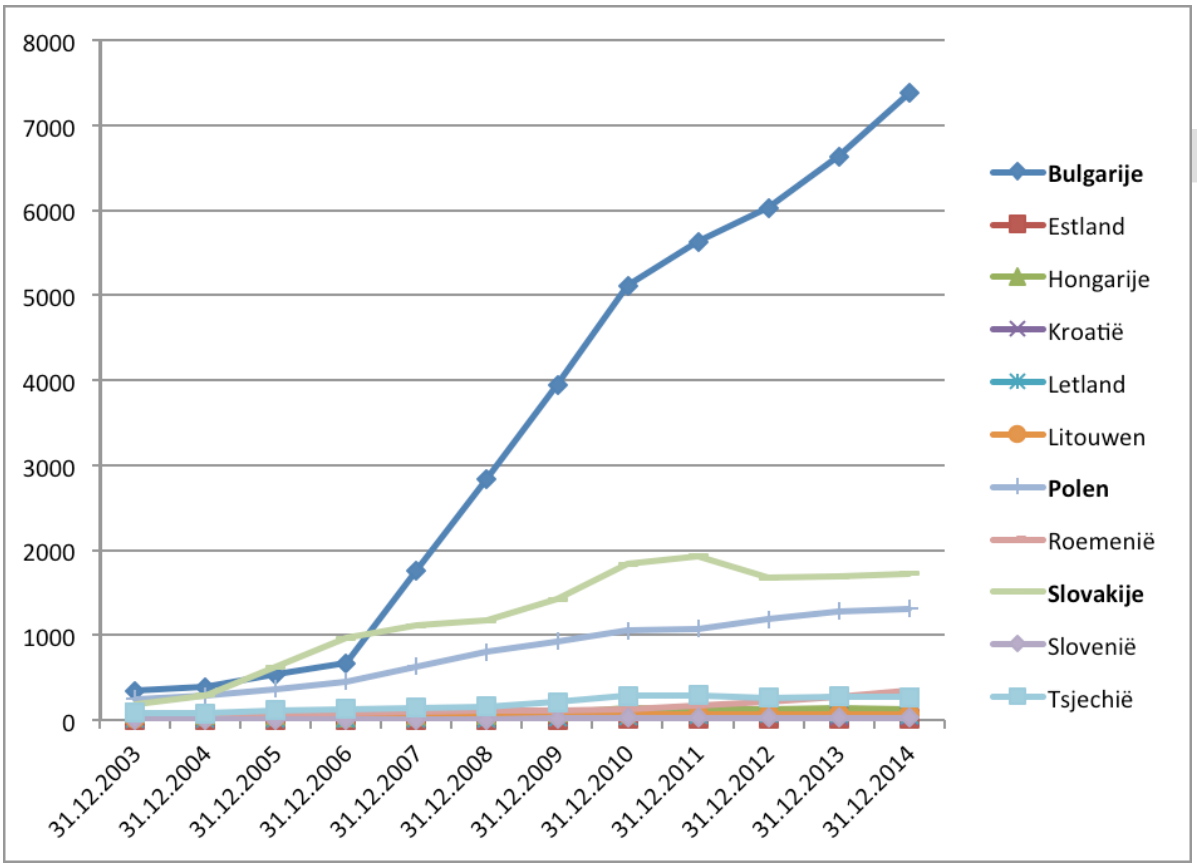
Our findings tie in with the European ETHEALTH report on migrant health. It stresses that (among other migrant groups) Turkish migrants run a higher risk for depression and chronic stress disorders than the general Belgian population. (Suijkerbuijk, 2014: 215)). Higher prevalence rates of depression in ethnic minorities in Belgium as compared to 23 other European countries was also confirmed by Missinni et al. (2012).

6 EASTERN-EUROPEAN COMMUNITIES IN GHENT

6.1 Introduction

A recent study from the Municipal Integration Service of Ghent (Municipal Integration Service Ghent, 2015) demonstrates an increase in the intake of new EU citizens in Ghent. The number of new EU citizens, coming from Central and Eastern Europe, was calculated by means of the number of registrations at the Office for Migration of the Civil Affairs Department. As demonstrated below, the relative and absolute number of new EU citizens has significantly increased since the accession of the Czech Republic and Slovakia, and Romania and Bulgaria in respectively 2004 and 2007 in the European Union.

Figure 1: Evolution of EU citizens in Ghent (Integration Centre Ghent)



Nationality	31.12.2003	31.12.2004	31.12.2005	31.12.2006	31.12.2007	31.12.2008	31.12.2009	31.12.2010	31.12.2011	31.12.2012	31.12.2013	31.12.2014
Bulgaria	341	392	534	667	1765	2835	3946	5112	5630	6024	5533	7280
Estonia	3	3	4	4	7	6	9	14	20	10	17	14
Hungary	76	55	43	36	49	68	92	152	135	132	140	137
Croatia											42	40
Latvia	13	14	12	18	20	22	36	46	59	79	73	63
Lithuania	21	30	36	39	36	40	64	63	76	71	75	72
Poland	248	289	371	460	638	805	934	1057	1081	1187	1285	1301
Romania	71	72	87	89	103	109	121	133	175	215	274	342
Slovakia	181	291	625	956	1112	1168	1423	1836	1930	1675	1688	1706
Slovenia	9	5	6	5	6	6	20	30	29	26	31	32
Czech Republic	85	81	115	133	150	157	213	288	298	266	277	270
TOTAL	1054	1232	1833	2425	3892	5455	6876	8731	9433	9685	10535	11257

The Bulgarian group of newcomers is remarkably higher compared to the total number of migrants coming from Central and Eastern Europe (CEE). On the 31st of December 2014, there were 7,280 registrations compared to a total of 11,257 new EU citizens in Ghent. About 65% of the newcomers originate from Bulgaria. Slovakian migrants are the second largest group of EU citizens in Ghent, with a total number of 1,706 registrations by the end of 2014.

Even though these numbers clearly show an increased amount of new intra-European migrants, it is necessary to take some issues into account when interpreting these numbers. Contrarily to what these numbers seem to imply, intra-European migration is not a new phenomenon in Ghent. In the late nineties several Slovakian Roma families migrated to Ghent, they formed a point of reference for other families to join them later on (Hemelsoet, 2013). Furthermore, some of these migrants have lived in illegality for years before being able to register legally after the accession of their respective home countries to the European Union (EU). A significant number of these 'new' migrants have lived in Ghent for over 15 years.

Although qualitative research shows that the majority of irregular Central and Eastern Europeans mainly live in Brussels, Antwerp or Liège, a large number of non-registered intra-European migrant still live in the city of Ghent. Several groups of intra-European migrants are consequently not included in the statistics. The aforementioned numbers do also not show people that have obtained Belgian nationality, children that have obtained Belgian nationality when they were born, people that were registered on the waiting list, people that are staying in Belgium for a short period of time nor workers on secondment (Verhaeghe, 2012: 26).

As to the ethnicity of these groups, most Bulgarians and Slovakians in Ghent belong to minority groups in their country of origin (Hemelsoet, 2012; De Mets, 2015). A large part of the economic migration of Bulgarians belongs to the Turkish-speaking minority group and Roma. This group does not only flee a country with few opportunities for employment or economic welfare, but also some extreme forms of historic and current discrimination (e.g. obligatory changing 'muslim' into 'christian' names and obligatory converting to Christianity). They dispose of a weak socio-economic position in their country of origin which does not necessarily change through migration. An estimated 50% of the Bulgarians, 90% of the Slovakians, 90% of the Romanians and 50 to 90% of the Czechs in Ghent are Roma (Hemelsoet, 2013; Verhaeghe et al., 2012).

'Roma' is not a nationality, it is an ethnic identity. That is the reason why it is impossible to indicate the exact number of Roma. Furthermore, they often do not report they are Roma for obvious reasons (Actieplan MOE, 2012). According to an estimate of Ghentian professionals in socio-cultural and other organisations, the number of Bulgarian Rila is about 4,428 from the 7,380 registered Bulgarians on the 31st of December 2014 (Integratiedienst, 2015). Bulgarian Roma are fairly invisible because a lot of them speak Turkish and are lost in the larger Turkish-speaking community in Ghent (De Mets, 2015; Hemelsoet, 2013).

31.12.2014 BR+VR	Number	% Roma	Estimated number of Roma
Bulgaria	7380	60%	4428
Slovakia	1722	90%	1550
Total	9102	66%	5978

Table 2: Estimated number of Roma in Ghent (Municipal Integration Service, Ghent).

6.2 Characteristics of the respondents

6.2.1 Reasons for migration

Ik woonde in Bulgarije, in een mooie stad, Lovetch. (…) De meeste van mijn jaren heb ik daar doorgebracht, maar elke dag werd de politieke systeem erger en erger. Omdat we tot de minderheden behoren, werden we verchristend en de politie heeft ons gedwongen om onze Turkse namen te veranderen in Bulgaarse namen. Deze naamverandering werd ook toegepast op de graven van onze grootouders. Aneta_01

Our sample consists of 63 respondents. The majority of these respondents are of Bulgarian descent (n=43). Additionally, most of them describe themselves as having Turkish ethnic roots. Only one of the Bulgarians describes himself as Roma. Taking into account their family and migration histories we suppose that this number is higher but was not reported upon because of stigmatization of Roma in Ghent. The second biggest group in our sample are Slovakians (n=19) of which all self-describe themselves as Roma. The remaining respondent is of Czech Roma descent. The Bulgarian-Slovakian divide in our sample is representative for the Eastern-European community in Ghent and is a result of the fact that three of the community researchers who've conveyed most interviews were of Turkish-Bulgarian and Slovakian-Roma descent.

The majority of the participants in our sample are second generation migrants. They moved to Belgium at a fairly young age with their parents. Over half of the participants have lived in Ghent for over ten years. One in five arrived in Belgium less than a year ago and the remainder of the participants (one in four) has been in Belgium between one and five years. When asked why participants moved to Belgium over half of the respondents say that they were in search of economic prosperity. One in four mentions that having family in Belgium made it easier for them to migrate to this country. One in seven mentions that they were discriminated as Turkish Bulgarians or Roma in their country of origin. We can suppose that this number is in fact higher but that, due to a lack of trust in the community researcher, not all respondents mention this. Lastly, a minority of respondents moved to Belgium because of personal problems such as divorce (n=3) and problematic substance use (n=2).

6.2.2 Ethnic identity

When we ask respondents if they feel Belgian only three respondents answer affirmative. One in eight respondents states that they want to feel Belgian but that they can't because they don't speak the language, they don't work here, or because they haven't been here long enough. The majority of the respondents reports not to feel Belgian because they were not born here. They are on the contrary proud to be Bulgarians or Slovakian Roma. Most of these respondents do not see this as a problematic issue. They are on the contrary very positive towards what they perceive as being Belgian (working a lot, having rights and freedoms). Most Roma for example are proud to be Roma but do not necessarily have negative feelings towards Belgians.

CR Ben je lid van een vereniging?
R Wij zijn al gelijk een vereniging! (Slowaakse Roma)
CR Op welke plaatsen in de buurt kom je vaak?

R Hier in Ledeberg waar ze allemaal wonen dicht bij het park Helena_R05

ik ben Roma, ik kan zomaar Belg niet worden, ik kan mij alleen aanpassen. Helena_R10

Only one in eight respondents display what we might call a reactive identity: they feel more Bulgarian/Slovakian or Roma because they have had negative experiences with Belgians. Another five respondents explicitly note that they do not know how to feel and that they feel in between cultures/ nationalities.

Ik weet niet als wie ik me voel. Ik ben hier 15 jaar, ik volgde cursus maatschappelijke integratie en Nederlandse talen. Nu nog steeds gaan ik lessen volgen. Ik doe me best om hier in het land te integreren. Uiteindelijk heeft België haar hand aan ons gestrekt. Ze heeft ons een onderdak gegeven. België heeft heel goede zaken voor mij gedaan. Anders weet ik niet waar ik zou zijn en wat ik ging doen. Ik wou vooral dat mijn dochter hier zou studeren en een toekomst bouwen. Aneta_R01

6.2.3 Communities and religion

When we ask respondents if they believe Bulgarian / Slovakian communities exist in Ghent they all respond affirmative. The description of the communities does however reflect the transposition of political and religious trouble in the home country, at least for the case of the Bulgarians. All 43 Bulgarians respond positively as to the existence of a Bulgarian community, but they relate to this perceived community in a particular way. Respondents confirm that there are various communities in Ghent: Turkish Bulgarians, 'ethnic' Bulgarians and Roma Bulgarians.

Most Bulgarians who have reported to be muslim (=12) as well as those who have not reported on religion but do mention their best friends are Turkish (=8), can be considered Turkish Bulgarians. All these respondents mention they do not feel connected to the Bulgarian community or only to their close group of Bulgarian friends and family. Six of these respondents explicitly mention that they avoid contact with the Bulgarian community because it consists of 'different groups' without going into further detail.

When comparing these answers to the answers of Bulgarians who denominate themselves as Christians and do not mention Turkish friends it becomes clear why the former group of respondents does not feel part of 'the Bulgarian community'. Ten of these respondents explicitly and pejoratively note that Bulgarians in Ghent are Roma or Turkish Bulgarians which implies that the ethnic discrimination towards Turkish and Roma Bulgarian (as documented in Bulgaria) persists in the Ghent Bulgarian communities. The fact that at least four Turkish Bulgarians attest of labor exploitation by Turkish Ghentians seems to confirm that no solidarity exists between Turkish and so called 'ethnic' Bulgarians in Ghent.

The story of Slovakian Roma (n=18) is somehow different. When these respondents were asked if they believe a Slovakian community exists in Ghent they all respond positively but all except one state that they do not feel part of this community. Five of these respondents attest that they feel more related to their extended family than to a proper 'community'. Two explicitly attest not wanting contact with Roma from other than Slovakian origin. Five respondents attest not to feel part of the community (without it being clear if they mean the Slovakian or Slovakian Roma community) because they respectively do not trust its members (2), take responsibility for themselves (2) or are stigmatized as a substance user (in one case). 14 respondents attest

to be Christians (six of whom are catholics) and half specifies that they also practice this religion.

6.2.4 Racism, perceived and structural ethnic discrimination

When we ask participants how they feel Belgians see them, whether they are confronted with their migration background or have the feeling they are discriminated against we get a variety of answers. Noteworthy mentioning is that racism and discrimination is very complex for Eastern European migrants because they are confronted with various types of racism and discrimination. The type of discrimination that is mentioned mostly (1/6) is discrimination on the labor market and on the job.

Generally speaking respondents seem to display a large tolerance towards racism; many mention for example that they have been discriminated against or have experienced racism but that these experiences are far worse in their home countries. Slovakian Roma for example feel that Belgians discriminate them but that Slovakian non-Roma are far worse. Turkish Bulgarians in their turn mention that they have been discriminated by Turkish Genthians while working for them. Then again, Bulgarians who do not have a Turkish background note that they feel discriminated by Belgians and that the reason for this is the large presence of Turkish-Bulgarians and Roma, whom they, as Bulgarians, do not relate to.

Onlangs had ik een gesprek met een politieagent. (…) Hij legde de nadruk op de volgende. Hij zei "We zijn beu van drie nationaliteiten. Eerst en vooral van de Turken. Als er een schiet- of vechtpartij is er meestal een doodgeval. Sowieso slagen en verwondingen soms dood. Ten tweede, de Bulgaren. We zijn beu van hun diefstal en financiële fiscale fraude. En ten derde, zijn de Noord - Afrikanen. We zijn beu van hun drugshandel." De politie zei dat ze beu waren van deze drie nationaliteiten.
Aneta_R12

6.2.5 Socio-demographic characteristics

The average age of the participants is 33,8 years old. Most participants are between 25 and 35 years old (n=27). 19 participants are between 36 and 56 years old and the remainder is younger than 25 years old. Three in four participants are male and one in four is female. Half of the participants have finished secondary education. One in ten participants is lower educated and another one in ten have attained higher education. We have no conclusive info about the education of ten respondents. Three in four of our participants is employed legally or illegally and one in five is unemployed. Half of our respondents are singles, of which nine are currently divorced. The other half is evenly divided into married individuals and individuals living with their partners. Half of our respondents have between one and three children. Furthermore, 20 of the respondents have divorced at least one partner in their lives. We do not have enough information to report on residence permits. We do know that eight respondents have attained the Belgian nationality, and that the majority has the double Bulgarian / Belgian nationality. At least one in seven respondents mentions that they have resided illegally in Belgium during several years before attaining a residence permit.

6.3 Nature of substance use

6.3.1 Prevalence in our sample

As described earlier, our sample consists of two major subgroups, participants of Slovakian and Bulgarian origin. The table below demonstrates the prevalence of used substance in the complete sample. Because of large differences in the reported prevalence as well as interviewer bias in our snowball sample (see supra), we will discuss the prevalence in these groups separately. We should stress that our sample is not representative for Bulgarian and Slovakian individuals residing in Ghent.

Substance	Total	Not Problematic	Male	Female	Problematic	Male	Female
Alcohol	37	31	21	10	6	4	2
Cannabis	40	27	19	8	11	7	4
Cocaine	24	16	11	5	7	3	4
Heroin	6	5	4	1	1	1	-
XTC	6	3	3	-	3	1	2
Pico	5	3	3	-	1	1	-
Sedative (prescribed) medication	4	2	-	2	2	-	2
Amphetamine	5	2	2	-	3	2	1
Psychedelic	2	2	2	-	-	-	-
Glue	1	-	-	-	1	1	-

6.3.1.1 Bulgarian respondents

Over half of the Bulgarian respondents use **alcohol** frequently. Compared to the Belgian population there are no big differences between this finding and the use of alcohol in the Belgian population (WIV 2013: 48). Somehow remarkable is the amount of Bulgarian **cannabis** consumers in our sample. One of the respondents uses cannabis as an alternative to heroin. Almost three in four Bulgarian respondents reports life time use of cannabis, and one in three reports on current use.

Almost half of the Bulgarian participants in our sample has ever used **cocaine**, and at least four of them still consume the product. Some of these persons specifically point out the use of cocaine in combination with alcohol. Cocaine use usually takes plays in nightlife. One of these persons uses cocaine as an alternative for XTC. Compared to cocaine, the use of **XTC** is less common within the Bulgarian participants. One in seven Bulgarian participants used to use XTC but none of the respondents consumed it over three times during last year.

Cocaïne gebruik in de weekends als ik uitga. Vooral nemen we deze in de disco. Ik word vrolijker van, voel me beter en word niet snel zat. Ik krijg ook geen slaap. Ik voel me echt goed. Ivan_R14

Four Bulgarian respondents referred to **heroin** as a substance they ever consumed. Three of them have ceased this use before arriving in Belgium. Only one of them is a current heroin user. Four Bulgarian participants report **amphetamine** use. One in ten participants report experimental use of **piko** before their emigration from Bulgaria. Piko is a methamphetamine better known as crystal meth. Additionally, three Bulgarian respondents used **sedatives** (anti-depressants and painkillers), and two of them use it on a daily base.

6.3.1.2 Slovakian respondents

Three in four of the Slovakian respondents report life-time alcohol use. Over half of these respondents use alcohol currently on a weekly base. As described earlier the actual rates may be higher, because possibly some respondents forgot, or consciously not mentioned their use during the interview. Most problematic alcohol users in our sample are of Slovakian descent.

Slightly remarkable is the prevalence of **cannabis** in our Slovakian sample. Only one in eight Slovakians reports on cannabis use, while almost one in five Slovakian participants argues secondhand that cannabis is used regularly in their community.

One person uses both heroin and cocaine on a regular base and one participant uses **sedatives**. One participant refers to the use of 'Toluen' (GHB) and specifies that if the substance would be available to him in Ghent, he would continue using it. Finally, **XTC** and **amphetamines** are not reported upon by our Slovakian participants.

6.3.2 Use in the communities

When we ask participants if substance use is common in Ghentians from Bulgarian / Slovakian origin a large majority of the respondents answers positively. Noteworthy mentioning is that many respondents state that 'everyone uses substances'. We should of course mention that, because we only spoke to individuals whom in fact use these substances, this image of use might be somehow distorted. Still, all Bulgarian respondents state very openly that the use of respectively cannabis, cocaine and alcohol is common in their own circles and generalizable for Bulgarians living in Ghent. The younger respondents (20-35) note that the use of cocaine in the weekend is well accepted among young people. Older respondents in their turn note that alcohol is well accepted and new drugs such as cocaine are more used by the younger generation.

All Slovakian respondents attest that alcohol use is well accepted in their close circles and community. In this group some participants are also worried about the use of other drugs such as cocaine in the younger generations.

6.4 Patterns of substance use

Half of the respondents report to have started using mostly alcohol, cannabis and coke before migrating to Belgium. The average age of first time use does not differ a lot, respectively 21, 19 and 22 years old. Over one in three respondents state that they have started using more in

Belgium and three respondents note that the reasons for their use has changed from recreative motives to relieving stress. Our Bulgarian respondents attest that cocaine and alcohol are usually used jointly in night life (specifically in Bulgarian party places) to keep the energy flowing. In three cases the use of coke is also mentioned to have better and longer sex. Furthermore the reason most given for using both alcohol and cannabis is to calm down and to relax.

6.4.1 'Problematic' use

Mensen die gebruiken gaan niet zeggen 'het is een probleem'. Alleen mensen die niet gebruiken spreken daarover. Helena_R04

One in five respondents answers affirmatively to the question whether they see their use as problematic. This low rate could well have to do with the judging way in which the question was asked by the community researchers. One in four respondents who do not describe their use as problematic do mention that their close family describes their use as problematic, mostly in Slovakian Roma (n=10). Participants with Bulgarian roots in their turn, more often mention that they would never talk about their use with close family because it is a taboo subject. Some respondents mention that they cannot talk to family members about these things because they live too far away. Consequently they do not receive peer or family feedback on their use. When we ask respondents what their friends think or say about their use one third of the respondents answers that their use is equal when compared to the use of their friends and consequently well accepted. Only two of these 21 respondents self-describe their use as problematic.

Ja we drinken graag samen. En zij denken ook niet dat er problematisch is, we denken dat de drugsgebruik slechter is. Harde drugs. Helena_R02

6.4.2 Reasons for continued use

Je feest en je vergeet over de problemen thuis, de facturen van België, de werkloosheid, de relatiebreuk .. Alles in feite. Aneta_R03

In Bulgarije nam ik minder alcohol. Sinds dat ik hier in België ben, drink ik elke avond alcohol. De problemen en stress hier dwingt me om alcohol te nemen. Aneta_R01

6.4.2.1 General Well Being

We asked respondents to rate the degree in which they are happy with their life on a scale of 0 to 10, 0 being unhappy with their lives and 10 being completely happy with their lives. Only one in six respondents graded their lives with a 7 to 10. These positive evaluations of the own life are mostly defined by being happy in the family and in two cases by having a good job and having a house in Bulgaria. Almost half of the respondents grades their life happiness between 1 and 5. Over one third of the respondents states that they would be happier with more financial security by means of a better job. One in four claims that optimizing their familial situation would make them happier, whereas one in eight respondents reports that having a diploma would make them happier. We will elaborate upon these issues below.

6.4.2.2 Financial and work-related problems

De betalingen overschrijvingen die we krijgen, dat komt zoveel bij mij. Ik zou moeten speciale richting afstuderen om dit alles te kunnen begrijpen. Helena_R02

At least one in ten respondents mention that they use substances because of financial troubles. Some have migrated to Belgian to turn around their bad financial situation in Bulgaria. One in six respondents account that they would like to be better paid in their job. Five respondents say that they want, but are not able to find a job. Some mention that they might not have migrated to Belgium if they had known they would not be finding a job here. The exploitation of Turkish Bulgarians by Turkish employers (Hemelsoet, 2013: 8) is mentioned several times in this context.

Toen ik de eerste dag hier aankwam werd ik gevraagd een joint te roken of wit te nemen. De meesten zijn er gewend aan. Ofwel gaan ze naar de casino gokken. Dat komt door het hard werk bij de Turken. Deze die de taal niet kennen werken voor de Turken. En daar wordt je uitgeperst als een citroen. Ik heb begrip voor het behoefte naar stimulerende middelen voor die mensen omdat je anders het werk niet aankan. Donka_R03

6.4.2.3 Familial problems

One in three respondents is positive about their family circle because they are happy living with their parents or their partners. Still, one in five respondents mentions to use substances because of familial problems. Many of our respondents have very complex family structures in which several family members live in other countries. One in four respondents mentions that some of their family members live in Bulgaria, Greece, Spain and Canada and that they miss them. Noteworthy mentioning is that only Bulgarian respondents account of the family members abroad and their consequent loneliness in Ghent. At least seven of the Bulgarian respondents report that they feel lonely in Ghent. The Slovakian Roma participants do account of divorce but are usually surrounded by a large family circle whom they can count upon.

One in three participants has ever divorced, five of whom say that they suffer because they do not see their children anymore, usually because they are in Bulgaria. Eight respondents explain that they started using more after the break up or divorce from their partner. Three respondents also mention violence in these relationships and one other mentions to have divorced because of serious addiction problems.

Ik zou één ding willen veranderen en dat is mijn gezin behouden zodat mijn kinderen een vader hebben. Aneta_08

Wij hadden grote familieproblemen. En ik zou niet zo vroeg trouwen. Helena_04

Another three respondents attest of the loss of a family member for their increased use.

6.5 Help seeking behavior

De beste vorm is om met iemand te praten zo als we nu met jou (community researcher) praten. Ivan_R12

When we ask participants if they have had any experience with substance abuse treatment or other specific services for their use only five answer positively. Three have contacted respectively a general practitioner for problematic alcohol use, a psychologist for suicidal thoughts and emergency care for problematic use. Two additional respondents account to have made use of heroin substitution centers in Bulgaria. Furthermore three other participants mention they regularly talk to respectively the priest (1) and a trustworthy person in a mosque (2). Nevertheless, during the interviews, nine participants specifically asked the community researcher for help. In five cases they asked help in finding a psychologist or psychiatrist. One participant asked for somebody to trust who can help getting over addiction, one participant asked for help for alcohol addiction, and another one help for translation.

At least four respondents mention that language is a large barrier in health care. Another three participants mention that treatment is too expensive for them. The majority of our respondents does not know the Dutch language. When asked what the ideal help would be, one in three Bulgarian respondents answers psychological help would be helpful. One in five of all respondents note that initially, wanting to stop is key to successful substance abuse treatment. Noteworthy mentioning is that when we ask respondents if they have received any help from their family, all Slovakian Romas who describe their use as problematic answer positively while only a small minority of the Bulgarians answers positively to this question. They, on the contrary mention that ideal help would consist of talking to someone whom they are not familiar with in any way.

When we ask if participants know something about substance abuse treatment services in Belgium most answer negatively. When we ask which services they regularly use we mostly hear about trade unions, health insurance, PCSW (OCMW) and to a lesser degree schools, municipal neighborhood centers and a center for general well-being (CAW). These could be proper venues for prevention and information initiatives targeted at Eastern-European users.

en waarom moet iemand van de gemeenschap iets doen, Als er bepaalde organisatie zijn moeten gewoon preventies nemen op tijd de mensen te informeren en zorgen... Ivan_R18

Both Slovakians and to a lesser degree Bulgarians state that co-ethnics do talk about substance use with each other but that no one perceives it as problematic.

Ja, ze spreken de kinderen aan maar denk jij dat er geluisterd wordt? Het zijn heel slechte reacties van Slovaken. De Belgen zijn in deze zaken anders gemakkelijker. Martin_R05

Contrarily, mostly Bulgarian respondents do note that drug addiction is a taboo subject and that co-ethnics will not necessarily help each other in case of problematic use.

In principe ontwijk ik Dampoort want daar wonen veel mensen uit mijn streek in Bulgarije. Daar ga ik nooit naartoe. Waarom? Ik gebruik wiet en ze roddelen vaak over mij dat ik een verslaafde ben en zo voort.. Zelf informeren ze mijn kennissen van Bulgaria dat ik wiet gebruik. Ik word vaak gebeld en geconfronteerd of dat echt zo is. Donka_07

6.6 Discussion

This exploratory study of substance use in the Bulgarian and Slovakian communities in Ghent provides us with some insights that can be adopted by care services and practitioners. These will allow them to better reach and approach these communities and their substance users in particular. Before getting into that, let's elaborate on some conclusions and the most remarkable findings.

On the 31st of December 2014, there were 7,280 registrations of Bulgarian **newcomers** compared to a total of 11,257 new EU citizens in Ghent. About 65% of the newcomers originate from Bulgaria. Slovakian migrants are the second largest group of EU citizens in Ghent, with a total number of 1,706 registrations by the end of 2014 (Municipal Integration Service Ghent, 2015). These proportions are similar in the current study. In the total sample of 63 participants, over two third is of Bulgarian descent and almost one third is of Slovakian descent. Different reasons for migration are mentioned such as the search for economic prosperity, family already residing in Belgium, being discriminated in their home country, and personal problems such as divorce and problematic substance use. As to the **ethnicity** of these groups, the literature points out that most Bulgarians and Slovakians in Ghent belong to minority groups in their country of origin (De Mets, 2015). This is also reflected in our study. Most of the respondents of Bulgarian origin have Turkish roots, one is Roma and a minority is ethnic Bulgarian. Furthermore all Slovakian respondents are Roma. Very few of the respondents (only three) feel Belgian, whereas the majority feels Bulgarian or Slovakian Roma and is proud to be so. However, one in eight claims wanting to feel Belgian, but failing to do so due to problems related to language, work, period residing in Belgium or due to not being born in Belgium. The groups earlier mentioned reoccur when the respondents map the different **communities** in Ghent. The Bulgarian respondents confirm that there are three communities in Ghent, i.e. Turkish Bulgarians, ethnic Bulgarians and Roma Bulgarians. They affiliate to the group that they are part of and don't feel connected whatsoever to the other groups present in the city.

This implies that the ethnic discrimination towards Turkish and Roma Bulgarians (as documented in Bulgaria) persists in the Ghent Bulgarian communities. As to the Slovakian Roma in the study, they confirm the existence of a Slovakian community in Ghent, but declare not feeling part of this community for various reasons. Somewhat related to this issue is the reported perceived and structural ethnic **discrimination**. Eastern European migrants are confronted with various types of racism and discrimination. Nevertheless they show a high tolerance towards racism experienced by native Belgian people, because they identify the racism experienced in their home country or between the different communities in the host country as far worse than the former one.

(Further elaboration is needed for this part)

7 THE COMMUNITY OF ASYLUM APPLICANTS, REFUGEES AND UNDOCUMENTED MIGRANTS

In what follows, we will take a closer look at the characteristics of the group of asylum applicants, refugees and undocumented migrants. We ground our description both in literature and in the description of research participants.

7.1 Definitions of the target group

Many definitions exist about refugees, asylum seekers and undocumented migrants (Keygnaert et al., 2014). Moreover definitions can change over time and can differ from country to country. Below we give you the definitions of the target group.

Refugee	Based on the 1951 Geneva Convention "a refugee is a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him—or herself of the protection of that country, or to return there, for fear of persecution" (Keygnaert et al., 2014).
Asylum seeker	"Someone who is seeking international protection. In countries with individualized refugee status determination procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee was initially an asylum-seeker" (Keygnaert et al., 2014). Specific for Belgium are all foreigners arriving in Belgium entitled to apply for asylum and ask for the protection of the Belgian authorities. This application is called the asylum procedure. The Belgian Government looks at whether the foreigner meets the criteria defined by the 1951 Geneva Convention relating to the status of refugees (http://fedasil.be/en/content/asylum-belgium).
Undocumented migrant	Undocumented migrants are those without a residence permit authorising them to regularly stay in their country of destination. They may have been unsuccessful in the asylum procedure, have overstayed their visa or have entered irregularly (http://picum.org/en/our-work/who-are-undocumented-migrants).

7.2 Specificities

The target group of asylum seekers, refugees and undocumented migrants is different from the other three target groups (Turkish, Eastern European and Congolese communities) in the because of the selection by (legal) status and not by ethnic and or cultural background or nationality (as is the case in the other 3 target groups). Consequently, an overlap with the other we have some overlap with the other three target groups.

Refugees, asylum seekers and undocumented migrants differ substantially from migrants and migrant communities who are well-established in a host country. The major differences lie in

their diversity: different nationalities, languages, ethnic, religious and cultural backgrounds (Lutz & Schatz, 2007). This means we cannot speak about a homogeneous group here (Burnett & Peel, 2001), and at least in some aspects (language, nationality, residence status), maybe even more heterogeneous then the other three study groups involved in this project.

What they do have in common is a wide range of experiences – happened in their home country or in other countries, that may affect their health status and current wellbeing (Burnett & Peel, 2001). Moreover, all have quite recent migration experiences and have not in Belgium for a very long time, rendering it more likely there are still ongoing acculturation and other processes. Further, several participants share particular migration experiences that happened in the home and host country (e.g., life in asylum centres, acculturation, insecurity about the residence status, constrained living circumstances because of the undocumented status, etcetera). For many participants, the migration trajectory is not (yet) 'history', but still an ongoing process.

As already mentioned, the target group of asylum seekers, refugees and undocumented migrants, is diverse in many ways. In this respect, it is extra important to demarcate the target group. Compared to the group of refugees, asylum seekers and undocumented migrants have in common that they are all still uncertain about their potential future in the host country (Lutz & Schatz, 2007)..

(Therefore asylum seekers are gathered into asylum centers (waiting for the approval of their asylum application) – as a community of asylum seekers. The undocumented migrants are often gathered by charity initiatives into reception services or gathered by own initiative into squads or other facilities for living – both as a community of undocumented migrants.)

7.3 Socio-demographic characteristics of the participant group

First of all we like to mention that the sample of this qualitative study is not representative for the group of asylum seekers, refugees and undocumented migrants in Belgium. In total we interviewed 71 people. Unfortunately 4 interviews turned out to be unusable[22] for further research. Consequently we included 67 interviews in our analysis. (double check numbers)

7.3.1 Gender

Concerning the gender of the sample of respondents we reached 83.6% men (N=56), compared to 16.4% women (N=11).

7.3.2 Country of origin

Almost half of the sample is coming from 3 particular countries: Morocco (16.4%), Iran (14.9%), and Afghanistan (13.4%). This most likely relates to the countries of origin of almost half of the community researchers. The search for respondents through snowball sampling has thus impacted this composition. Besides these three main countries, we find a large variety in the nationalities involved (Figure 1).

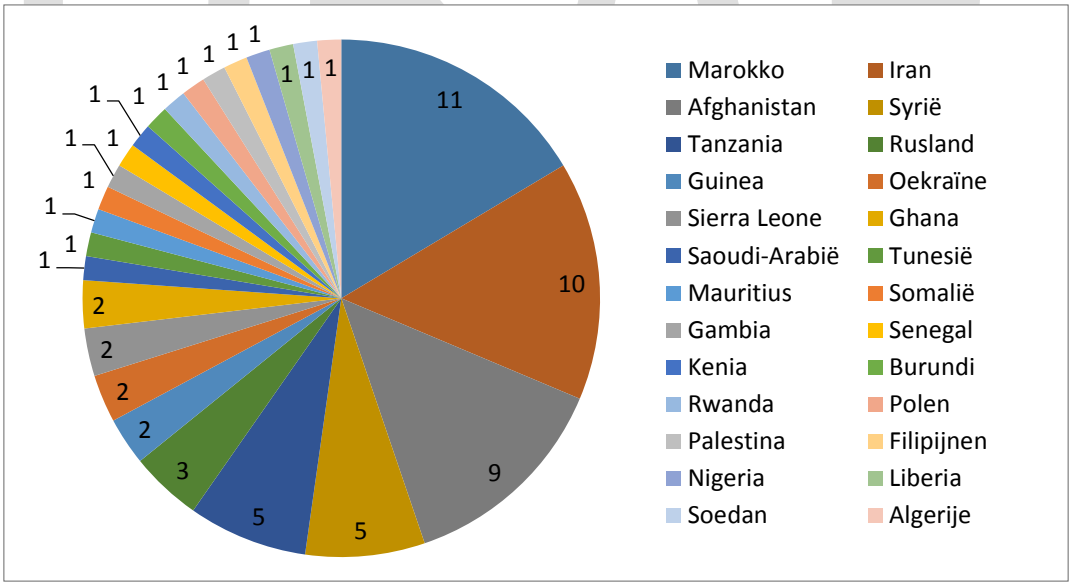


Figure 1 - country of origin

[22] One interview conducted almost none information on paper. One respondent did not fall under the category of asylum seeker, refugee or undocumented migrant. Another respondent was interviewed twice by 2 different community researchers. Finally one interview was by accident not recorded, so no transcription could be done.

7.3.3 Type of residence documents

As mentioned above, three different groups can be distinguished: asylum applicants, recognized refugees, and undocumented migrants. All of them have the flight experience in common.

Among the category of recognized refugees, we grouped respondents with both refugee status as with subsidiary protection (although no respondents termed residence status as such), so with different types of residence documents: a 1-year-residence permit, 2-years-residence permit, a 5-years-residence permit, or a permanent residence permit.

Besides the 30 recognized refugees (44.8%), we reached 31 undocumented migrants (46.3%). Only a minor part of the respondent group (N=6; 9.0%) was still in the asylum procedure (for an overview on the residence status related to participants' nationalities: see table 1). A potential explanation for the low number of asylum applicants in this sub study was given by the community researchers in this sub study: several researchers explained during intervision moments and individual meetings with the project assistant that it was very hard to convince people with an ongoing asylum procedure to participate in this sub study. The following quote can help to explain why so little asylum applicants were willing to participate in this research:

"Ik wil met niemand daarover spreken omdat ik bang ben dat ik daardoor geen verblijfsvergunning krijg en teruggestuurd word naar Afghanistan. Daarom wil ik ook niet dat u mijn stem opneemt, anders zou het probleem kunnen zijn voor mijn asielaanvraag. Ik vertrouw in u omdat u zweerde dat dit absoluut anoniem blijft". (Afghani female respondent SI3, asylum applicant, translated from Dari into Dutch)

As a consequence, some participants (of whom all are asylum applicants), asked not to audiotape their interview. In the CAB-meetings, it was also mentioned that the research terminology might have refrained people from participating. For example, the word 'interview' could have provoked bad feelings and anxiety among asylum applicants.

		Type of residence permit			
		asylum applicant	recognized refugee	undocumented migrant	Total
Nationality	Afghanistan	2	5	2	9
	Algerije	0	0	1	1
	Burundi	0	1	0	1
	Filipijnen	0	1	0	1
	Gambia	0	0	1	1
	Ghana	0	0	2	2
	Guinea	1	1	0	2
	Iran	0	8	2	10
	Kenia	0	0	1	1
	Liberia	0	0	1	1
	Marokko	1	0	10	11
	Mauritius	0	1	0	1
	Nigeria	0	0	1	1
	Oekraïne	0	2	0	2
	Palestina	0	1	0	1
	Polen	0	0	1	1
	Rusland	0	3	0	3
	Rwanda	0	1	0	1

	Saoudi-Arabië	0	1	0	1
	Senegal	0	0	1	1
	Sierra Leone	0	0	2	2
	Soedan	0	0	1	1
	Somalië	0	1	0	1
	Syrië	1	4	0	5
	Tanzania	1	0	4	5
	Tunesië	0	0	1	1
Total		6	30	31	67

Table 1 - Type of residence permit by nationality

7.3.4 Number of years in Belgium

Almost all respondents are at least one year in Belgium, with the largest group of 38 respondents (56.7%) even already residing in Belgium for 5 years or more.

Number of years in Belgium		
Less than 1 year	3	4.5%
1-4 years	18	26.9%
5-14 years	27	40.3%
15 years or more	11	16.4%
unknown	8	11.9%
TOTAL	67	100.0%

Table 2 - Number of years in Belgium

7.3.5 Religion

The religion that people adhere is quite diverse, with as main religion islam. Yet, a quite large group indicated not being religious (table 3).

Religion		
Christianity	9	13.4%
Islam	22	32.8%
Buddhism	1	1.5%
Non-religious	22	32.8%
unknown	13	19.4%
TOTAL	67	100.0%

Table 3 - Religion

7.4 Nature and patterns of substance use

7.5First use of substances

In studying the first use among the participants in this sub study the distinction is made between where the first use started. Does the first use happened in the country of origin, during the flight trajectory, or in the host country Belgium? The suggestion to analyze first use this way this distinction was made by the Community Advisory Board.

A part of the participants in this case study started already to use drugs in their country of origin, while another part started their use of drugs in the host country Belgium. Amongst the latter group, there is a considerable part of the undocumented migrants participating in this study. A few participants used drugs for the first time during the flight.

Different explanations and personal stories were given when asking the interviewees to tell about the reasons to start using drugs. We distinguish hereafter between the reasons mentioned by participants who started using drugs in their home country, the reasons for those who initiated their drug use in Belgium, and the few participants who started using drugs while fleeing from the home to the host country.

7.5.1 Country of origin

Most of the participants who started using drugs in the country of origin indicated that they started using drugs together with friends, in a recreational way, also induced by the fact that in particular countries, drugs seem to be easily available.

"Er waren een aantal jongens die terugkwamen uit Iran [to Afghanistan]. Daar woonden ze al een paar jaar als vluchteling. Daar kwamen ze voor de eerste in aanraking met drugs. Het waren mijn buren en we werden zeer gemakkelijk bevriend met elkaar. Iedere keer, in onze vrije tijd, vroeg ik ze over hun ervaringen in Iran en hun bezigheden daar. Naast hun andere ervaringen, vertelden ze ook over drugs en de effecten daarvan. Na een tijd wilde ik er ook eens van proberen. Dat was zéér gemakkelijk te vinden in onze omgeving en was spotgoedkoop. Op deze manier werd ik verslaafd aan de verschillende soorten drugs, zoals marihuana, heroïne en opium. Ik heb ze altijd voor de gezelligheid gebruikt. Gewoon om me te amuseren en om bij mijn vrienden te horen". (Afghani, male, permanent document, from Dari to Dutch)

Another part of the participants explained their first use in the context of family problems (e.g., the death of one of their parents), abuse or mistreatment.

"Ik werd uitgehuwd toen ik 14 jaar was. Ik ben vier keer zwanger geraakt maar elke keer een miskraam als gevolg. Mijn man ging een tweede keer trouwen omdat ik geen kinderen ter wereld kon brengen. Ik werd regelmatig geslagen door mijn man en ook door zijn nieuwe vrouw. Ik heb dagen zonder eten doorgebracht. Ik wou scheiden, maar mijn man stemde daar niet mee in. Uiteindelijk heb ik elders opvang gekregen waar mijn man mij niet kon vinden. Daar ontmoette ik een vrouw die verslaafd was aan de alle soorten drugs. Ze werd mijn best vriendin. Spijtig genoeg nam ik haar verslaving over. (…) Toen ik daar in het vrouwenhuis was, had ik veel verdriet en was ik enorm bang van mijn man. Omdat een man in Afghanistan alles kan doen. Ik kon niet slapen, niet concentreren en ook niet nadenken.

Mijn vriendin wilde me helpen door mij drugs te geven om me zo in rust te brengen. Door het verdriet en eenzaamheid vond ik hierdoor mijn troost. Toen dacht ik dat ik sowieso vermoord ging worden door mijn man. Ik voelde me goed toen ik onder invloed van drug was". (female, Afghan, from Dari to Duthc, doucment?, Sima 3)

Other participants explained their first use in the context of serious political problems happening in their country of origin, was as most mentioned reason the occurrence of war and armed conflicts. One respondent indicated the presence of a dictatorial regime in the country of origin as the reason for the drug use.

"Cannabis in Syria was rarely exist, I just tried it the first time some months before I left Syria, the hashish and cannabis started just after the Syrian misery started. As I was watching my country destroying, while I can do nothing regarding that … Use them [the drugs] to forget really, the feeling of inability to do something, as I said before, is the worst feeling can be ever. Moreover, you feel helpless towards your country, your community and your history … This homeland that you loved and raised in. The matter that when you use hashish for the first time, there will be no more barrier to hold you back from using it again". (Syrian female respondent SD1, recognized refugee, translated from Arabic into English)

"Antidepressieve middelen om mijn slaap te regelen, omdat ik slaapproblemen heb door mijn slechte verleden". (Iran, male, undocumented, English)

7.5.2 Host country

Also in the host country, Belgium, there is a – even more – diverse spectrum of reasons that participants gave to indicate why they started using drugs. Yet, in this context, participants mention different elements occurring at the same time, and linking closely.

First, also in the host country, there is an important impact of participants' social networks, in particular their friends, to start using drugs. Yet, this influence often occurs in relation to interviewees' stressful living situations. First, several participants mention huge stress in relation to the negative answers they received on their asylum application and their lack of residence documents.

"Interviewer: Why did you start to use drugs? Respondent: Through my friend. In Africa, we didn't have a job, we didn't have nothing. So it's like now, we used to meet a lot of friends. The same places, the same houses, the same rooms, we come sit and talk, we have nothing to do. Somebody come with this, somebody comes with coke, somebody comes with heroine, somebody come with the drinks, somebody comes with the weed. But on the table, all of this to share. We use all to share. So I simply started there. They told me, you have to try this, have you tried this? I said yeah why should I? They convinced me. They said: When you do this, everything is… The time we meet each other, everybody, it's hard to explain, they say 'yesterday I was in a social'… They refused me, this and this, everybody has this story. They say yes, they told me I have to leave (order to leave the territory), they say, try this, and when you try it…. You feel okay. You feel happy". (Tanzania, male, undocumented, English)

"Interviewer: How did you come in contact with drugs?

Respondent: Before for the problem of stress.
Interviewer: Because of stress. And?
Respondent: Just stress. I started to smoke, and smoke heroin, then smoke cocaine. For the problems. No papers". (Tanzania, male, undocumented, no translation – respondent DE3)

Another participant indicated the stressful living situation in the asylum centre, in relation to the uncertainty about his residence documents and thus also his future, which initiated the use of drugs:

"The first contact with this substance was in Liege, where I lived in before; at that time I was very unhappy, (…) and it was in refugee centre. There, I started to take this substance. It was because of the stress, and I was in a huge nervous tension, because my papers condition, everything was difficult. I was new in the country at that time, I didn't know what shall be my destiny! This thing (the marihuana) was something that made my nerves calm down. And at that time, it was so cold and I couldn't go out of the centre, because there was nothing outside, and it was a village and I didn't know my destiny, I was like between life and death". (Palestine, refugee, english, male,)

Two participants even actually started to take drugs at the moment they received the negative answer to their asylum procedure:

"I started doing that in 2007, the time they told me you have to go back home. Our life is crazy". (male, Tanzania, undocumented, English)

"(…) they take my paper after six years that I was here. I was working before, I didn't use drugs. They took my paper and I was getting crazy that someone came to me and gave me something. I was getting crazy. One time, three times,...". (male, Iran, undocumented, English, 15 years in Belgium)

Participants indicated that their overall lack of activities, in particular the lack of a job, in relation to strong feelings of loneliness, painful memories about past experiences, and a lack of any future induced huge stress and pain, which seem to be alleviated by the drugs they are using. Yet, also in following quote, the impact of friends also using drugs is mentioned.

"Sinds ik hier in Gent woon, kwam ik in aanraking met deze middelen omdat ik mijn tijd wou vullen. Door mijn eenzaamheid, zonder werk en geen positieve toekomst, geraak ik zwaar onder druk. Door het gebruik van deze middel verlicht het gevoel van de pijn. Stel je eens voor dat ik werk heb, dan heb ik geen tijd om na te denken over mijn donkere verleden, over mijn familie. Zo voel ik me minder eenzaam, en geen straatloper. Ik zou ook niet zo veel vrije tijd hebben om samen met mijn vrienden uit te gaan en deze middelen te gebruiken". (Afghan, man, 2 years document, from Dari to Dutch)

7.5.3 During the flight

A last, small group of respondents mentioned that they used drugs for the first time during their flight to Europe and Belgium. The hard and unsafe conditions characterize the flight experience of these respondents.

"When I left Afghanistan and I moved to European through an illegal way, on the way we have to stay in Jangles, water, mountains, and we had worries about our life and worries about our families. So my friends, I was accompanying them on the way, they were using substances, and they told me to feel relax and not to have worries about the dangerous ways we are passing, about your life and family, so use substances, that will forget all your worries that you have. So there I started with my friends to use substances". (Afghani male respondent HA5, recognized refugee, translated from Pashtu into English)

"Twee jaar geleden werd ik in Griekenland verslaafd aan alcohol. Daar had ik een zeer moeilijke levenssituatie. Ik had geen verblijfsvergunning, geen werk, geen toekomst, geen huis om te wonen. Meestal sliep ik onder de bruggen of op straten. Alcohol was de enige manier om even te kunnen rusten en pijn te kunnen vergeten. Maar wanneer het effect van de alcohol was uitgewerkt, realiseerde ik mij de benarde situaties weer". (Afghani, male, permanent document, from Dari to Dutch)

Some declared they were put in prison in a country on their way to Belgium, where they started to use substances.

7.5.4 Reasons for ongoing use

Over time, the reasons to continue to use drugs remained the same, altered sometimes or were completed with additional reasons.

First, the lack of residence documents and the hereto related uncertainty about the future remained a very important reason to continue using drugs.

"Als ik een verblijfvergunning ontvang dan zou ik motivatie hebben om te stoppen". (Afghani, female, asylum application, from Dari to Dutch)

This undocumented status resulted in very difficult living situations, including living in the street, lack of income, lack of job opportunities, bad housing, lack of activities during daytime, etcetera. The stress related to these extremely difficult living circumstances was oftentimes indicated as the main reason to take drugs, in an attempt to alleviate this huge emotional burden.

"When I first deal with the drugs was in Italy; I took it just for fun, but now, it is for another reason, it is because of my situation and to dodge from the responsibility, and to run away from the thoughts that I have. Taking the substances make me relax and relieve my mind from thoughts; but I feel now, it has some bad effects on my health. (…) When I feel the world gets narrow, when I don't have anything to do or any job and no documents and even not a house to stay as a normal people, and I can't see my parents, this is why I keep taking the drugs, to make me run away from my problems". (Tunesian, male, undocumented, from Arabic to English)

One participant even mentions that the entire life situation is too hard to still keep on standing and thinks about committing suicide:

"I left 1998 and I lived in Spain, then went to Italy; then France till I came to Belgium in 2012. But till now, I didn't find settlement. Maybe I'll go to Sweden or Norway or any country that I can find myself; or I'll take more dosis of heroin and end my life, wallah [he was swearing], I get tired from this alienation. I love my homeland, but what to do back there with all the suffering and the hard living". (Moroccan, male, undocumented)

Yet, also participants with a (temporary or definitive) residence status mention these overall difficult living circumstances, in particular the lack of a (proper) job and related income, the lack of things to do (and too much 'free time'), and the overall loneliness they are facing.

"Door mijn eenzaamheid, zonder werk en geen positieve toekomst, geraak ik zwaar onder druk. Door het gebruik van deze middel verlicht het gevoel van de pijn. Stel je eens voor dat ik werk heb, dan heb ik geen tijd om na te denken over mijn donkere verleden, over mijn familie. Zo voel ik me minder eenzaam en geen straatloper. Ik zou ook niet zo veel vrije tijd hebben om samen met mijn vrienden uit

te gaan en deze middelen te gebruiken". (Afghani male respondent SI2, recognized refugee, translated from Dari into Dutch)

"Because, you know, we get many, many problems here. You know why we smoke? You know… people… we don't have happy to smoke these things. But if we smoke the things… we feel okay. We are okay, because we have many things…" (male, Tanzani, 5 years doucment, English)

"Ik heb zo vaak beslist, maar als ik te veel vrije tijd heb, dat ik samen kan komen met mijn vrienden met wie ik altijd deze middelen gebruikte". (Afghani male 2 years document, translated from Dari into Dutch)

Some participants also mention difficult experiences in the past, and the hereto related emotional problems, which they try to manage through taking drugs:

"Ik heb te veel vrije tijd, geen werk, geen andere bezigheden, daarom ging ik regelmatig naar mijn vriendinnen en gebruikten we samen drugs. Mijn zwarte verleden, mijn eenzaamheid en mijn heimwee zijn ook de sterkste redenen dat ik nu de middelen gebruik. Ik voel geen verschil tussen vandaag en vroeger in mijn middelgebruik. (…) Eigenlijk heb ik al een paar keer aan mezelf gezegd dat ik het niet meer zal gebruiken, maar als ik telkens in een emotionelz put zit, gebruik ik het weer." (Afghani, female, asylum applicant, from Dari to Dutch)

"Maar toen ik naar belgie kwam gebruikte ik meer en de reden is om mijn problemen en het verdriet te vergeten". (Iran, from Farsi to Dutch, male, Farhani4?)

In following quote, the respondent narrates how he took drugs because he felt so hungry, since he had no income. At the same time, also the confrontation with acts of racism and discrimination, and his overall feeling of not belonging to the Belgian society evoked huge stress and made him needing to take drugs to lower the stressful feelings.

"Ik begon hier weet (marihuana) te roken, weet kalmeert mij tegen stress, want we hebben geen veiligheid hier. De politie zoekt je mond. (…). De reden [om te gebruiken] is om te zwijgen en te vergeten. Na een tijdje voelde ik weet als normaal, het kan mij niet meer kalmeren. Ik had honger altijd, ik had een lage inkomst en moest voor huur, elektriciteit, gas betalen; om naar werk te zoeken moet ik voor vervoer ook betalen en werk moeilijk te vinden is. Dan begon ik opium te gebruiken, omdat opium deed mij vergeten mijn problemen. En ook had ik niet honger met opium. Er is veel verschil tussen 2 keer en 3 keer eten per dag. Om als Belgen te kunnen eten, heb ik nooit geld genoeg. (…) In het begin gebruikte ik niet elke dag. Het was als plezier toen ik in Iran was. Ik was niet verslaafd, maar hier in België… Stel je voor dat je één dag identiteitskaart heb en de dag daarna illegaal. Als je in de kou moet buiten blijven, wat doe je dan? Ik gebruikte opium of alcohol, wanneer moest ik buiten slapen. Ook voor plezier om een dag blij te zijn, maar de Belgen hebben hun eigen werk en mag kiezen voor hun gewenste job. Dus ze hebben veel opties voor het leven en hebben geen middelen nodig om ze blij te maken. Ik heb een verdrietig leven, ik gebruik opium om ten minste een paar uren blij te zijn en mijn problemen vergeten". (Iran, male, ?Farhani 6, from Farsi to Dutch)

Almost all participants mention the impact of their (lack of) social network on their continuing use of drugs: some mention the negative impact of friends using drugs onto their own addiction problems, others indicate that the lack of a social network leads them to using more drugs, in an effort to deal with the feelings of loneliness, while still others mention that their addiction prevents them from establishing social networks, with people from their own nationality or ethnic background or with Belgian people.

"Ik ben lid van een fitnessclub. Mijn hobby's zijn koken, samen met vrienden naar muziek luisteren, alcohol drinken, marihuana roken en samen met vrienden uit te gaan. Ondanks dit ook in het Christendom verboden is, toch drink en smoor ik." (Afghani male, permanent documents, from Dari to Dutch)

"Ik heb minder contact met Afghanen omdat ik er niet zo goede ervaring mee heb, bijvoorbeeld word ik verslaafd door hen". (Afghani male, permanent documents, from Dari to Dutch)

"Tot nu toe heb ik geen enkele Belgische vriendin. Eén van de redenen is, dat ik niet wil dat er iemand achter mijn verslaving te weten komt". (Female, Afghani, documents? Sima3, from Dari to Dutch)

"Het is een deel van hun leven, wij vluchtelingen zijn geïsoleerd hier in de Belgische gemeenschap en dat is een reden dat we getrokken worden aan drugs. Ze [de Belgen] willen ons niet, ik kan dat zien en voelen, ze zeggen dat soms. We willen vriend zijn met de Belgen, we willen leven in België. We willen naar Belgische café's gaan, in plaats van samen drugs gebruiken en onze vrije tijd op die manier verspelen". (Iran, male, ?, Farhani3_alek)

One participant indicates that experiences of racism and discrimination, and the related limited social network, the lack of a job and the precarious financial situation) impact the continuation and intensification of drug use in the host country:

"Ja, heel weinig gebruikte ik in Iran. Elke weekend of om de twee weekenden. Ik ben gek geworden. Ik ben niet junky. In het Apartheidsregime werden handen en voeten van de mensen vastgebonden, maar hier [in België] wordt je mond gesloten. Ik was bijna opgenomen geworden in een psychiatrische inrichting door de politie, terwijl ik geen geschiedenis had als een psycopaat. Als je financiële en sociale problemen hebt en je familie voor 15 jaar niet kunnen zien en je wordt overal gediscrimineerd, gemeente, interimkantoor en geen aangifte kan indienen omdat de politie doet dat niet. Dus om al deze problemen te vergeten gebruik ik drugs. Anders moet ik zelf vermoorden. Ik heb altijd geleerd dat met praten kan je alles doen ,dat is de enige onderscheid tussen mens en dieren. Zolang dat ik geen vrijheid heb om te praten, gebruik ik drugs en ik weet dat ik een dag dood gevonden word in een straat". (Iran, male, ?Farhani 6, from Farsi to Dutch)

Last, the availability of drugs in the Belgian society is also mentioned:

"Maar jammer, in België overal drug beschikbaar is. Overal kan je gemakkelijk drugs vinden. Ik denk het is gemeenschappelijke probleem. (…) Als het niet gemakkelijk te vinden was, dan zou je ook minder gebruiken. Als in iedere straat mensen staan drugs te verkopen en de politie doet niets; in zulke omgeving word je gemakkelijk verslaafd". (Iran, male…)

Overall, when looking at whether the migration background of the participants can be seen as having an influence on their substance use, we found that in about two thirds of the interviewees, this was the case.

TABLE…: Role migration background on substance use * Problematisch gebruik Crosstabulation

		Problematic use		
		no	yes	Total
Role migration background on substance use	no	9	8	17
	yes	12	27	39
	unknown	3	8	11
Total		24	43	67

"The migration experience is very difficult. The way to here is not easy, and also living in a new culture is not easy. For example, in the refugee centre, I couldn't eat well, I didn't like the food (…). I can't speak the language! There are people from different countries and cultures. And I feel that the Belgian don't accept us as refugees and strangers. (…) I'm not speaking about the nation, they are very kind; I am speaking about the authorities!! And I don't blame them for what they think about us, we came here and we do many bad things". (Palestinian male, refugee, English)

7.6 Current use of substances

Participants have been contacted for their legal or illegal substance or medicine (ab)use. Prevalence rates in our sample can be found below. These numbers contain only the self-reported substance use of the respondent. So probably the actual use is higher because respondents may not mention – consciously or unconsciously – the use of certain substances they use or has used.

Furthermore, a distinction is made between recently used substances (used by the respondent in the last 30 days) and substances used over their entire lifetime. Concerning to the ranking of the most used substances, there is no big difference between recently used and lifetime used substances. Cannabis is the most used substance in this sample, followed by alcohol and cocaine. In addition, heroin use is almost as high as cocaine use.

Table….

Self reported substance use	**Recently used substances (in the last 30 days)**		**Lifetime used substances**	
cannabis[23]	37	55,2%	49	73,1%
alcohol	36	53,7%	42	62,7%
cocaine	14	20,9%	28	41,8%
heroin	12	17,9%	21	31,3%
opium	5	7,5%	8	11,9%
tobacco (incl. chewing tobacco)	5	7,5%	9	13,4%

[23] Including marihuana and/or hashish

sedative (prescribed) medication[24]	4	6,0%	4	6,0%
Methadon[25]	2	3,0%	4	6,0%
antidepressants[26]	2	3,0%	2	3,0%
magic mushrooms	1	1,5%	1	1,5%
antipsychotics[27]	1	1,5%	1	1,5%
amphetamines	1	1,5%	1	1,5%
ecstasy	1	1,5%	4	6,0%
Tramadol	1	1,5%	2	3,0%
morphine	1	1,5%	1	1,5%
Dimedrol	0	0,0%	1	1,5%
water pipe	0	0,0%	1	1,5%
Captagon	0	0,0%	1	1,5%
kosha	0	0,0%	1	1,5%
		out of 67		*out of 67*

7.6.1 Problematic substance use or not?

> "I myself don't have any problem but some people told me that I have a problem, but don't feel that, I don't bother anyone". (Syrian male respondent ES1, asylum applicant, translated from Arabic into English)

This quote gives an impression of the meaning of problematic substance use. Very important to note is the fact that we applied self-reporting of problematic use.. So we asked respondents whether they see their own use as problematic, from their point of view, as opposed to the perspective of their family, friends, professionals in the drug care treatment, or any other persons. (this part could be moved to the general introduction of all cases).

The results indicate that almost 2/3 of the respondents (N=43) report problematic use (now or in the past), while 1/3 of the respondents (N=24) do not see their use as problematic. When studying the problematic use by the type of residence permit, there seems to be an (almost) equal division between problematic users and non-problematic users for the group of asylum applicants and recognized refugees. For the group of undocumented migrants, there are much more problematic users reached for this study, than non-problematic users. Looking at the number of years in Belgium, the biggest proportion of problematic users can be found in the category of respondents who are staying 1-4 years in Belgium.

[24] Including benzodiazepines (for example Valium or Diazepam)
[25] Medicine that is used as substitute product for heroin users who are in treatment
[26] For example Seroquel XR
[27] For example Paraxetine EG

Table 4:

Aantal jaren in België * Problematisch gebruik * Type verblijfsdocument Crosstabulation

Type of residence permit			Problematic use		Total
			no	yes	
asylum applicant	Number of years in Belgium	< 1 year	1	0	1
		1-4 years	0	2	2
		5-14 years	2	1	3
	Total		3	3	6
recognized refugee	Number of years in Belgium	< 1 year	2	0	2
		1-4 years	3	7	10
		5-14 years	3	4	7
		15 years or more	3	3	6
		unknown	3	2	5
	Total		14	16	30
undocumented migrant	Number of years in Belgium	1-4 years	0	6	6
		5-14 years	5	12	17
		15 years or more	1	4	5
		unknown	1	2	3
	Total		7	24	31
Total	Number of years in Belgium	< 1 year	3	0	3
		1-4 years	3	15	18
		5-14 years	10	17	27
		15 years or more	4	7	11
		unknown	4	4	8
	Total		24	43	67

7.7 Other problems related to the use of drugs

Although not explicitly asked for, many participants express how the (long-term) use of substances evoked other problems.

First, health problems – often of serious nature – were frequently mentioned.

> *"Daarnaast zit ik met de handen in het haar door mijn telkens achteruitlopende gezondheid en psychologische implicaties zoals vergeetachtigheid, maagpijn, geldverspilling". (male, Afghan, permanent documents, from Dari to Dutch)*

> *"Door het gebruik is mijn geheugen zeer zwak geworden. Ik vergeet te snel, hoest te veel en moeilijk kan slapen. Overdag ben ik meestal duizelig en fysiek zwak, soms krijg ik ademhalingsprobleem". (female, Afghan, asylum application, from Dari to Dutch)*

As indicated when stipulating possible reasons for (the continuation of) the drug use, emotional problems are frequently mentioned:

> *"It affects a lot my financial situation, it affects now also my health. I feel my body is not strong like before. Before, when I wake up in the morning, after taking the drugs, I feel like sober, but now, when I wake up, all my body hurts, and I feel discomfort. It affects me a lot, I feel the sadness and always stressed, hating everything, then I wish that God helps me to stop taking these things". (Tunesian, male, undocumented, English)*

Also, many financial and psychological problems are reported on:

> "Ik besef dat het gebruik van deze middelen echt problematisch werd omdat ik constant hoest en er moe van liep. Mijn keel en mijn borstkast doen pijn. Fysisch ben ik echt zwak geworden, kan niet snel lopen, niet goed voetballen. Daarnaast heb ik nu slaapstoornissen en het gevoel dat ik te zwak geworden ben op vlak van sexuele activiteiten. Ook het geld dat ik er voor uitgeef". (male, Afghan, 2 years documents, from Dari to Dutch)

The fact that most respondents don't have a job is also frequently mentioned, both as the cause and as a result of the drug use, but also as a huge problem caused by participants' status as undocumented migrant.

> "Als ik zonder werk hier en daar in de stad loop voel ik me absoluut niet goed in mijn vel. Ik denk dat iedereen me ziet als een straatloper. Ook voel ik me niet goed bij mijn langenoten en ben beschaamd dat ik nog altijd geholpen word door OCMW". (Afghan, male, 2years document, from Dari to Dutch

> "Ik heb me ingeschreven bij alle interimkantoren, werkwinkels enz... Ik woon hier graag, maar het enige dat me echt frustreert, is mijn werkloosheid". (Afghan, male, 2years document, from Dari to Dutch)

All respondents mention that they miss their family, and many also indicate how they feel very lonely and suffer from this loneliness:

> "Mocht mijn familie hier zijn, voelde ik me minder eenzaam. Zonder mijn familie voel ik me ook hopeloos en verdriet hier in België". (Afghan, female, asylum applicant, from Dari to Dutch)

7.8 Experiences with support and care

7.8.1 Professional support within drug treatment structures

About one third of the respondents (N=21) have received formal, professional addiction treatment; two thirds of the respondents (N=43) thus have never received any professional care or support for their addiction problems.

Most respondents who received professional support visited a medical doctor (often a general practitioner), who often prescribed medications for the substance user. Yet, it was not always clear whether these consultations were executed within the framework of a broader treatment program or not. The interviewees did not tell much about their experiences here, nor their satisfaction with it. One respondent explicitly mentioned the difficulty that it is also possible that you get addicted to methadone:

"Ik was tevreden [over de professionele ondersteuning]. Gewoon één ding vind ik belangrijk te zeggen en dat is als een verslaafde vraagt om de dosis van de vervangmiddel te verhogen, de dokter doet dat en dat vind ik niet goed, omdat vervangmiddel gebruiken is het ook verslaving. Moet je dat gedurende een korte periode gebruiken en dan afbouwen tot nul mg. Anders word je verslaafd op de vervangmiddel. (…) Ik herinner me dat iedereen naar daar [MSOC] gingen voor behandeling. Opium was duur en om onze kosten te verminderen gingen we daar vervangmiddel vragen, maar we wisten niet dat verslaving op methadon is erger dan opium". (Iran, male , English)

TABLE Formele hulp * Problematisch gebruik Crosstabulation

		Problematic use (self reported)		
		no	yes	Total
Formal help experience	no	20	23	43
	yes	3	18	21
	unknown	1	2	3
Total		24	43	67

TABLE Aantal jaren in België * Formele hulp * Type verblijfsdocument Crosstabulation

Type of residence permit			Formal help experience			Total
			yes	no	unknown	
asylum applicant	Number of years in Belgium	< 1 year	0	1		1
		1-4 years	0	2		2
		5-14 years	1	2		3
	Total		1	5		6
recognized refugee	Number of years in Belgium	< 1 year	0	2	0	2
		1-4 years	3	7	0	10
		5-14 years	2	5	0	7
		15 years or more	0	5	1	6
		unknown	0	5	0	5
	Total		5	24	1	30
undocumented migrant	Number of years in Belgium	1-4 years	3	3	0	6
		5-14 years	8	9	0	17

		15 years or more	3	1	1	5
		unknown	1	1	1	3
	Total		15	14	2	31
Total	Number of years in Belgium	< 1 year	0	3	0	3
		1-4 years	6	12	0	18
		5-14 years	11	16	0	27
		15 years or more	3	6	2	11
		unknown	1	6	1	8
	Total		21	43	3	67

7.8.2 Other types of professional support

Some other types of professional support were mentioned in the interviewees' narratives, in particular psychosocial (CAW) and psychological (CGGZ) support, and support with their overall financial and living situation (OCMW). Also organisations providing free food are mentioned, in particular by the undocumented migrants.

"You see, this card here, you see [shows a card from a centre for outpatient psychological support]. I go there, because now I stopped to smoke. The things still come in my mind every day. So I go to look for another way. Maybe they can help me". (male, Tanzania, 5 years document, English)

7.9 Direct reasons to look for help

Participants mention a variety of reasons to look for help for their addiction problems. The problems as mentioned in 4.5 are already leading to the need to search for professional help with the addiction problems, but participants also mentioned some particular reasons. First, a possible reunification with family members or the longing to being reunited with family was mentioned as a reason to stop using substances:

"Ik doe mijn best om ermee te stoppen voordat mijn vrouw naar België komt. Een Afghaanse vrouw zal nooit een verslaafde aanvaarden als haar echtgenoot. Ook doe ik mijn best een goede voorbeeld te zijn voor mijn toekomstig kind". (Afghan, male, permanent documents, from Dari to Dutch)

"It is very important for me that I can see my children again; so I have to save money, and not to loss it on drugs; believe it or not, for about 11 days, I have no money; if I need to eat, I visit some friends". (Palestinian, male, refugee, English)

Also here, the importance of being given documents, in relation to the familial situation, is mentioned:

"If they give me now my paper, I stop with methadone, and I try to organize my life because now I have a child. My child is almost 9 years. And I need to think about him and not about myself". (Iran, male, undocumented, English)

Being referred by friends in the social network or a professional (i.e. medical doctor) helped to go seeking for professional support with the drug care.

"So that time, I say to my friend 'you know this situation?', he said 'yes, I know', so 'how can I start to live there?'. He said if you go live there, there's this place MSOC, you get the methadone and you get okay this and this". (male, Tanzania, 5 years documented, English)

One participant told how he arrived in Belgium with a serious addiction problem and withdrawal symptoms, and was referred to an MSOC by the doctor of the asylum centre where he was staying at that time.

One participant indicated how his prison sentence helped him to stop using drugs.

"I knew, it was a problem to me, when I lost five years from my life in the jail. There, I stopped everything, even the cigarettes I was jailed three times the last one was three years and four months. The last one, I felt I was wrong and guilty, and I should not go through this way". (Tunesian, male, undocumented, English)

In a few cases, the migration experience itself was the start of receiving adequate drug care treatment for their addition. As this Palestinian refugee told:

"I'm now far away from what I was. I'm very different from when I first came. I was an addict to drugs, now I have my medicine and always I have it with me, I've stopped the drugs to the medicine in our countries (Arabic countries), there is no treatment from addiction. What I'm taking now as a medicine is prohibited in my country. There [in Palestine], I have to think from where I can get my drugs, how can I buy it, how can I get the money to buy it, then I have to think: how can I deal with it; I was afraid that the authorities may get me in prison, sometimes even the person whom I deal with, is a collaborator with the authorities in this case, I may be get in a deep problem. (…) I've a huge change in my life here [in Belgium]. I can find my medicine easily (…). I was addicted in my country, but here, I started to be treated. I have now a document file in a Sanatorium to treat addiction in Gent. I stayed two months there, then I was transferred to Sint-Niklaas, I'm now following the treatment from the pharmacy". (Palestine, subsidiary protection (5years), English, male)

7.10 Barriers to professional drug treatment

Little participants had found their ways towards professional drug treatment, which reveals the need to try to further investigate the reasons hereto. A number of elements has been mentioned by the participants which will be discussed further below.

7.10.1 Lack of knowledge about professional drug care

A first barrier towards searching for help is that many respondents don't know at all that such kind of support exists for them or don't know where to go. One reason here could be that also in their countries of origin, there was no such a kind of professional support in case of addiction problems.

"Tot nu toe heb ik nergens om hulp gevraagd want wist niet dat er voorzieningen voor bestaan". (male, Afghan, from Dari to Dutch, permanent document)

"Ik ken geen hulpverlening in België. Dat is eigenlik de eerste keer dat ik er over hoor. (…) Tot nu toe heb ik er geen hulp voor gezocht". (Afghan, male, 2 years document, From Dari to Dutch)

7.10.2 Language problems

Another obstacle that was mentioned were language problems, both in the accessibility of services as in the treatment programs themselves.

"Yes, I think it is easy [to find this help], but for people like us who don't know the language it is not easy". (Saudi-Arabian male, recognized refugee, translated from Arabic into English)

"The rehabilitation from addiction needs two ways: one is the medical treatment and the other is psychological treatment, and for that, I have to stay in the sanatorium from four to six months, but I can't talk the language, so how can I get treated without communication?" (Palestinian, male, refugee, English)

7.10.3 Lack of residence documents and ongoing residence procedures

The residence status of the participants was already indicated as an important problem in the start and/or continuation of the interviewees' addiction problems. Yet, this was equally mentioned as an important barrier to initiate the step to professional care and treatment for their addictive problems. Several respondents narrated that they were denied certain types of treatment because of their undocumented status. One participant told how initially, when he had a temporary residence document, he could receive professional support, But from the moment that this temporary document ended without renewal, and he thus was undocumented, further support was refused.

"When I had documents to stay in Belgium, I received treatment. But now I don't have documents, so I receive nothing, no treatment". (Afghani male respondent HA1, undocumented migrant, translated from Dari into English)

"Respondent: I want to change but I didn't find anything. I want to go to Sloten, een ander hospitaal to help me. If I find a hospital to help me. 10 dagen misschien ik stop met drugs.
Interviewer: Waarom ga je niet naar afkickcentrum zoeken?
Respondent: Afkickcentrum, ik heb geen papieren. Ik vraag dat voor afkickcentrum, maar hij zegt jij moet papieren hebben. Ik praat met de dokter. Hij zegt misschien kan ik helpen" Morocco, undocumentend, male, Dutch)
"Interviewer: Why is it so difficult to seek help? Waarom is het zo moeilijk om hulp te zoeken?
Respondent: Geen papieren". (Morocco, undocumented, male, Dutch)

"I know there is help, but if anyone has no residency papers like me, they won't help him, they only help the very bad hopeless conditions, I knew centers like for example afkickcentrum, and if I go there, they won't help me. (…) He was my friend (the one who died) in Brussels, and he was in a very bad condition. He went to the afkickcentrum, they refused to help him, because he didn't have the residency documents, they asked for the card [SIS card] to reduce the cost of treatment, and if I don't have the residency papers, I can't pay the cost of my treatment" (Tunesian, undocumented, English, male)

Also if one is still in an ongoing (asylum) procedure, there is huge anxiety that the addiction problems are revealed, and therefore, the step to treatment services is too difficult.

"Ik wil met niemand daarover spreken omdat ik bang ben dat ik daardoor geen verblijfsvergunning krijg en teruggestuurd word naar Afghanistan. Daarom wil ik ook niet dat u mijn stem opneemt, anders zou het probleem kunnen zijn voor mijn asielaanvraag. Ik vertrouw in u omdat u zweerde dat dit absoluut anoniem blijft". (afghan, female, asylum application, from Dari to Dutch)

7.10.4 Discrimination and lack of trust

One participant explicitly mentioned that he felt not being respected in certain types of drug addiction treatment, and expressed his overall distrust in this type of treatment:

"Ik ken alleen maar een organisatie waar je moet elke dag gaan je mond open doen en ze druppelen iets in je mond. Dat vind ik een soort belediging. Een verslaafde is ook een mens en moet gerespecteerd worden. Ik geef niet toe dat ik een verslaafde ben; als ik dat toegeef, dan moet ik zeker daar gaan om iets in mijn mond te druppelen.Iik ga nooit naar zo'n organisaties omdat ze geven je iets om jouw pijn te stoppen, maar je voelt een andere pijn omdat word je niet gerespecteerd". (Iran, Farhani6?, male, from Farsi to Dutch)

The same element was also narrated by a participant in relation to mainstream services:

"Problem with this people is assistance, assistance, assistance. They call each other assistant. But let me tell, they are not good at all. They teach us nothing. Not me, everybody. I'm just straight. I just talk for the others. Please don't forget this message. Because you know what? These people are taking advantage of the people. (…) The assistents, the people of the OCMW. We are human being. There is nobody perfect. Everybody has their own mistakes. But these assistents of the OCMW take advantage of one mistake to punish you. But sometimes, they make mistakes. They just wake up to say sorry. And I respect that sorry. But they tell me we will make our mistake. They are not sorry for us. Always punishment. (…) They always watch your back. (…) They have to listen to us, they have to agree their mistake. But the punishment. Many people cry. Because they never been in school. You give them a big letter from the Netherlands. You have to read. They call you, they say come in. You have to explain again and this and this and this. And that's not good. (…) They say and this and this and this and ask do you understand? They give you paper but if you forget, they punish you. After punishing, they call you". (Tanzania, 5 years documented, male, respondent CH1)

7.11 Suggestions to improve professional addiction care

Although not extensively, some suggestions were made to improve the professional care systems for people with addiction problems. Besides tackling the above mentioned barriers, following elements were mentioned:.

First, several participants suggested to offer treatments without medicinal support, or at least treatments in which there is more than only treatment with medicines.

"Ze moeten de dosis controleren, niet laten de verslaafde meenemen naar huis. De dosis niet verhogen en methadon ter plaatse gebruiken. Maar jammer zie ik in België dat om de klant altijd tevreden te houden, verhogen ze de dosis. Op dit manier kan de verslaafde niet stoppen, hij blijft verslaafd. (…). Ik ken mensen die al vijf of tien jaar methadon gebruiken, ook hoge dosis ,70 of 80mg. In het begin ze waren verslaafd op veel minder. Als de behandeling meer dan twintig dagen duurt, dan wordt het moeilijk om de methadon te stoppen". (Iran, male, English)

Second, participants suggested that it is important that the client remains in control of the help that is provided.

Third, other ways of 'treatment' are suggested, such as doing sport, finding a job, and having more activities to do during daytime.

"Als ik werk heb dan voel ik me sterk, verantwoordelijk en nuttig zowel voor mijn zelf als voor de anderen. (…) Maar ik weet als ik niet zo veel vrije tijd heb dan kan ik wel stoppen met het gebruik van deze middelen". (Afghan, male, 2 years document, From Dari to Dutch)

Last, the role of the community is mentioned, since this helps to consider possible cultural differences (traditions and customs) of the substance user.

"Our community have tradition and customs which came somehow from the religion, but the right way to deal with these people (who drinks a lot) should be by considering him a person who needs help, and the community must help him, you can add that there are no civil organizations to offer education and awareness for such issues. So for these reasons you can say that the way that community do is ok". (Syrian male respondent SD4, recognized refugee, translated from Arabic into English)

7.12 Informal support and feelings of shame – addiction as a taboo

Almost all participants explicitly indicated they did not want their family – mostly still residing in the country of origin – to know about their addictive problems. The fear of being stigmatized or even excluded is very high, although many participants regret that they cannot be open to their family members.

"Ik ben getrouwd en heb geen kinderen, had ook een goede relatie met mijn familie. Ik doe er alles aan hen van de waarheid over mijn verslaving te onthouden. Als mijn vrouw en mijn familie dat te weten zouden komen, zou dit zeer denigrerende situaties teweeg brengen. Ik word als een straatloper gezien. Niemand heeft respect aan mij. En iedereen lacht mijn familie uit. Het frustreert me natuurlijk enorm. Omdat mijn familie een zeer belangrijke rol speelt in mijn leven". (Afghani participant, male, permanent documents, from Dari to Dutch)

Addictive problems are surrounded with great stigma:

"Ik spreek er met me mijn familie niet over. Het is een grote schande voor mijn familie en voor mijn landgenoten. Volgens de Islam is het gebruik van deze middelen sterk verboden. Daarom spreek ik er enkel met mijn vrienden over, met wie ik het samen gebruiken". (Afghani participant, male, 2 years documents, from Dari to Dutch)

"I always made my family away from what I'm doing here, my family in Tunisia don't know that I take the drugs they only knew that I drink alcohol, Alhamdu lillah (thanks to God) that is my mother don't know! And if she knows, she'll get sick" (Tunesian, undocumented, English, male)

In contrast with their lack of openness about the addiction problems towards their family, some participants indicated that they talked about their problems with some friends (often also drug users) of which some were belonging to their own nationality or ethnic community.

"Sommige van mijn landgenoten adviseren me om er mee te stoppen en geven me advies daarover". (Afghani participant, male, 2 years documents, from Dari to Dutch)

"Ik heb met niemand contact behalve een aantal vriendinnen die hetzelfde gebruiken als ik. Volgens mij niemand weet dat ik drugs gebruik". (female, Afghani, asylum application, from Dari to Dutch)

Yet, there were also participants who never talked to anyone about their drug problems.

"No. I don't speak about that, I don't think about that! I don't like. I cannot forgive myself that I use three months". (Iran, English, undocumented, male)

For most participants, their social networks are very limited, and mostly they have friends from the same nationality or other non-Belgians.

7.13 The role of religion

We want to specifically devote a section on the role of religion in the participants' narratives. A very diverse picture is sketched here. For some participants, religion plays no any role in their lives, while others consider it as a pivotal element.

"Geloof speelt een belangrijke rol in mijn leven. Ik ben moslim, ga regelmatig naar moskee en bid dagelijks en volg de ramadan. Voor mij is het belangrijk dat ik een lid ben van mijn religieuze gemeenschap". (Afghan, man, 2years document, from Dari to Dutch)

"I go every Friday to the Mosque, and there I hear advices like: Allah (God) may keep our sons from those things, and I heard the Imam advises the families to watch their children not to go in that way I mean the drugs road, but in the end I think it's not a religious matter". (Tunesian, male, undocumented, English)

Further, some interviewees attribute a positive role of religion and religious beliefs in their recovery process of the addiction problems.

"Interviewer: So you think that religiously community may find solutions for these people? Respondent: Maybe if they go look for these people, they may find solutions for the young Muslims who deal with these substances. Like me myself, I can't go to them to solve my problems, but if they themselves looked for me or guided and helped me to get back to the right way, maybe I'm not like what I'm now! Every person has his reason, but if they look after him, they may save him and help him". (Tunesian, male, undocumented, English)

"The drugs in the religion is something not acceptable, but I look to my situation that I'm a sick person. In my case, the religion is fair to me, maybe in the beginning, I was an immoral, but then it was not my fault, it was because of some bad friends who wanted me to be so". (Palestinian male, refugee, English)

Yet, others see their drug problems as highly in contrast with their religion, which renders it for them even more difficult to accept these problems and certainly to talk about it.

"I wish I can get rid of that thing [drug problems], it is not for us (the Muslims). It is prohibited in our religion. I hope that God will lead me to be strict to my religion (…), because I like my religion". (Tunesian, male, undocumented, English)

"Ik wil niet over geloof praten. Omdat ik me schuldig voel als ik erover praten". (Afghan, female, asylum applicant, from Dari to Dutch)

"Interviewer: Denk je dat religie kan mensen helpen afkicken?
Respondent: Ja, als je contact hebt met religieuze mensen, dat kan je motiveren afkicken, omdat ze zijn reinig, ze roken zelfs niet en ze kunnen je helpen". (Iran, male, refugee, respondent FA3, translated from Farsi to Dutch)

For most participants, the contrast between the religious prescriptions about drug use and their own addiction problems makes it impossible to talk about this addiction with religious servants or with family or community members.

"Interviewer: Can you speak with religiously committed persons?
Respondent: Honestly, no! I dare not! Not because I fear to speak with them, but I respect the person for not to know about my drugs problems. I go to the Mosque and I follow my prayers". (Tunesian, male, undocumented, respondent ES4, translated from Arab into English)

"Interviewer: Wat is de reactie van uw omgeving ten aanzien van middelen?
Respondent: They don't agree because it's forbidden (Haram).
Interviewer: Hoe gaan zij om met middelengebruik?
Respondent: They look at him so lowly, as if they are better than him! They detracted him, and they look at a person who drinks alcohol and who don't pray as a bad person and a futile". (Syria, asylum applicant, male, respondent ES1, translated from Arab into English)

7.14 Discussion

8 THE CONGOLESE COMMUNITY IN MATONGE, BRUSSEL

8.1 Contextual introduction

8.1.1 Migration history

Congolese people are to be found all over Belgium, with a concentration in urban areas and particularly the Brussels Capital Region (Demart, 2013; Schoonvaere, 2010). The presence of the Congolese community results of different immigration waves, either of individual or more collective nature. During the Belgian colonization period, very few Congolese had come to Belgium (Etambala, 1993). The first significant (but still relatively limited) wave of Congolese migrants arrived after the independence of the Congolese State (Martiniello & Kagné, 2001). During the decolonization process, mass migration to Belgium was not stimulated, in contrast to the situation in neighboring countries France and the Netherlands (Demart, 2013). In 1970, only 7.827 sub-Saharan[28] Africans – of who 1.409 were students- , were counted in Belgium.

By the year 2000, this number had increased to 25.833 (Mazzocchetti & Wayens, 2012). This figure, however, only refers to people not holding Belgian citizenship. Increased immigration was triggered by political troubles and increasing poverty rates, despite – and some would argue because of - , the structural adjustment programs of the World Bank. By 2010, the Subsaharan African community in Belgium consisted of about 130.000 people and 40% of them were of Congolese origin (Schoumaker & Schoonvaere, 2012). This figure includes both migrants with and without Belgian citizenship. In large majority, they are first or second generation migrants: either newcomers or children of migrants (Mazzocchetti & Wayens, 2012). The first wave of migration was composed of students and to some extent political opponents to the Mobutist regime (Demart, 2013).

There was at first no outspoken economic component to this migration, even if a considerable part of the student population would eventually remain in Belgium in light of the deteriorating situation in their home country (Demart, 2013). Some Congolese came to Belgium in the framework of professional mobility linked to companies they had worked for in Zaïre (the name of the country during a large part of the Mobutu regime). The second wave of migration was in large parts linked to the instability of the region after the decline of the Mobutist regime and the replacement by the Kabila regime in the nineties. The third wave is foremost to be explained by the rising poverty of the population in Congo, civil war, the failing of the state structures and the weakness of redistributive policies.

8.1.2 Religion

Religion plays an important role in the life of a lot of Congolese migrants (Maskens, 2013). Three main religious traditions can be distinguished among Congolese migrants in Belgium: the Roman-Catholic faith, the protestant orientation (*Eglise du Réveil*, closely linked to the Pentecostal Movement) and the Kimbanguist faith (Demart et al., 2013). Moreover, the regular religious practice is an important characteristic of the Congolese community in Belgium. A minority of the population are Muslim and there is also a small proportion of agnostics and atheists.

[28] The term subsaharian designates a synonym and an euphemisation of the racial category « Black » (Mazzocchetti & Gregoire, 2013).

8.1.3 Discrimination

The Congolese group is one of the most vulnerable groups on the Belgian labor market, as was shown in the Diversity Barometer Work (2012) and the Socio-Economic Monitoring (2013, 2015). Even if they are among the highest skilled migrants (judging by the proportion of people with a university or higher education degree), they have a high level of unemployment. This does among other things suggest there is a considerable problem of discrimination in hiring processes (Brans, Jacobs et al., 2004). There is also a problem of access for ethnic minority groups to the housing market, as documented in situation tests in the Diversity Barometer Housing (2014), with a high likelihood that Sub-Saharan Africans are particularly affected.

Discrimination levels in daily life are reported to be high and are linked to a pattern of lower levels of identification to Belgian society (Demart, 2013; Garbin & Godin, 2013; Kagné, 2000; Manco et al., 2013; Mazzocchetti & Wayens, 2012). Despite comparable levels of discrimination they experience, the Congolese community should not be seen as a homogeneous entity. Indeed, the Congolese community is socially and politically divided and internal distinctions related to migration trajectories are of some significance. During the fieldwork, some people underlined the fact that more recent Congolese migrants were not to be equated to people who are established already for longer periods in the country. In the most outspoken cases, the new migrants are sometimes by the older migrants even considered to be "*racailles*" ("thugs"). The interviews during the fieldwork in any event clearly show that the respondents stemming from different migration waves emphasize they belong to different social classes and have different socio-economic statuses.

8.1.4 Relatedness to the general population

The colonial past is very present in the mind of the young people we met, more even than for the older respondents we have spoken to. This reflects findings of earlier research (Demart, 2013; Garbin & Godin, 2013; Kagné, 2000; Manço et al., 2013; Mazzocchetti, 2012). They often make reference to the colonial past to underline the fact that the Belgian State exploited Congolese resources and did not sufficiently care for Congolese people. Evaluations of the Belgian state are not always positive, low identification to Belgian society is reported and the Congolese community itself is highly valued. We will come back to this issue in the section on identification.

> « Vous savez, nous les africains, nous avons une famille élargie, un Africain quand il voit son frère, chez nous le cousin, le neveu, n'existe pas, nous sommes des frères. Je vois pas mal de frères Africains et parfois des frères Congolais à Matongé. C'est un endroit idéal pour se rencontrer quoi et parfois un peu des souvenirs du pays » (Charles)

8.2 The respondent pool

The Congolese sample is composed of 45 people, from 18 to 64 years old. There are 10 women and 35 men. Given we made use of community researchers who did not always follow the guidelines and due to reluctance among part of the respondents to provide this information, it was difficult to establish a precise view of socio-demographic characteristics. We can say, however, that there is a variety within the sample. Some respondents hold Belgian citizenship or have dual nationality, while others only hold Congolese citizenship. Among those holding only Congolese citizenship, different legal statuses are represented (refugees, asylum seekers and undocumented). Some respondents are born in Belgium, others in Congo. Even if recruitment of respondents took place in Brussels – and more particularly the neighborhood of *Matongé* - as a point of departure, none of the interviewees actually seemed to lived there. They resided either in Flanders or Wallonia, often in the periphery of Brussels.

Due to the origin of our community researchers and the fact substance use is quite taboo, we opted not to strictly enforce geographical limitations to find the respondents as the research design originally prescribed. Moreover, even if the neighborhood *Matongé* is a hub for the Congolese community, the actual residential presence of the Congolese community is limited there and the neighborhood does function as a meeting place stretching far beyond the Brussels' context. That is the reason why the neighborhood effect - in a strict understanding - is not at work in this case study. Community researchers were asked to look for respondents following a double stage strategy: first recruit in the own social circles and then expanding beyond through a logic of snowball sampling.

8.2.1 The recruitment area: Matongé

The presence of Congolese migrants in Belgium is often associated with the Brussels' neighborhood "*Matongé*" (nicknamed after a neighborhood in Kinshasa) in the municipality of Ixelles (Demart, 2008). Even if relatively few Congolese people actually live there, the area has become a meeting point and hub for Congolese in Belgium. The neighborhood even is a reference point for (non-Belgian) Congolese officials or politicians. Within the Congolese community it is a common place that when you want to meet someone that you know, you go to *Matongé*. With a high and visible presence of Congolese restaurants, food shops, clothes shops and hairdressers, ethnic entrepreneuring embodies the 'Congolese' character of the neighborhood.

More recently, the neighborhood has also become a reference for other Sub-Saharan-African migrants. The importance of Matongé in the daily practice and in the cultural references of the Congolese community – and more generally Sub-Saharan African populations - is not reflected in the residential patterns, as official statistics do not show an overrepresentation compared to other statistical sectors in the Brussels Capital Region. Nevertheless, given the central sociological role for the Congolese community focusing on the neighborhood Matongé as a starting point to examine the Congolese community in Belgium makes sense (Demart, 2008). Matongé has been the starting point of the field work, but quickly we extended the search of respondents, community researchers and the associated partner beyond the precise geographical area. Matongé is a symbol, a meeting point for the Congolese community, but not a place where Congolese people live (Bensaïd, 2015). Moreover, Matongé turned out not to have the same significance for all the Congolese people included in our sample:

« Ça fait longtemps que j'ai quitté le Congo, depuis 97 ... Ça fait combien fait de temps ça ? Mais je vais à Matongé là où il y a vraiment tout le Congo seulement faire mes cheveux mais je ne reste pas parce que leurs manières, leurs cheveux rouges verts tout ça, ça m'énerve leur façons de crier fort et tout ça, ça m'énerve, ça me rend malade mais il y a des choses que je dois chercher malheureusement la bas. Donc je vais vite et je repars. »

Furthermore, Matongé also seems to be losing some of its attractiveness for Congolese youth.

« A Matonge, la communauté est assez homogène. Bon y a une certaine diversité mais c'est un quartier vraiment bloc/ghetto quoi. De ce que je vois, il y a plus des gens de l'ancienne génération qui traîne à Matonge que les gens de mon âge quoi. C'est plus les tontons et tantines qui sont à Matonge avec une petite minorité qui ont ma tranche d'âge. Et je veux aussi rajouter que c'est souvent ceux qui viennent du Congo, c'est peu ceux qui ont grandi ici qui traînent à Matonge. Allez, moi je ne sens aucune appartenance, aucune attache, à Matonge. » (Babassou, 25 ans, Née au Congo)

For our study it was an entry point, but we did not contain our data collection to this particular area.

8.2.2 Identification and living experience

In our sample, the Congolese identity is associated with different characteristics, which often translate a strong social cohesion and an elevated level of social control. These characteristics are summarized in the following extract of an interview:

"Parce qu'il suffit simplement d'aller chez un Congolais, tu trouves la façon…. La nourriture, la façon de parler, la façon de s'habiller tout ça, ça vous met ensemble quoi."(Charles)

We will further examine the discourse of our respondents on these main characteristics in order to better understand better the manifestation of the Congolese identity, fully conscious that this is a social constructive in a narrative developed in an interview context. It should be noted that some respondents emphasized that these characteristics are not the same for all ethnic groups stemming from Congo. First of all, some respondents consider the food as an important part of their Congolese identity.

"Oui, j'ai l'attitude congolaise, parce que je mange toujours mes repas congolais, je mange le pundu, le madesu, la chikwange, pour manger des frites comme vous les belges et les pizzas et tout, c'est rarement donc heureusement, aujourd'hui, j'ai mangé des pizzas chez toi à la maison" (Chris)

Others emphasize clothing is an integral part of the Congolese identity. Particular attention is paid to being well-dressed, in a 'European way' as well as in traditional Congolese clothes.

« ça va être cliché. Etre congolaise bon, y a la sape, la sapologie, c'est cliché. »

Also, the particular way of interacting with each other is said to be characteristic because it implies the strong feeling of brotherhood and this is defined as a mark of the Congolese community. Even when two people with Congolese origins do not know each other, they will embark on a conversation:

"Je le décris, de la façon où on vit, la façon dont, quand on se rencontre même si je vois la personne automatiquement je sais que celui-ci c'est un congolais même si il n'a pas encore heu… on ne sait pas encore vu mais sa façon, ses gestes, sa façon de parler, la tonalité, tout ça. Je sais qu'il vient de telle région, de telle province ainsi de suite et puis, la façon dont il m'accueille, je l'accueille, la façon dont on change des idées, la façon dont on parle ainsi de suite. » Charles

Furthermore, a number of respondents emphasize that the Congolese identity is a set of values and traditions:

« Alors, être congolaise pour moi, même si je ne suis pas née au Congo, mes parents m'ont transmis certaines traditions, certaines cultures et ç'est ça pour moi, être congolaise, ne pas oublier d'où on vient et connaitre ses racines. » (LA, 22 ans).

Not surprisingly, the link with the country of origin is also an important identity building feature for people from Congolese origin:

"Être congolais, pour moi, j'appartiens à un pays, je suis le fils de ce pays-là. C'est ça la fierté" (Charles)
"Comme un nationaliste c'est des gens fort attachés à leur pays susceptible au critique qu'on peut donner à leur pays donc je décris un peu le congolais comme ça c'est quelqu'un qui veut pas reconnaitre les torts qui se passent autour de lui qui se rapportent disons à son pays c'est comme ça que je le décrirais donc pout c'est un nationaliste c'est quelqu'un qui veut a tout pris dire que tout va et pas reconnaitre les torts de sa communauté par fierté"

Some respondents furthermore take pride in the history of the country of origin as an identity marker, also embracing a pan-African reference:

« Non allez, sans blaguer, il y a aussi une histoire très forte. Je pense direct à Lumumba, représentation de l'Afrique entière. Sans me vanter, mon pays regorge de beaucoup de richesse, de matières premières. C'est aussi de la diversité culturelle parce qu'il y a de plus en plus de cultures qui s'installent au Congo : pakistanaise, belge, chinois, etc. Et aussi, force de caractère. C'est un très assez africain en général »

Religion, however, clearly does not produce a consensus to define the Congolese identity, given the important religious diversity among the Congolese population in Belgium and, indeed, in Congo itself. However, there seems to be a reference to an overall Christian identity, surpassing divisions between for instance the Roman-Catholic church and Pentecostal churches which widely flourish.

« Pour moi, non mais j'ai quand même l'impression que quand tu es congolais être chrétien c'est un peu comme une norme. Fin quand j'étais là-bas c'était tout le monde et partout. Les écoles, les camions avec des versets écrits dessus, des églises de partout. Du coup, j'ai l'impression que ça appartient vraiment à la culture."

Not all members of the Congolese community stress positive aspects. Indeed, the image of the Congolese identity and community is also quite negative among some of its members:

"Bah il y a des « saoulards » des alcooliques-là, ils ont de cheveux rouges, verts, bleus. Ils s'habillent mal, ils fument du chanvre donc euh... Ce sont des choses que non je supporte pas. Ils sont entrain de copier maintenant les gens des films des choses comme ça. Moi je... Ils me font honte. Être noir, c'est la honte. Ils font honte avec ce qu'ils font... Oui parce que c'est la honte pour nos enfants congolais maintenant. Avant vraiment il y avait l'éducation, tu n'aurais jamais vu ton enfant se trimballer comme ces hommes, fumer... Mais maintenant c'est à la mode. Ils doivent mettre 4-5 boucles d'oreilles, des piercings, tatouages et tout ça. Moi tout ça ça m'énerve alors... Je prie Dieu que mes enfants aient pas ça et ... Merci beaucoup. »

« Franchement, un peu bordélique. Une communauté bordélique. Du genre, ils ne savent pas vraiment ce qu'ils veulent dans la vie, leurs objectifs, la plupart du temps. Et on n'est pas très soudés, assez dispersés. Il y en a peu qui sont nationalistes. C'est pas un côté raciste hein ce que je veux dire. Mais quand je vise ceux qui sont plus nationalistes c'est ceux qui ont grandi ici. Moi aussi j'ai grandi ici, j'ai aussi des réflexes, mais dans ma tête, j'ai été éduquée d'une manière congolaise, je n'oublie pas d'où je viens. Et la plupart du temps, les jeunes qui ont grandi ici, oublient d'où ils viennent. C'est que les parents, les oncles et les tantes qui ont encore ce sentiment d'appartenance. Il y en a peu qui ont grandi ici qui savent même parler lingala ou qui ne connaissent même pas la semoule ou la musique congolaise. Je fais partie vraiment d'une minorité, on peut me dire que je suis une bledarde dans l'âme par rapport à ma génération. »

Some respondents even claim this negative image of the Congolese – or even the pan-African - community is a reason to avoid too intense interaction with other people of Congolese background.

« Non, la communauté congolaise, on est tous des frères mais ça ne m'intéresse pas d'aller dans la communauté congolaise parce qu'il y a toujours des problèmes entre nous, les frères africains. Il y a la jalousie, on n'est pas comme les blancs, donc il y a une différence là par rapport au blanc. Le mode de vie, que nous les Africains, nous vivons en Europe. C'est pour cela, que pour éviter ça on peut se croiser dans la rue ou dans un café et voilà, on arrête là ou dans une fête, mais se croiser tout le temps, ça créer toujours des problèmes. C'est pour cela que moi, ça ne m'intéresse pas d'être avec nos frères tout le temps. » Chris

Almost all respondents maintain contact with the country of origin, even if some have never visited it and a lot of them still have a part of their family living in Congo. The evolution of communication means is often cited to help maintain a link with the country of origin, family and friends.

« Moi, pour avoir des nouvelles de mon pays, je suis toujours donc tous les jours comme je te dis, sur internet. moi ça me fait plaisir d'avoir tout le temps des nouvelles de mon pays. »

This, however, does not mean that transnational contacts lead to frequent trips, as the financial cost of air traffic constitutes a prohibitive barrier:

« Tu rentres souvent au Congo?
Non, c'est surtout à cause des moyens financiers. Je n'y suis retournée qu'une fois, lorsque j'avais 13 ans. Mais je sens quand même l'appartenance au pays. J'ai beaucoup de contact avec mes grand-mères, mes oncles et tantes. On s'appelle souvent quoi » Babassou, 25 ans, née au Congo et arrivée à un an

With regard to identification to Belgium and Belgian society, a number of respondents do identify themselves as being 'Belgo-Congolese', stressing a hyphenated identity, or rather identify with the multicultural character of the city-region of Brussels:

« Bein, écoute, je me sens belgo-congolaise. Je ne peux pas dire que je suis belge à 100% parce que j'ai aussi un autre bagage culturel qui a été certes inculqué ici mais qui a beaucoup de place dans ma personnalité. Et je ne me sens pas belge belge belge parce qu'il y a des choses qu'un belge pourrait dire (quand je dis belge, c'est belge de sang ou par la descendance) ou pourrait se permettre de faire que moi je ne pourrais pas. Parce que j'ai ce bagage congolais qui ne va pas et qui fait que je dois m'adapter à un moment en fait. Je dois adapter les deux personnalités » (Isi, 27 ans, parents nés en Belgique, grands parents congolais)
« Je me considère quand même comme bruxelloise car il y a une multiculturalité dans la ville de Bruxelles. Donc c'est pas vraiment distingué un "bruxellois de souche" d'un "bruxellois étranger". Je me considère vraiment bruxelloise parce que c'est une ville cosmopolite aussi. J'apprends beaucoup de cette diversité de culture. » (Babassou, 25 ans, née au Congo et venue à un an).

Other respondents, however, clearly state they do not feel entirely Belgian and rather identify as being Congolese:

« Je ne compare pas la mentalité belge sans comparer la mentalité belge et celle de mon pays mais s'il faut dire que je me sens ou pas belge je peux même sur 10 dire que me sentant belge j'ai 6/10. Sans oublier mes origines. Ça je le dis sans comparer les mentalités. Mais si aujourd'hui je retourne dans mon pays et qu'on pose la même question « vous vous sentez congolais ? » Je dirais carrément 10/10 donc 100%. »

« Parce qu'il y a quand même une différence de comportement. Je suis plus à l'aise avec les congolais parce que je sens que je suis dans ma communauté, j'ai moins de tabou et je suis plus moi même que quand je suis avec des belges ou des français. Parce qu'avec eux, il y a certaines choses que je ne vais pas commencer à dire ou des points de vue qui peuvent offenser. […] Exactement, j'ai une certaine retenue parce que je n'ai pas envie d'offenser. C'est pas un côté raciste, je suis très nationaliste. Donc il y a certaines choses par rapport à l'histoire, la colonisation, l'Occident où je suis scandalisée et où les autres ne vont pas me répondre d'une manière… » Babassou (25 ans)

Perhaps less surprisingly, identification to Belgium and feeling 'Belgian' is highest among people who have obtained Belgian citizenship, even if in this case also the reference to a typical 'Brussels' identity is sometimes apparent. For some people of mixed Subsahara African and European origin, blood ties seem to play an important role in identification.

"Bah je suis belge parce que mon père est belge ... c'est l'origine. C'est le père qui fait un enfant, j'ai le sang de mon père donc je suis belge." (Cécile, 50 ans)

"Est-ce que tu es fort attachée à cette communauté?
"Non. Enfin, ça depend. Si jamais il se passe quelque chose au Congo, alors là je me sentirais vachement concernée. Dans le sens où c'est quand même de là que je viens. Donc il y a quand même ce petit côté "j'appartiens à ce pays là". Mais sinon ici en Belgique, pas du tout." Neko 20 ans)

"Et c'est quand tu te retrouves à l'étranger que tu te rends compte à quel point tu es bruxellois. Meme pas belge hein, mais bruxellois. Moi je me suis retrouvé au Nigeria et je me suis dis "purée là j'ai envie d'une mitraillette quoi". Plein de petites choses qui te marquent vraiment au fer "tu es bruxellois quoi". (Isi, 27 ans)

For some, even if a clear preference with regard to an African identity is claimed, it is stated that being born in Belgium and holding Belgian citizenship leads to patriotic identification:

« ça signifie appartenir à la patrie Belge. Représenter la Belgique dans un conflit ethnique. Bien sûr, je suis africain avant tout, mais je trouve, que je suis belge et je suis fière d'être belge »

When asked about the sub identity of feeling a Brussels citizen – which is often an important identity marker across groups living in the Brussels Capital Region – a number of respondents are somehow ambiguous.

« Personnellement, ça dépend à mon égard je pense que je n'ai pas trop de soucis puisque bon je cherche à m'intégrer et comme je travaille aussi je crois qu'ils ont une bonne opinion vis-à-vis de moi »

« Je pense que dans les bruxellois, il y a beaucoup de personnes comme moi, qui ne sont pas originaires d'ici, donc je pense qu'ils me voient comme l'une d'entre eux. » (LA, 22 ans)

"Les bruxellois ... Franchement je n'ai jamais fait attention à ça parce que depuis que je suis en Belgique j'ai habité d'abord en Wallonie à Liège. Quelque temps après je suis venu m'installer à Bruxelles. C'est vrai que bon quand on est un primo arrivant donc celui qui vient d'arriver donc il a toujours tendance à voir que les gens, les autres le voient d'un autre œil. Mais moi personnellement je ne peux, jamais juger les bruxellois par rapport à ça. Je me suis intégré, j'ai des bonnes relations avec les gens même les gens qui ne me connaissent pas, je peux engager une conversion et ça passe » (Monsieur X)

Language is often mentioned as an important identity marker, most often referring to a reality of multilingualism. Respondents often emphasis they live in a multilingual environment and switch routinely between different languages:

« A la maison on parle notre langue maternelle donc le swahili, moi avec mon partenaire mais si on veut s'adresser aux enfants parfois en flamand parfois en français Et avec vos amis ? En français on parle en français. Mais si je suis avec mes amis de mon pays, mes compatriotes on parle en lingala. »

The migration trajectory and its impact on social status for some respondents is deemed to be more important for identity issues than identification to Belgium or Congo as such. A number of respondents indeed state that they have experienced status loss of downward social mobility as a result of migration:

« Oui... Bon quand j'étais au Congo j'étais reine. Je ne savais pas nettoyer. Et maintenant je vais nettoyer pour avoir de l'argent. Mais il y a des gens qui manquent tout ça donc ça va. » (Cécile, 50 ans)

"Bon comme pour le moment je suis au chômage. J'ai travaillé mais pas pour longtemps, j'ai travaillé... Pendant quelques années et puis pour le moment je suis au chômage je ne peux pas dire que ma vie est idéale parce que je n'ai pas de travail ça c'est de un. De deux même si j'avais du travail, en Belgique les gens ne font que payer payer payer ma vie par rapport à ça je dirai que c'est 4,5." Monsieur X

Another respondent stresses some pressure of the parents was experienced in relation with the choice of studies, when reflecting on his social status.

« Non il y a certains trucs que je changerais quand même. Je retournerais en arrière et je n'aurais pas fait sciences po. J'aurais fait la mode ou tout ce qui est art. J'ai plutôt suivi mes parents que mon cœur. Même si sciences po je réussis, j'ai des excellentes notes, je ne suis pas en accord avec moi-même point de vue étude. C'est que ces derniers temps que je suis un peu plus épanouie parce que j'ai eu mon stage en Angleterre et que je me dis que je vais finir et partir. Que je vais enfin pouvoir faire ce que j'aime, entrer en contact avec les gens, la mode, le design. Dans le pays de mes rêves, l'Angleterre ça a toujours été le pays de mes rêves »

Taking all this together, it is safe to claim that multiple processes of identification and differentiation are present within the Congolese community. As a result, not all Congolese respondents actually feel as being entirely part of the Congolese community. A strong emphasis if put on having a Congolese or African identity and the specificities of the Congolese community are routinely emphasized but this does not necessarily lead to absolute identification. Hyphenated-identities ('Belgian-Congolese') are embraced, but tensions in combining multiple identities are also highlighted. These conflict-prone identification processes are reported by the different types of alcohol and drug users among our respondents.

An important conflict-prone element linked to identification processes is articulated in the statement to "behave like Belgian people".

"Comme une fausse africaine, littéralement. […] Parce que tout le monde m'a toujours dit que je n'étais pas Congolaise et que j'étais Belge. Que ce soit des membres de ma famille, à l'école, à Bruxelles tout le temps.[…] En gros c'est parce que je ne corresponds pas aux stéréotypes typiques je pense et que je me comporte un peu plus comme une belge. La mentalité m'est rentrée dans la tête du coup vu que j'ai grandi ici. (Neko, 20 ans)

A famous expression – "I am a bounty" - is used by this young respondent to describe this kind of "white" behavior. It echoes the statement by another (somewhat older) respondent who used to frequent people from the fashion and night scène, including a fair number of Belgians.

« Comme une bounty (=noire à l'extérieur, blanc à l'intérieur). Parce que c'est point de vue de mon éducation, parce que c'est cliché, parce que c'est triste, parce que dans notre communauté le fait que tu sois bien éduqué et que tu ne cries pas fort ou que tu sois plus calme, en retrait, que tu parles bien. Et donc on me dit que je suis une bounty ». Babassou, 25 ans.

It is furthermore stressed that this process of differentiation is also at work in Congo and not just in Belgium.

" Au début j'en avais marre parce que ça fait bizarre d'entendre ça. Et d'ailleurs, quand je suis allée au Congo c'était la même chose, dans la rue on me traitait d'européenne. Au début je le prenais mal et puis finalement je me suis dit qu'au fond j'étais belge et que c'était comme ça. " (Neko, 20 ans)

"Behaving like a Belgian" is, however, not really socially valorized in many groups of the Congolese community in Belgium. Indeed, it is considered to be a kind of betrayal or disloyalty to adopt the values of the state which colonized the country of origin.

« Si mais ça dépend vraiment. Moi mon histoire et l'histoire de ce pays ici font que ça serait compliqué pour moi de dire en même temps et belge, je trouve. Parce que j'ai grandi au Congo, totalement et c'est assez mal vu chez nous fin…. dès qu'on arrive ici, on se prétend appartenir au pays qui nous a colonisé. C'est assez mal vu. Je suis ici depuis 3 ans, j'ai vécu 18 ans au Congo donc je ne me sens pas du tout belge mais pour un mexicain ça se pourrait oui. Ça ne me choquerait pas non plus. »

« Pas du tout. Depuis que mes parents sont partis, je ne côtoie quasiment pas de Congolais. »
« Au Congo je dirais 1 voire 0,5 parce que j'ai eu la chance disons d'avoir les moyens financiers que j'ai et le Congo est un pays très très très pauvre donc voilà. Et ici, on sent moins les différences d'argent je dirais donc 3-3,5. On le sent moins mais on le sent quand même. Déjà quand tu dis que tu

étais dans une école belge là-bas et que tu viens pour faire tes études ici c'est déjà un peu le luxe à leurs yeux. Les personnes qui ne sont pas d'origine congolaise ne le remarqueraient peut être pas mais nous on sait que c'est un luxe.
Est-ce que tu te sens proche des membres de ta communauté en général ?
Ici oui. Je dirais 3 parce que comme j'ai dit je ne parle pas très bien lingala, je sens qu'on a pas les mêmes délires parfois. Par exemple, ce qui peut se passer dans la vie quotidienne des gens, la musique aussi en général. Nous à l'école par exemple on écoutait beaucoup de rap américains, fin c'est vraiment comme si on était la petit Belgique de Kinshasa. » (Jess, 20 ans

Among our respondents, participation to civil society is often limited to ethnic minority associations, with associative involvement foremost being directed towards the country of origin:

"Cette association c'est pour avoir surtout des nouvelles du pays. On échange presque tous les mois les nouvelles du pays et ... Intervenir en cas de besoin, pour les gens qui souffrent chez nous. Dans la communauté LEGA.

8.3 Nature and patterns of substance use

The respondents we were able to involve in the study through the community researchers either use one, two or three substances targeted in the design research: cannabis, alcohol, cocaine, crack (purified cocaine), heroine, methamphetamine, Xanax. It should be stressed that we did expect some difficulties in working with community researchers to undertake research into this taboo topic and were knowledgeable that the Congolese community is a difficult community to be targeted for research. However, we had not anticipated that the fieldwork would be difficult to the degree it was. We cannot sufficiently stress that the fieldwork has been really challenging. A lot of people who were contacted in the framework of the project, have refused to take part in this research project. At some point the community researchers did not bother anymore to keep track of the number of refusals, wishing to focus on (rare) successful contacts.

A number of reasons for the high refusal rates and difficult recruiting can be listed: The fear to be reported to the police or judicial services, the fear to give a bad image of the Congolese community and the resistance to - or the misunderstanding of - the research categories ("no I am not a real addict", "no I am not a problematic user") are some of the reasons that explain the high level of refusals. Even if this is somewhat disappointing we should hence admit this research project can only be considered to be a first step in a more in depth research agenda into substance use within the Congolese community and should be read with necessary caution at the risk of over interpretation.

Nevertheless, we do believe it is an important step forwards as an exploratory study into a difficult topic regarding a relatively understudied ethnic minority community. Making use of community researchers in fairness was sometimes as much a hindrance as an advantage to the research process, as considerable effort had to be put in training and socialization of the community researchers to 'play the game' of the research objectives. To cite but one example, at the timing of the redaction of this report, a community researcher who had abandoned all contact with us, showed up almost literally at the last minute delivering five interviews (of which findings are not included in this report), without having informed us at earlier stages he was still on board. Overall, the conducted interviews show different kinds of use in terms of frequency, and of substance nature. Due to the differences in social acceptance of the different substances within the Congolese community, the following section is structured by means of the types of substances used by our respondents.

8.3.1 Alcohol

Overall, consumption of alcohol seems to be not conceived as a (potential) problem, but as a normal social practice among a part of the Congolese persons interviewed. One can, obviously, say the same thing about the attitude towards alcohol in the dominant culture in the receiving society.

« Les médicaments et tout ce qui est drogue, ça ne fait pas partie de mon éducation donc je n'y touche pas. Mais par, contre l'alcool je ne suis pas soule mais j'adore boire les mojitos, le rosé, vin rouge, vin blanc. Surtout le mojitos. Mais ça c'est souvent le weekend quoi, quand je sors avec des amis. C'est vraiment social. Après ça dépend. Par mois, je peux dire qu'une ou deux fois par mois, à la maison avec mon père en plus, on boit du vin. Mais être soule, ça je n'ai jamais connu quoi, j'ai des limites. En général en soirée, je n'ai jamais été ni pompette, ni soule quoi. » (Babassou, 25 ans)

Given the high social acceptability of alcohol, it is sometimes difficult for people to recognize or accept identification of problematic consumption patterns. Alcoholism is regarded to be a taboo topic and respondents state family members routinely prefer to downplay or disregard problematic behavior. Some respondents do suggest there is a particular cultural component to this, in which one prefers to externalize the sources of problems – also referring to malignant effects of curses and spells – rather than to face personal (and interpersonal) responsibility for behavioral patterns.

« Ouais l'alcool, il y a une réelle consommation. Maintenant ça dépend aussi comme je t'ai dit, des générations. Les plus âgés je ne m'y connais pas trop dans leur consommation, mis à part ceux que je vois toute la journée à Matongé mais ça c'est vraiment des cas. Faut comprendre que la communauté africaine et congolaise ce sont des communautés dans lesquelles les relations parents-enfants sont très distantes. Donc par exemple, moi j'ai des copines blanches qui ont déjà vu leurs parents bourrés à des diners et qui en rigolent. Chez nous c'est tabou. La figure de l'autorité n'est pas la même, il y a une distance de dialogue entre les parents et les enfants. Maintenant moi dans ma famille il y a des sujets où ma mère fait en sorte qu'on parle mais maintenant moi il y a des sujets pour lesquels je suis un mur. Donc par rapport à l'alcoolisme de ce certains, y en a qu'on sait/ parce que moi on a déjà vécu ça dans ma famille élargie. Tu vois que la personne n'est pas bien mais les africains ont aussi une manière différente de voir les problèmes. Beaucoup de gens vont dire "c'est la sorcellerie, on m'a jeté un sort" au lieu de se dire qu'il y a réellement un problème psychologique.» (Isi, 27 ans)

Apart from health issues, alcohol dependency and frequent consumption is in some cases triggering theft and delinquent acts, as one of our respondents admits and this can be a stimulus for the individual to reconsider their behavior and consumption patterns:

"Si tu n'as pas l'argent comment tu peux boire ? Tu peux pas boire d'alcool donc tu auras toujours des problèmes ou bien tu vas aller dans un magasin pour voler donc là ce n'est pas bien. Moi ça me suis déjà arrivé un jour, ça fait des années je n'avais même pas un sou mais j'avais envie de boire, je suis allé voler dans un magasin et on m'a arrêté et à partir de là j'ai dit même si j'ai rien je ne peux pas aller voler dans un magasin pour boire l'alcool. » (Chris)

Overall, use of alcohol is widely accepted and not at all regarded to be problematic. It is also socially accepted for women, so there is no particular gender dimension here. An interaction effect with religion is, however, to be observed. We will later come back to this point. All in all one can safely say that consumption of alcohol is seen to be fairly normal and largely downplayed, as the following extracts of interviews show.

"Sinon pour l'alcool, vu que je ne m'y connais pas trop, généralement c'est de tester un nouveau truc à chaque fois dont je ne connais absolument pas le gôut. Mais je ne bois que quand je sors quoi. Ça coûte trop cher."(Neko, 20 ans)

« Non non. Pour le moment non. La consommation de joints j'en parle pas et je trouve qu'elle est très raisonnable. Apres d'alcool non je pense qu'il n'y a pas à s'inquiéter parce que je pense que j'ai passé l'âge où j'allais dans l'excès quoi. Là ça va. »

« L'alcool, ouais, les joints ça dépend mais c'est vraiment rare. Quand tu vas à un festival ou à un bon concert reggae. Mais c'est pas du tout une addiction, je fume une fois ou deux par an. Boire ça s'est calmé maintenant mais avant j'avoue que je buvais pas mal quand je sortais. Et c'était pas maladif non plus, c'était festif. » (Isi, 27 ans)

The following extract of interview clearly shows that there is a differential perception of the substances in the Congolese community. As in the receiving society, alcohol use is socially legitimate, while other substances are far less accepted, but all depends on consumption levels too. This respondent for instance states that alcoholism would be regarded by the parents as more problematic than cannabis consumption.

« Oui, c'est plus mal vu parce que voilà, la consommation d'alcool ça s'est inscrit dans les moeurs, tout le monde consomme. Tandis que le joint c'est plus mal vu. Mes parents préféreraient je pense que je leur ramène un fumeur de joint qu'un alcoolo. Moi je trouve que c'est plus mal vu. Après, ça dépend dans quelle ville aussi. »

However, it should be stressed also that this perception of alcohol clearly depends on the religious orientation of Congolese people. Only the atheists and the Roman-Catholics among our respondents of Congolese origin consider the use of alcohol entirely not to be a problem. They report it as a commonly acceptable and very widespread practice in the Congolese community. Those who lived in Congo also told us that in Congo, drinking alcohol is very widespread. Some respondents report that they drank less in Congo because they had less money to spend on "those kind of things" in Congo than in Belgium. Some alcohol users began to drink in Belgium, while one had never drank alcohol in Congo. Strikingly, protestant male alcohol users, report that their life partner does not approve their alcohol use and urge them to stop as soon as possible. Indeed, within the Pentecostal Movement alcohol consumption is frowned upon. There seems to be an interaction effect between religion and gender here.

The older Congolese and those who work, routinely report they drink with other Congolese friends. Also the younger Congolese stress the importance of social drinking, but emphasize they also do it with friends from different origins and with Belgian people. Alcohol use has been routinely described as a means to relax and reduce the pressure after work; but also as a social lubricant as regular practice during friend meetings in a bar after work. Some respondents, however, also mention that alcohol and tobacco are used as stress reducers in the face of problems, such as uncertainty linked to the regularization of residence:

"Euuh ça fait longtemps , ça fait longtemps que je... Je fumais mais de temps en temps mais c'était quand même très rarement . Je fumais rarement , non ça c'était euuh... Parce que quand on a des problèmes on se dit en prenant telle ou telle substance, peut-être cela pourra apporter une solution à ça. Moi j'ai commencé à fumer de temps en temps parce que j'avais des sérieux problèmes par rapport à la régularisation de mon séjour. Et alors je me sentais à chaque fois s je fumais une cigarette me consoler..."(Monsieur X)

Some male respondents have recognized that their alcohol use is problematic. In this context, the following extract of an interview is interesting as it underlines the trouble caused by alcohol, but it also reflects that a similar level of daily use compared to other respondents can be interpreted as being problematic or unproblematic:

« Je peux dire que cet usage est problématique pour moi parce que parfois quand je rentre du boulot, je prends quelques verres parfois je suis saoul, je dors et puis le matin, quand je me réveil c'est avec des fatigues et quand je vais travailler, là donc euh, ça ne va pas, je commence à avoir des maux de

tête, je commence au lieu de travail donc c'est un peu exagéré. » (SK, 39 ans, sa femme et ses enfants sont au Congo)

" Si je suis à la maison, je peux prendre au moins 10 cannettes de bières. » Chris

Sometimes warnings by family members trigger behavioral change:

« Oui il y a ma sœur qui était là, mes nièces qui ont vu que j'étais vraiment saoûl et c'est à partir de là que ça m'as appris beaucoup de choses que l'alcool c'est dangereux j'ai commencé maintenant à gérer » (Chris)

8.3.2 Cannabis

Even if decriminalized in Belgium, use of marihuana is not legal neither in Belgium, nor in Congo. Matongé is a well-known place to buy marihuana and reports on drug selling in the neighborhood often appear in the press. In the area, the majority of dealers are "black". The dealing is often visible and consequently largely known within the Congolese community. The associative representatives therefore also suggested us to go to the neighbourhood to find Congolese users. But even if Matonge is a place to find dealers and buy marihuana, the users do not automatically stay in the neighbourhood to use the product and are hence not that easily to contact there. Use of Cannabis is perceived in a variety of ways according to our respondents. In some families it is largely condoned, while in others it is a taboo topic and practice.

« Pour eux, c'est … les avis sont partagés, ça dépend de l'appartenance, du niveau social, il y a des gens qui ont un peu étudié qui sortent de bonnes familles où les parents disent qu'il ne faut même pas toucher, c'est un sujet tabou et il y a des familles un peu, je dirais pas beaucoup d'instructions, qui trouvent que ce n'est rien, c'est banalisé vraiment. » (titi)

The social acceptance in Belgium of the cannabis is, however, reported to be different to the situation in Congo. Indifference and passive acceptation is said to be more common in Belgium than in Congo.

« L'usage de substance est-il répandu dans votre pays d'origine? *Oui, mais caché. Est-ce un problème pour vous? Non, de ce côté-là, non. C'est là où je fais la différence entre mon pays d'origine et mon pays d'accueil puisque chez nous, par exemple, quelqu'un qui fume dans la rue c'est mal perçu mais ici, les jeunes d'aujourd'hui fument dans la rue, c'est normal, il y a des gens qui disent « oui, c'est que de l'herbe, c'est quelque chose de naturelle », il y a ce manque de respect. » (Titi)*

Some cannabis users have begun to smoke before drinking alcohol, but often alcohol consumption precedes cannabis consumption. All interviewed cannabis and alcohol users do not consider themselves to be "addicts", given the assessment they make of the frequency of their use:

"je ne suis pas un tox' non plus et je fume un joint par jour en soirée plutôt, un joint en fin de soirée, avant de dormir ou quoi, ou genre regarder un petit film»

When informing on the significance and desired effects of cannabis consumption, the described and researched effects of cannabis are varied. Some present marihuana use as part of youthful rebellion or a passing practice linked to being young.

"Non, parce que mes parents, ils n'ont jamais su que je fumais de l'herbe et ils n'étaient même pas concernée. C'est avec ce genre de trucs, qu'on fait souvent attention que l'entourage ne sache pas. Il n'y avait aucun de vos proches qui étaient au courant ? Si mes cousins vite fait, les gens de cousins sinon en ce qui concerne les adultes, non, non." JL 23 ans

Others emphasize it is an instrument in enhancing or producing a state of relaxation.

“parce que ça me calme un peu, ça me mets à l’aise, si je puis dire ça comme ça, parfois quand je suis un peu énervé ou quand je ne vais pas bien, je fume parce que quand je fume ça me décontracte, ça me fait m’évader quoi, je m’évade “ (Kingston,)

The need to “escape” is furthermore not related to the age of the respondents. This particular respondent for instance states he has begun to smoke in his thirties.

“J’ai commencé quand j’ai senti que ça ne va pas, bon j’vais des groupes d’amis qui ont essayé de m’entrainer et j’ai trouvé que « ah ça c’est bon », avec les groupes des amis, ça m’a beaucoup aidé, de m’évader, de me promener, je me sentais vraiment,… j’oubliais beaucoup de choses qui me faisait mal, et puis je pensais qu’avec ça, je peux être mieux, pour finir j’ai trouvé que c’était bien » Charles

Respondents are nevertheless aware that this quest to “escape” and “relax”, brings health risks. The following interviewee states he foremost sees a health risk linked to the combined used of tobacco:

“Problématique, je ne dirais pas ça, mais c’est vrai qu’un joint par jour, ça revient à 7 joint, ça revient à 31 joints. Avoir 35-40 joints par mois, point de vue de ma santé, c’est vrai que c’est pas très très bon, c’est pour ça que je ne mets pas beaucoup de tabac, j’essaie de fumer un peu en pure mais bon je fume toujours quoi et c’est pas très bon pour la santé,” (Kingston)

This same respondent, however, finds justification for his cannabis consumption in its perceived positive effects:

“La fumette, ça me fait beaucoup réfléchir aussi, comme ça peut m’évader quand je suis évadé et voilà, c’est je dirais comme une petite thérapie pour moi, quand ça ne va pas bien, histoire d’être à l’aise, quand en fin de journée, quand je suis fatigué, un petit joint ça fait toujours plaisir puis voilà.(Kingston)

Clearly, the use of cannabis is among our set of respondents not limited to the youthful, as also older respondents holding regular jobs report consumption, even indirectly stimulated by colleagues:

« Non, les personnes ne m’ont pas avertis, c’est un concours de circonstances, un jour j’ai essayé à mon lieu de travail, il y avait des collègues qui fumaient ça et je me suis dit pourquoi je n’essayerais pas et j’avais fumé et j’ai eu du mal à travailler et c’est là, que je me suis dit que ça me causait quand même des tords. »Titi

This is, obviously, not a particular characteristic within the Congolese community, as also in the dominant group of the receiving society there is a wide variety in profiles of users. Our respondents do report that in most cases the family does not foster or encourage the practice of cannabis consumption:

« Non pas du tout, pas du tout, mon père, il me répète toujours que il préfère me voir boire un verre que fumer quoi » (Kingston,)
« non, déjà de un, je n’en parle pas à ma famille puisque je sais déjà leurs opinions là-dessus et ça sera mal vue. Donc, je n’en parle pas. Je crois que pour eux, ça devrait être problématique, je n’en parle pas, c’est un sujet tabou donc c’est mon petit jardin secret. » (Titi,)
« Alors je dirais déjà l’amour, tout ce qui est couple, c’est un peu compliqué pour moi et puis au-delà de ça, j’ai quand même pas mal de problèmes de drogues, on peut dire ça comme ça, mais je ne trouve pas que c’est ça mais les gens autour de moi penses que c’est des problèmes. Un joint de temps en temps, je ne vois pas trop où est le problème. C’est quand même quelque chose que j’aimerais améliorer puisque ça fait du mal autour de moi. » (LA, 22 ans)

Nevertheless, it is clear most respondents see cannabis consumption as relatively harmless. Even if less socially accepted than alcohol, it is not seen as highly problematic.

« Votre usage de substance est-il fréquent dans votre communauté? Oui, quand même. oEst-ce un problème pour vous? Non, parce que du coup je peux fumer avec des autres personnes de ma communauté donc non, ce n'est pas vraiment un problème. oComment est-il perçu dans votre communauté? Mal, c'est très mal vu. ? […] Comme j'ai dit ils trouvent ça un peu mal, ils ne trouvent pas ça normal de fumer et aussi, disons, vu qu'on est assez religieux, ben c'est quand même un pêcher. » (LA, 22 ans)

As is often the case with cannabis consumption, it is often also associated with a social practice among friends, furthering downplaying potential problems:

« C'est clair que quand on est avec des amis, on en fume plus comme j'ai dit, quand on est en soirée, on en fume plus donc ça affecte mon usage, c'est clair, ouais. » (LA, 22 ans)

Among both the alcohol as cannabis users, almost all respondents stress that the relationships with their families are good and regular, also when they do not live anymore with their parents in the same household. However, occasionally a respondent did point out that cannabis consumption led to problems in the relational sphere:

« C'est problématique parce qu'à la maison quand tu arrives, tu sens, quand votre femme vous demande « qu'est-ce que tu sens-là, qu'est-ce que tu as ? » tu essayes un peu de mentir, puis ça fait des problèmes, il y a pas la paix et puis, il faut entrer très tard à la maison parce que il faut passer du temps avec les groupes des amis et vous oublier que vous avez laissé une femme à la maison et retourner à la maison, il n'y a que des problèmes. Le cannabis, c'est le problème. Il n'y a pas la paix » (Charles, 48 ans).
C'est quand j'ai vu que mon comportement a commencé à changer, chez moi, à la maison. Insulter, crier, rentrer tard à la maison, voler dans le sac,… à partir de ce moment, j'ai commencé « Non, Non, Non… ».

Furthermore, cannabis use could also lead to problems with the police and judicial authorities.

« Judiciaire, puisque j'ai été interpellé pour usage de cannabis. Oui bon, il faut dire que c'était bien longtemps, quand j'étais jeune, à l'époque on ne pouvait pas avoir l'usage de la drogue comme telle, donc j'ai eu quand même quelques soucis avec. » (Titi)

In those cases where the respondents report themselves periods of excessive and problematic use of cannabis, as an explanation the state of unemployment is cited as an important reason:

'C'était plus le cannabis et j'ai associé ça à l'alcool. C'était souvent des souvent des sorties en boite, et il y avait consommation de drogues, consommation d'alcool donc c'était vraiment… j'ai eu une période entre mes 20-23 ans, où c'était vraiment régulier, c'était presque problématique pour ma vie. Que veut dire régulièrement pour vous ? et à quelle quantité cela correspond-il? Régulièrement, c'était quand je fumais un joint au bout de 2h-3h, quand je n'avais plus cet effet-là, je devais fumer un autre donc ça me faisait facilement 4-5 par jours.
oQuelle situation ou quelle circonstance a conduit à cela ?manque de travail. » titi

8.3.3 Other substances: hard drugs

The interviews of regular users of hard drugs constituted a difficult endeavor, particularly with regard to the heroin users. None of the community researchers or research interns involved in the project were able to locate and recruit heroin users. The lead researcher hence had to develop a strategy mobilizing her own extended social networks, making use of a snowball sampling approach trying to identify potential interviewees. Once identified and recruited, these users repeated at several occasions they found it particularly hard to talk about a phenomenon they considered to be in the sphere of their intimacy. Another difficulty has been to actually meet them once appointments had been fixed and then to do the actual complete interview once the respondent had accepted to participate and turned up at an agreed time and place of meeting. The urge and quest for the product of those respondents often made it difficult for them to stay quite or stay focused and concentrated. Unfortunately this did not always guarantee high quality interview material. However, a number of tendencies can be highlighted.

In the case of the regular hard drug users of crack, cocaine and heroin, the narratives of the recruited respondents show a particular pattern. Couple problems, separation or a big affective breakdown were said to correspond or having triggered either the beginning or the intensification of the hard drug use. Nevertheless, the interviewees do not go that far to suggest their regular use would be uniquely linked to one single cause, but rather as the result of an addition of different factors. Sometimes particular trauma are, nevertheless, singled out. One of the respondents linked use to child abuse and violence experienced. Ethnicity or culture is never identified as having any causal effect among our respondents. Even if they have frequent contacts with the Congolese community, they are not their only social contacts, especially not when in relation to their drug consumption.

These hard drug users reported to not only use with other Congolese people (origin or citizenship), but also with other Sub-Saharan-African people or people of Moroccan, Belgian or Turkish background. They often also sell drugs to organize and fund their personal use. Talking about this proved to be a difficult endeavor and one can understand when focusing on the life stories of those respondents who did provide us with a more in depth view of their use of hard drugs and related life style. One of our female respondents admitted she prostitutes herself to pay for her substance use, while male hard drug users often also were active as dealers. The female respondent in case was supposed to have stopped using and opt for a substitutive treatment, but appears to continue using heroin. She does, however, signal a clear willingness to stop using heroin and other substances in order to try and reconstruct the relationship with her son. As a reason for her drug use, she refers to affective problems she had in the relationship with her mother. She has remained a considerable period without a fixed location to live, but now she has found an apartment and is able to assure the necessary resources to pay for it on a monthly basis. If we would have met her in other circumstances and at another time in her life, holding the interview would have been problematic.

8.3.4 Prescribed Medicine

Only one respondent has reported the use of medicine (in this case Xanax). The respondent has had severe problems of mental health that have led her to leave the parental house, but she did not want to give any details to the community researcher who interviewed her. Obviously we are not dealing with a statistically representative sample of respondents here, but the relative absence of references to abuse of prescription medicine is striking.

8.4 Use of treatment and other facilities

Judging by responses provided by our respondents, information about treatment or facilities related to drug or alcohol use is certainly not absent, but does not seem to penetrate in all categories of the Congolese community. Some young respondents have parents who have incited them to stop smoking cannabis, even enrolling them in the cannabis clinic. However, the collective therapy orientation does not seem to produce trust for users who try to find a solution. Some alcohol users recognize they have an issue of problematic use but do at the same time feel they are able to manage their problem on their own:

"Non, je n'ai pas la motivation parce que moi-même je sais comment gérer mes affaires. » (Chris)

The context in which respondents would most easily agree to find help to stop drinking is in the medical context, which seems to have a particularly high prestige in the Congolese community :

« Peut-être si un médecin me dit qu'il faut arrêter de boire peut-être que je chercherais de l'aide pour arrêter de boire mais pour l'instant je sais comment gère ma situation donc, il n'y a pas de soucis quoi. Non, ce n'est pas difficile, c'est facile. Peut-être si tu vas chez un médecin, il te fait des examens, il trouve que tu es malade, que tu as un problème de santé, tu es obligé de demander de l'aide pour que tu puisses arrêter l'alcool donc voilà. Certaines personnes n'arrivent pas parce qu'ils sont accros, donc c'est pour cela, qu'ils n'arrivent pas et ils peuvent mourir comme ça. Parce que le médecin, te dit qu'il faut arrêter de boire parce que tu as la cirrhose de foie et toi, tu n'arrêtes pas tu continues à boire en cachette et après ça devenir quoi ? Tu tomberas toujours malade, tu vas mourir, donc chacun, sait comment voir ses affaires. Moi, si un médecin me dit qu'il faut arrêter de boire l'alcool, je ferais mon mieux pour arrêter de boire.» (Chris)

Some hard drug users go to the treatment service, but do not necessarily stop to use as soon as they go to these services. In the interviews we did, it is important to distinguish between the persons who do not know the range of existing facilities and treatment, those who know but they do not want to use them and those who have tried them. An additional distinction should also be made according to the type of substance use.

As far as alcohol use is concerned, it is clearly often difficult for users to recognize a potential problem as alcohol use is highly associated with festive practices and events. Furthermore, consumers often state they manage their consumption patterns as they "never feel really drunk". Given that alcohol consumption is legal and social acceptance high, problematic use is easily downplayed. However, there does seem to be some pressure present linked to alcohol consumption when people are embedded in a social network in which religion plays an important role.

Cannabis consumption is perceived differently. While alcohol is more openly consumed and discussed, one prefers to turn a blind eye with regard to cannabis. Several young respondents stated it would be difficult to discuss cannabis use openly with family members and they hence prefer to avoid discussing it. Even if several respondents state that cannabis is disregarded as relatively harmless, the also state that open consumption of cannabis tends to be frowned upon within the family and the larger community. Given negative associations, one tends to avoid it as a discussion topic.

The taboo on hard drugs is even bigger. The taboo is actually so powerful that we had considerable difficulty in finding users and even more so in convincing them to participate to the study. Community researchers also proved to be quite reluctant to probe and address the issue or met with resistance when seeking support in locating potential interviewees.

Respondents and particularly parents often do not know the range of existing facilities for support and treatment. Judging by the interviews, the lack of knowledgeability of services which could provide for help does not remain limited to issues of alcohol or drug use but are

part of a broader pattern of poor knowledgeability of possibilities of assistance in the wider area of children's education. Furthermore, delinquent behavior by youngsters is preferably handled by parents through repressive solutions. Especially in the case of hard drug use or severe patterns of drug addiction, a common response seems to be family rejection (following a number of trials to convince them to stop), while it is also reported that one often simply prefers to deny the problems and not discuss or hear them. Blaming problems on external sources such as witchcraft or evil spells seems to be one of the strategies to deal with cognitive dissonance on this level.

Experiences of youngsters who know and have been enrolled in treatment facilities and care structures, are not always successful. A case in point is one young Congolese respondent who was pushed by his parents to seek help but dropped out of treatment as he was afraid the service would reveal other personal problems. This person did embark on a treatment trajectory but did not participate full scale, partly because when reestablishing friendship ties with his personal social network he routinely picked up old habits of consumption.

8.4.1 Specific barriers

Once awareness of the existence of care and treatment services is established, a number of specific barriers are highlighted by respondents to not enroll in a care trajectory. The taboo surrounding drug use and dependency is pointed out as a major obstacle. One commonly cited reason is the fear one will not be able to find a trustworthy person who will be able to really help:

> *« Je pense que pour une personne qui souhaite vraiment en parler, c'est un peu difficile parce qu'il faut voir à qui il faut parler de ça. Tout le monde n'est pas ouvert à ce genre de choses. »*

The taboo is reinforced by fears for the imagined negative effects of social control by the family and the larger community, even if the "elephant in the room" is that use is also a part of reality in the own social network :

> *"Jamais de la vie ! Déjà l'alcool, c'est tabou avant l'alcool, c'était tabou quand j'étais mineur, maintenant je peux prendre des verres avec mes oncles, je bois des verres… quoi qu'une fois j'ai déjà fumé des joints avec mon oncle, qui a 40 ans. »*

In this regard the double standard is also interpreted as reflecting the social status of substance users. The more highly educated will be discrete and hide consumption, while more vulnerable and poorly educated people are said to consume more openly. Admitting use and *a fortiori* problematic use is hence equated to social devaluation:

> *"C'est pas fort répandue, je pourrais dire dans toutes les communes qu'on a, en parlant de Kinshasa, c'est pas dans toute les communes où… vous allez voir, il y a deux catégories, il y a la catégorie où les gens qui sont un peu instruits qui en consomme mais discrètement, caché. Par contre il y a une autre catégorie : les enfants qui ne parviennent pas à s'en sortir puisque la famille est plus derrière alors ils utilisent cette drogue-là, puisqu'on en trouve facilement et ça ne coute pas cher, même leur parent ne savent plus avoir le dessus parce que les enfants en consomment tous les jours et ils banalisent la chose. C'est vraiment diviser en deux en faites, c'est lié à l'instruction je dirais »(Titi)*

Consequently, a blind eye is turned to actual practices, consumption patterns are downplayed and one stresses frequent use does not equate to a genuine 'addiction'. In the following excerpt the youngster stresses that his cannabis use should not be a reason to label him as an 'addict' needing support:

"Ben parce que, pour moi, ça a marché donc voilà. Mais je ne sais pas pour moi, si j'étais accro comme certains mais voilà, quoi, j'ai réussi à m'en sortir, si moi j'ai réussi alors pourquoi pas ? » JL 23 ans

Shame indeed is reported to be a major obstacle in asking for assistance or even discussing potential problems :

« Jamais. Je ne peux pas. Pas même parler de ça parce que c'est une honte ». Charles

Fear of being the object of gossip with the community thus constitutes a major barrier to establish contact with service providers. Several respondents state they would not wish to be put into a situation where they might meet someone or be seen by someone from the community:

"Parce que quand tu y vas, tu as peur de tomber sur des gens que tu connais, qui te connaissent alors tu y vas, tu vois ces gens-là et tu te dis « oh, ils vont aller parler de moi que je suis ceci, je suis cela », c'est ça parfois qui fait que c'est un peu complique d'y aller. » Charles 48 ans.

« Je crois qu'il n'y a personne à part en parler maintenant comme je fais là. Je n'ai jamais parlé de ce sujet. Il faut quand même dire une chose, c'est quand même gênant, c'est honteux, l'usage de cannabis. Quand on doit en parler à quelqu'un, c'est quand même gênant ». (Titi)

« la peur d'être vu. Pourquoi ? parce que on est toujours gêné de la personne qui est en face, on arrive à un stade où on se dit, je suis déjà allé très loin et je crois personnellement si je veux arrêter, je vais arrêter de moi-même. Je ne pense pas que c'est un problème pour moi puisque, en plus le cannabis ce n'est pas une drogue dur, je ne pense pas être dépendant donc ça me fait du bien, j'en fume jusqu'à aujourd'hui donc je n'ai pas besoin d'aides, je ne trouve pas » (Titi)

For some respondents there also seems to be a certain level of mistrust of care facilities, as they do not rule out the possibility that care givers might report illegal activities or the use itself to the police and judicial authorities:

"Jamais, je ne peux pas le faire parce que il y a le risque qu'il peut aller me dénoncer, il peut parler de moi, je me méfie."

As a consequence, the preferred solution to dealing with consumption issues or addiction is to purely focus on encounters in the "normal" medical sphere, such as general hospitals:

"oui, quand vous demandez, il faut aller plus loin dans le sens que parfois, tu as des aides, bon tu vas à l'hôpital pour les prises de sang, à l'hôpital Brugman pour la prise de sang, parfois tu tombes sur quelqu'un comme psychologue pour parler un peu avec toi, quelqu'un qui t'accompagne psychologiquement et socialement et ça te fait du bien. » Charles

Some of the respondents also seem to think they do not really need help when deciding to change their habits and seem to underestimate efforts, the need to drop the habit or to overcome the hardness:

« je n'ai jamais demandé de l'aide puisque je crois quand même si je veux arrêter, c'est ma décision personnelle. » (Titi)

Finally, a number of respondents point to their perception that there are no prevention or care services in their country of origin. While some respondents think there are no prevention or care services because substance use would not really be seen as an issue, others stress that the taboo is so big that care services will have a big challenge in convincing potential 'clients' to take the step to seek assistance:

« Comme je vous ai dit, je ne suis pas né au Congo donc je ne sais pas vraiment pas comment cela se passe là-bas pour tout ce qui est drogue et aide. Mes parents non plus, je ne les ai pas demandés, déjà qu'on en parle pas, je ne vais pas demander comment ça se passe au Congo avec ça mais euh, je ne pense pas qu'il y ait beaucoup d'aides là-bas par rapport à ça, parce que comme j'ai dit, je pense que c'est assez toléré. » (La 22 ans)

"Et s'il y en avait vous pensez que les gens iraient consulter ?
Ha ça c'est... Moi je pense que c'est un service au départ , si aujourd'hui il ya des services comme ça qui viennent au Congo au départ ils auront presque personne. Parce que même ici c'est très difficile pour que quelqu'un accepte d'aller consulter un service comme ça. Il faut qu'il y ait les gens derrière la personne avec des conseils, dire « écoutez on va voir le centre, tel centre » et tout ça. Mais au départ la personne refuse. Et à la longue elle accepte .
Donc c'est pas légitime d'aller consulter ?
Non c'est très difficile." Monsieur X

The overall effect of the taboo and double standards regarding substance use, is that there seems to be a lack of knowledge and information about both prevention of as symptoms of problematic alcohol and drug use. Routinely in the narratives of our respondents, 'real' problems with drugs and alcohol are equated to problematic situations of youngsters, particularly those having scholarly problems. As a consequence, the relevance of prevention and care seems to be seen as a niche issue which not necessarily personally affects them.

During the fieldwork, the only civil society association we encountered trying to explicitly work on prevention of drug use of youngsters, used a prevention DVD produced by the Scientology Church. It can be pointed out that this association was recently removed from the list of associations worthy of receiving public subvention. As is the case for quite a number of African associations, it was deemed to lack a sufficient degree of professionalism to receive public support. We might point out that during the field work we came across similar prevention material issued by the Scientology Church in the waiting room of a Congolese doctor of Matongé. The doctor informed us that he had stopped delivering substitutive treatment because his patients felt insecure. He justified the presence of material from Scientology as his sole source of information he could provide to patients. He reported that representatives of Scientology came over on a weekly basis to bring new leaflets on the dangers of drugs and had observed that patients actually read and retain these leaflets. Discussions with other Subsahara-African doctors in Matongé revealed that there knowledge about drug use and drug users among their patients is quite limited, if not absent.

8.5 Conclusions

The present case study does not show any specific pattern of alcohol or drug use within the Congolese community. Nor did it point to a specific way of dealing with alcohol and drug use within the Congolese diaspora. We did not encounter any reference to a strategy of sending problematic users to the country of origin or efforts to handle addiction in such a way as an alternative to institutionalized care or rehabilitation facilities in Belgium. What it seems to be specific to the Congolese community and population is the large taboo regarding drug and alcohol use, even as a topic for debate or exchange of information. Nevertheless, one cannot claim that there would be no problems related to levels of alcohol and drug consumption within the Congolese community. We did find several respondents reporting worrying substance use, particularly among youngsters.

We did anticipate the challenge of researching this target group, but the research project turned out to be much more difficult to put into place than we had expected. It is clear that members of the Congolese community have a considerable level of fear that their community might be put in a negative perspective. Even if the enrolment of community researchers was meant to facilitate access to and participation of co-ethnics, in practice this often turned out to even have

the opposite effect. Indeed, considerable effort had to be put in even convincing the community researchers of the legitimacy of the project, let alone push them in daring to find respondents and inciting them to participate as interviewees. The simple fact that the Congolese community was a targeted research group was sufficient reason to create mistrust. Once this mistrust was alleviated between the academic research team and the community researchers, community researchers in turn themselves had to convince their (potential) respondents. That the topic of the research project is substance use and alcohol and drug use did furthermore not facilitate things. It became immediately clear that this topic constituted a huge taboo.

The challenge was not only that the research design did put the focus on alcohol *and* drug use, even a focus on the generally quite accepted – or at least condoned – practice of alcohol consumption would have created similar problems. Trying to recruit respondents to talk about alcohol alone, indeed, equally produced quite some resistance. Considerable effort had to be put into taking away or at least diminishing this level of mistrust. A commonly mentioned reason to refuse an interview - or drop out of earlier engagements - was the fear to be reported or gossiped about. Engaging community researchers did not necessarily diminish the challenge, in some cases even on the contrary. A hard drug users recruited by the academic researcher explicitly stated he would avoid to visit a care- or help service in which a black person might work, especially before knowing the institution one would get in touch with.

Working with co-ethnics as community researchers in such a case obviously can be as much a hindrance as an advantage. It appears from this research experience that it would be necessary to equally exploit research tools that are based on alternative ways of construction of a trust relationship with Congolese users. In hindsight, the ethnographic method (de Sardan, 1995) and a multiple interview based device - which in the end we had also to mobilize to facilitate interpretations and make sense of the data in our interviews undertaken by community researchers - would be more useful to understand in depth the specificities of the drug and alcohol use within the Congolese community. This unfortunately would also necessitate a longer time frame for the research endeavor.

In all honesty, we are forced to admit that the CBPR approach, as initially foreseen and designed in this research, was not the optimal tool to identify and analyze the patterns at work with regard to alcohol and drug use in the Congolese community. Many factors could be evoked to understand this matter of facts. Firstly, at the general level, the long history of real (and perceived) discrimination of the Congolese population and forms of post-colonial resistance has led to the construction of internal and external group processes to reject the stigmata of the Subsahara-African diaspora (Goffman, 1975; Jamoulle and Mazzocchetti, 2011).

Mobilising co-ethnics did not turn out to be a sufficiently effective strategy to try and alleviate reverse stereotypes of Belgian society as mechanisms of defense and survival in confrontation with the host society to which identification is sometimes problematic. It would be an interesting point of focus to try and understand whether the use of drugs and alcohol might be interpreted as a consequence of patterns of stigmatization, discrimination and lack of future perspectives. No elements directly point into this direction on the basis of the material we collected, but we cannot claim it was possible to examine this hypothesis in an in-depth manner using the current research design. For this a more longitudinal approach would be necessary and a research design focusing on international contextual comparisons (for instance between Belgium and Congo) would be required.

Obviously, this surpasses what can be done by making use of community researchers in the Belgian context. In the same perspective, the influence of age, cohort and generation on the nature of the use would merit to be more deeply analyzed in our target group. This also would require a different research design. Secondly, the CBPR and the snowballing sample procedure have some vulnerabilities. Mobilizing co-ethnics can surely facilitate access to the

ethnic minority community, especially when studying less sensitive topics. When confronted with a taboo topic, resorting to a snowballing procedure has a clear downside. Even asking potential gate keeper to identify potential interviewees carries the risk of naming and shaming both individuals as the community at large. Social desirability is always a challenge, but seems to be a particular thorny issue here. Some community researchers stated the impression they had that some respondents they had interviewed clearly did not mention all the substances they use and dissimulated particular patterns. They often report that they experienced unease and resistance for a number of reasons.

Respondents had a considerable level of disbelieve whether the anonymity clause would be really respected, and furthermore showed signs of not wanting to be morally judged by the community researcher. We furthermore had to invest quite some energy in making community researchers actually accept and embrace the necessity from refraining from any moral judgements during the interview process. At several points we observed a potential bias introduced by the community researchers, reflected for instance in the difficulty to locate users of hard drugs.

Given the level of mistrust of co-ethnic, in the end the academic researcher had to step into the process and contact and conduct herself additional interviews to assure this profile would equally be included in the collected data. Moreover, even when the community researchers did succeed to fulfill their tasks of recruiting and interviewing, they did not always gather or document all necessary information, leading to a lot of missing data and information. This severely complicated to tasks for analysis. Nevertheless, notwithstanding all these caveats, we did eventually succeed in gathering a reasonable amount of data regarding a wide diversity of profiles of members of the Congolese community having consumed alcohol or drugs. Even if the initial targets were not achieved, a relentless effort to achieve as much as possible the data collection goals does enable to formulate a number of conclusions with regard to (the narratives related to) alcohol and drug use within the Congolese community in Belgium, taking the Matongé neighborhood as a point of entry.

8.6 Recommendations

The following recommendations are to be drawn, based on the information collected through the interviews of users undertaken by the CR's and the academic researchers, complemented with insights collected through contacts with multiple representatives of Congolese associations, local services, existing facilities in Brussels and Liège and Congolese doctors in the Matongé area. We wish to highlight the following points:

There is a need to do active prevention about the risks related to substance use and provide information on the existing care and treatment facilities in the areas and spaces where Congolese people live and hang out. The knowledge about drug and alcohol use and abuse is clearly only scarcely disseminated in and through Congolese associations and strategic meeting locations. The fact that the Scientologist prospectus about drug and alcohol seems to be the only information we came across during our field work, but also that it turns out to be actively read and used in those places, points to the urgent need of (perhaps targeted) information. These practices could help to sensitize the families and friends of substance users to recognize and interpret the behavior of problematic users and to give them adequate resources in exploring alternatives to conflict or inertia in addressing their challenges.

There is also an urgent need to find (and maintain) Congolese associative actors interested in, and willing to handle, the drug and alcohol use issue, not only for young people but also for adults. On a more general scale, this requires a firmer organizational support for Congolese civil society actors. The fact that we had a lot of difficulties to find (and keep on board) a civil

society community partner for the CBPR exercise, reflects the fact that a lot of Congolese associations do not have a professional – let alone permanently viable – approach or (infra)structure currently allowing for effective partnerships for community outreach either with regard to substance (ab)use issues or any other issues. Indeed, the limited resources we were able to propose, seemed to be some of the only potential financial support mechanisms to their disposal and we constantly had to explain, assure and negotiate they would only be used for the project and task at hand.

9 CONCLUSIONS

10 RECOMMENDATIONS

11 FUTURE RESEARCH

13 LITERATURE

Acherrat-Stitou, Z. (2009). Islam en psychiatrie in Nederlands een verkenning. *Psyche & Geloof, 20*(2), 8.

Adrian, M. (2002). A CRITICAL PERSPECTIVE ON CROSS-CULTURAL CONTEXTS FOR ADDICTION AND MULTICULTURALISM: THEIR MEANINGS AND IMPLICATIONS IN THE SUBSTANCE USE FIELD*. *Substance use & misuse, 37*(8-10), 853-900.

Agirdag, O., Vanhoutte, M., Van Avermaet, P., & Mahieu, P. (2011). De impact van sociaaleconomische en etnische afkomst van de leerlingen en de impact van samenstelling van het leerlingenpubliek van scholen op de wiskundeprestaties. *Schoolleiding en -begeleiding: school en samenleving, 27*(11), 49-61.

Alegria, M., Carson, N., Goncalves, M., & Keefe, K. (2011). Disparities in treatment for substance use disorders and co-occurring disorders for ethnic/racial minority youth. *Journal of the american academy of Child & adolescent Psychiatry, 50*(1), 22-31.

Amaro, H., Arévalo, S., Gonzalez, G., Szapocznik, J., & Iguchi, M. Y. (2006). Needs and scientific opportunities for research on substance abuse treatment among Hispanic adults. *Drug and Alcohol Dependence, 84*, S64-S75.

Antoin, J., Raes, V., Lombaert, G., van Deun, P., De Vos, G., Goemanne, D., Guzman, A., Macquet, C., Van Bouchaeute, J., Vandevelde, D., & Versele, D. (2012). De TDI-registratie in de RIZIV-revalidatiecentra voor verslaafden. Jaarlijks rapport van het registratiejaar 2012. (J. Jackson, Trans.). Brussel: Wetenschappelijk Instituut voor Volksgezondheid (WIV).

Argeriou, M. (1997). An examination of racial and ethnic differences within a sample of Hispanic, White (non-Hispanic), and African American Medicaid-eligible pregnant substance abusers: The MOTHERS Project. *Journal of Substance Abuse Treatment, 14*(5), 489-498.

Ashmore, R. D., Deaux, K., & McLaughlin-Volpe, T. (2004). An Organizing Framework for Collective Identity: Articulation and Significance of Multidimensionality. *Psychological Bulletin, 130*(1), 80-114. doi: 10.1037/0033-2909.130.1.80

Ashmore, R. D., Jussim, L., Wilder, D., & Heppen, J. (2001). Conclusion: Toward a social identity framework for intergroup conflict. *Rutgers series on self and social identity, 3*, 213-250.

Barth, F. (1969; 1998). *Ethnic groups and boundaries: The social organization of culture difference*: Waveland Press.

Beauvais, F., & Oetting, E. (2002). Variances in the etiology of drug use among ethnic groups of adolescents. *Public health reports, 117*(Suppl 1), S8.

Becares, L., Nazroo, J., & Stafford, M. (2009). The buffering effects of ethnic density on experienced racism and health. *Health Place, 15*(3), 670-678. doi: 10.1016/j.healthplace.2008.10.008

Becares, L., Nazroo, J., & Stafford, M. (2011). The ethnic density effect on alcohol use among ethnic minority people in the UK. *J Epidemiol Community Health, 65*(1), 20-25. doi: 10.1136/jech.2009.087114

Becker, H. S. (1963; 1991). *Outsiders*: Simon and Schuster.

Bekker, M., & Van Mens-Verhulst, J. (2008). GGZ en Diversiteit: Prevalentie en Zorgkwaliteit. Tilburg: Universiteit Tilburg.

Belone, L., Lucero, J. E., Duran, B., Tafoya, G., Baker, E. A., Chan, D., Chang, C., Greene-Moton, E., Kelley, M. A., & Wallerstein, N. (2014). Community-Based Participatory Research Conceptual Model: Community Partner Consultation and Face Validity. *Qual Health Res, 26*(1), 117-135.

Berger, P. L., & Luckmann, T. (1967). *The Social Construction of Reality: A Treatise in the Sociology of Knowledmann*: Anchor books.

Berliner, D. (2008). The Anthropologist in the Middle of a Tug-of-War. *Men and masculinities, 11*(2), 174-185.

Bernard, H. R. (2011). *Research methods in anthropology: Qualitative and quantitative approaches*: Rowman Altamira.

Berry, J. W. (1994). Acculturative Stress. In W. Lonner & R. Malpass (Eds.), *Psychology and culture*. Boston: Allyn & Bacon.
Berry, J. W., & Ataca, B. (2007). Cultural factors in stress. *Encyclopedia of stress, 2*, 672-678.
Bhugra, D., & Becker, M. A. (2005). Migration, cultural bereavement and cultural identity. *World Psychiatry, 4*(1), 18-24.
Bhui, K., Bhugra, D., & McKenzie, K. (2000). *Specialist services for minority ethnic groups?* : University of London, Institute of Psychiatry.
Biewener, C., & Bacqué, M.-H. (2014). *L'empowerment, une pratique émancipatrice*: La Découverte.
Bogart, L. M., & Uyeda, K. (2009). Community-based participatory research: partnering with communities for effective and sustainable behavioral health interventions. *Health Psychol, 28*(4), 391-393.
Boone, S., & Vanhoutte, M. (2014). Vroege Oriëntering: bron van ongelijkheid. In I. Nicaise (Ed.), *Het onderwijsdebat*. Antwerpen: EPO.
Broers, E., & Eland, A. (2000). Verslaafd, allochtoon en drop-out. *Vroegtijdig vertrek van allochtone verslaafden uit de intramurale verslavingszorg*.
Bronfenbrenner, U., & Bronfenbrenner, U. (2009). *The ecology of human development: Experiments by nature and design*: Harvard university press.
Bryssinck, D. (2013). Bemoeizorg tussen ethiek en pragmatiek. In C. Van Kerckhove, C. De Kock, & E. Vens (Eds.), *Ethiek en Zorg in de hulpverlening*. Gent: Academia Press.
Bucerius, S. (2013). Becoming a "trusted outsider": Gender, ethnicity, and inequality in ethnographic research. *Journal of Contemporary Ethnography, 42*(6), 690-721.
Bucerius, S. (2014). *Unwanted: Muslim Immigrants, Dignity, and Drug Dealing*: Oxford University Press, USA.
Burkhart, G., Gyarmathy, V. A., & Bo, A. (2011). Selective prevention: Addressing vulnerability to problem drug use in Europe. *Drugs: education, prevention and policy, 18*(6), 447-453.
Cacari-Stone, L., Wallerstein, N., Garcia, A. P., & Minkler, M. (2014). The promise of community-based participatory research for health equity: a conceptual model for bridging evidence with policy. *American Journal of Public Health, 104*(9), 1615-1623.
Cahnman, W. J. (1962). Culture, Civilization, and Social Change*. *The Sociological Quarterly, 3*(2), 93-105.
Caponio, T. (2006). *Città italiane e immigrazione: discorso pubblico e politiche a Milano, Bologna e Napoli*: Il mulino.
Cargo, M., & Mercer, S. L. (2008). The value and challenges of participatory research: strengthening its practice. *Annu Rev Public Health, 29*, 325-350.
Carling, J., Erdal, M. B., & Ezzati, R. (2014). Beyond the insider–outsider divide in migration research. *Migration Studies, 2*(1), 36-54.
Chae, D. H., Takeuchi, D. T., Barbeau, E. M., Bennett, G. G., Lindsey, J., & Krieger, N. (2008). Unfair treatment, racial/ethnic discrimination, ethnic identification, and smoking among Asian Americans in the National Latino and Asian American Study. *American Journal of Public Health, 98*(3), 485-492.
Chan, J., To, H.-P., & Chan, E. (2006). Reconsidering social cohesion: Developing a definition and analytical framework for empirical research. *Social Indicators Research, 75*(2), 273-302.
Charmaz, K. (2006). Constructing grounded theory: A practical guide through qualitative research. *SagePublications Ltd, London*.
Chartier, K. G., Vaeth, P. A., & Caetano, R. (2014). Focus on: ethnicity and the social and health harms from drinking. *Alcohol research: current reviews, 35*(2), 229.
Chaudry, M., Sherlock, K., & Patel, K. (1997). Drugs and ethnic health project: Oldham and Tameside: Manchester: Lifeline/Preston: University of Central Lancashire.
Chédebois, L., Régner, I., van Leeuwen, N., Chauchard, E., Séjourné, N., Rodgers, R., & Chabrol, H. (2009). Relative contributions of acculturation and psychopathological factors to cannabis use among adolescents from migrant parents. *Addictive Behaviors, 34*(12), 1023-1028.

Cheong, P. H., Edwards, R., Goulbourne, H., & Solomos, J. (2007). Immigration, social cohesion and social capital: A critical review. *Critical Social Policy, 27*(1), 24-49.
Chow, W., Law, S., Andermann, L., Yang, J., Leszcz, M., Wong, J., & Sadavoy, J. (2010). Multi-family psycho-education group for assertive community treatment clients and families of culturally diverse background: A pilot study. *Community mental health journal, 46*(4), 364-371.
Ciftci, A., Jones, N., & Corrigan, P. W. (2013). Mental health stigma in the Muslim community. *Journal of Muslim Mental Health, 7*(1).
Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological medicine, 45*(01), 11-27.
Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance use & misuse, 43*(12-13), 1971-1986.
Cottew, G., & Oyefeso, A. (2005). Illicit drug use among Bangladeshi women living in the United Kingdom: An exploratory qualitative study of a hidden population in East London. *Drugs: education, prevention and policy, 12*(3), 171-188.
Dahlgren, G., & Whitehead, M. (1991). Policies and strategies to promote social equity in health. *Stockholm: Institute for future studies*.
De Donder, E. (2014). Factsheet Cannabis. In VAD (Ed.).
De Gendt, T. (2014). Turkije aan de Leie: Lannoo Uitgeverij.
de Graaf, R., Bijl, R. V., Smit, F., Ravelli, A., & Vollebergh, W. A. (2000). Psychiatric and sociodemographic predictors of attrition in a longitudinal study The Netherlands Mental Health Survey and Incidence Study (NEMESIS). *American journal of Epidemiology, 152*(11), 1039-1047.
de Graaf, R., Have, M. t., Van Dorsselaer, S., Schoemaker, C., Beekman, A., & Vollebergh, W. (2005). Verschillen tussen etnische groepen in psychiatrische comorbiditeit. Resultaten van Nemesis. *Maandblad geestelijke volksgezondheid, 60*(7/8), 703.
de Graaf, R., ten Have, M., van Gool, C., & van Dorsselaer, S. (2012). Prevalence of mental disorders and trends from 1996 to 2009. Results from the Netherlands Mental Health Survey and Incidence Study-2. *Soc Psychiatry Psychiatr Epidemiol, 47*(2), 203-213. doi: 10.1007/s00127-010-0334-8
De Kock, C. (2012). Huwelijksmigratie in Gent. Gent: Turkse Unie van Gent in opdracht van Managers van Diversiteit 2011.
De La Rosa, M., Vega, R., & Radisch, M. A. (2000). The role of acculturation in the substance abuse behavior of African-American and Latino adolescents: Advances, issues, and recommendations. *Journal of psychoactive drugs, 32*(1), 33-42.
De Neef, I. (2011). Allochtone ouderen van Turkse origine met psychische moeilijkheden. Verkennend onderzoek. Gent: PopovGGZ.
de Vroome, T., Coenders, M., van Tubergen, F., & Verkuyten, M. (2011). Economic Participation and National Self-Identification of Refugees in the Netherlands1. *International migration review, 45*(3), 615-638.
De Vylder, K. (2012). Antwerpse Drughulpsverlening. Een optie voor de ECM-druggebruiker. Antwerpen: De8 Antwerps Integratiecentrum.
Deaux, K. (2013). Social Identification *Social psychology: Handbook of basic principles* (pp. 777–798). New York: Guilford Press.
Demart, S. (2013). Congolese migration to Belgium and postcolonial perspectives. *African Diaspora, 6*(1), 1-20.
Demart, S., Meiers, B., & Mélice, A. (2013). Géographies religieuses et migrations postcoloniales: déclinaisons kimbanguistes, pentecôtistes, et olangistes en Belgique. *African Diaspora, 6*(1), 122-149.
Derluyn, I., Vanderplasschen, W., Alexandre, S., Stoffels, I., Scheirs, V., Vindevogel, S., Decorte, T., Franssen, A., Kaminski, D., & Cartuyvels, Y. (2008). *Etnisch-culturele minderheden in de*

verslavingszorg. Les minorites ethnico-culturelles et le traitement des problemes de drogues. Gent: Academia Press.
Deutsch, N. L. (2008). *Pride in the projects: Teens building identities in urban contexts*: NYU Press.
Domenig, D., Fountain, J., Schatz, E., & Bröring, G. (2007). *Overcoming barriers: migration, marginalisation and access to health and social services.* . Amsterdam: Foundation Regenboog AMOC.
Drieskens, S., & Gisle, L. (2015). Gezondheidsenquête 2013. Rapport 3: Gebruik van gezondheids- en welzijnsdiensten. Brussel: WIV-ISP.
Ebin, V. J., Sneed, C. D., Morisky, D. E., Rotheram-Borus, M. J., Magnusson, A. M., & Malotte, C. K. (2001). Acculturation and interrelationships between problem and health-promoting behaviors among Latino adolescents. *Journal of Adolescent Health, 28*(1), 62-72.
Eggerickx, T., Bahri, A., & Perrin, N. (2006). Internationale migratiebewegingen en allochtone bevolkingsgroepen. *Statistische en demografische gegevens*.
Elchardus, M., & Glorieux, I. (2012). *Voorspelbaar uniek. Dieper graven in de symbolische samenleving.* Leuven: LannooCampus.
EMCDDA. (2013). Drug prevention interventions targeting minority ethnic populations: issues raised by 33 case studies. Luxembourg: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).
Ersanilli, E. (2009). Identificatie van Turkse migrantenjongeren in Nederland, Frankrijk en Duitsland. *Migrantenstudies, 25*(1), 42-51.
Etambala, Z. A. (1993). In het land van de Banoko: De geschiedenis van de Kongolese/Zaïrese aanwezigheid in België van 1885 tot heden. *Steunpunt Migranten–Cahiers n, 7*.
Favril, L., Vander Laenen, F., & Decorte, T. (2015). *Schadebeperkende maatregelen voor de stad Gent. Een onderzoek naar de lokale noden en prioriteiten*: Maklu.
Finch, B. K., Hummer, R. A., Kol, B., & Vega, W. A. (2001). The role of discrimination and acculturative stress in the physical health of Mexican-origin adults. *Hispanic Journal of Behavioral Sciences, 23*(4), 399-429.
Finn Ma Mat, P. (1994). Addressing the needs of cultural minorities in drug treatment. *Journal of Substance Abuse Treatment, 11*(4), 325-337.
Finney, N., Kapadia, D., & Peters, S. (2015). How are poverty, etHnicity and social networks related? : York: Joseph Rowntree Foundation.
Fountain, J., Bashford, J., Underwood, S., Khurana, J., Winters, M., Carpentier, C., & Patel, K. (2004). Drug use amongst Black and minority ethnic communities in the European Union and Norway. *Probation Journal, 51*(4), 362-378.
Fountain, J., & Hicks, J. (2010). Delivering race equality in mental health care: report on the findings and outcomes of the community engagement programme 2005-2008: University of Central Lancashire.
Garbin, D., & Godin, M. (2013). 'Saving the Congo': transnational social fields and politics of home in the Congolese diaspora. *African and Black Diaspora: An International Journal, 6*(2), 113-130.
Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in mental health nursing, 26*(10), 979-999.
Geys, B., & Murdoch, Z. (2010). Measuring the 'Bridging' versus 'Bonding' Nature of Social Networks: A Proposal for Integrating Existing Measures. *Sociology, 44*(3), 523-540. doi: 10.1177/0038038510362474
Giband, D. (2011). Les villes de la diversité. Territoires du vivre ensemble.
Gibbons, F. X., O'Hara, R. E., Stock, M. L., Gerrard, M., Weng, C.-Y., & Wills, T. A. (2012). The erosive effects of racism: reduced self-control mediates the relation between perceived racial discrimination and substance use in African American adolescents. *Journal of personality and social psychology, 102*(5), 1089.
Green, L. W., George, M. A., Daniel, M., Frankish, C. J., Herbert, C. J., Bowie, W. R., & O'Neill, M. (1995). Study of participatory research in health promotion. *Review and recommendations*

for development of participatory research in health promotion in Canada. Ottowa, Ontario: The Royal Society of Canada.
Grüsser, S. M., Wölfling, K., Mörsen, C. P., Albrecht, U., & Heinz, A. (2005). Immigration-associated variables and substance dependence. *Journal of studies on alcohol, 66*(1), 98-104.
Guy, H., Bertrand, B., & Philippe, B. (2005). Dictionnaire de la science politique et des institutions politiques: Paris: Armand Colin.
Haasen, C., Blätter, A., Gharaei, D., Toprak, M. A., Haferkorn, J., & Reimer, J. (2004). Psychosocial aspects of opiate dependence among Turkish migrants in Germany. *Journal of Ethnicity in Substance Abuse, 3*(1), 1-10.
Hagedorn, J. (2008). *A world of gangs: armed young men and gangsta culture* (Vol. 14): U of Minnesota Press.
Haker, F., van Bommel, H., & Bloemen, E. (2010). Zorg voor asielzoekers met psychische problemen. Amsterdam: ASKV/Steunpunt Vluchtelingen.
Heckathorn, D. D. (2011). Comment: snowball versus respondent-driven sampling. *Sociological Methodology, 41*(1), 355-366.
Hedström, P., & Swedberg, R. (1998). *Social mechanisms: An analytical approach to social theory*: Cambridge University Press.
Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and brain sciences, 33*(2-3), 61-83.
Hesse-Biber, S. N., & Leavy, P. (2010). *The practice of qualitative research*. London: Sage.
Hjern, A. (2004). Illicit drug abuse in second-generation immigrants: a register study in a national cohort of Swedish residents. *Scandinavian Journal of Public Health, 32*(1), 40-46.
Hooghe, M., & Vanhoutte, B. (2010). Subjective Well-Being and Social Capital in Belgian Communities. The Impact of Community Characteristics on Subjective Well-Being Indicators in Belgium. *Social Indicators Research, 100*(1), 17-36. doi: 10.1007/s11205-010-9600-0
Israel, B. A., Coombe, C. M., Cheezum, R. R., Schulz, A. J., McGranaghan, R. J., Lichtenstein, R., Reyes, A. G., Clement, J., & Burris, A. (2010). Community-based participatory research: a capacity-building approach for policy advocacy aimed at eliminating health disparities. *American Journal of Public Health, 100*(11), 2094-2102.
Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: assessing partnership approaches to improve public health. *Annual review of public health, 19*(1), 173-202.
Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (2001). Community-based participatory research: policy recommendations for promoting a partnership approach in health research. *Education for health, 14*(2), 182-197.
Jackson, M. S., Stephens, R. C., & Smith, R. L. (1997). Afrocentric treatment in residential substance abuse care: The Iwo San. *Journal of Substance Abuse Treatment, 14*(1), 87-92.
Jamoulle, P. (2010). Problemen in verband met de overdracht binnen families in volkswijken met een sterke concentratie van allochtonen. Samenvatting van een nota van Pascale Jamoulle in samenwerking met Manu Gonçalves. 2010: Koning Boudewijnstichting (KBS).
Jung, C. (2004). Immigration et toxicomanie. *Revue Toxicobase, 13*(1), 1-3.
Kagné, B. (2000). Africains de Belgique, de l'indigène à l'immigré: L'héritage colonial: Un trou de mémoire. *Hommes & migrations*(1228), 62-67.
Kamperman, A., Kamproe, I. H., & de Jong, J. T. V. M. (2003). De relatie tussen culturele aanpassing en psychische gezondheid bij 1e generatie Turkse, Marokkaanse en Surinaamse migranten. *Gedrag & gezondheid, 31*(3), 163-174.
Kanmaz, M. (2007). *Moskeeën in Gent: tussen subcultuur en sociale beweging: emancipatiedynamieken van moslimminderheden.* (Doctor), Universiteit Gent, Gent.
Karlsen, S., Nazroo, J. Y., & Stephenson, R. (2002). Ethnicity, environment and health: putting ethnic inequalities in health in their place. *Social Science & Medicine, 55*(9), 1647-1661.
Keygnaert, I., Dialmy, A., Manço, A., Keygnaert, J., Vettenburg, N., Roelens, K., & Temmerman, M. (2014). Sexual violence and sub-Saharan migrants in Morocco: a community-based

participatory assessment using respondent driven sampling. *Global Health, 10*, 32. doi: 10.1186/1744-8603-10-32
Khan, K., Zervoullis, K., Carpentier, C., & Hartnoll, R. (2000). Mapping available information on social exclusion and drugs, focusing on 'minorities' across 15 EU member states. *EMCDDA scientific report, Volumes I and, 2*.
Kim, D., Subramanian, S. V., & Kawachi, I. (2006). Bonding versus bridging social capital and their associations with self rated health: a multilevel analysis of 40 US communities. *J Epidemiol Community Health, 60*(2), 116-122. doi: 10.1136/jech.2005.038281
Knipscheer, J., & Kleber, R. (2005). Migranten in de ggz: empirische bevindingen rond gezondheid, hulpzoekgedrag, hulpbehoeften en waardering van zorg. *Tijdschrift voor Psychiatrie, 47*(11), 753-759.
Kokoreff, M. (2010). *La drogue est-elle un problème?: usages, trafics et politiques publiques*: Payot & Rivages.
Krieger, N. (2012). Methods for the scientific study of discrimination and health: an ecosocial approach. *American Journal of Public Health, 102*(5), 936-944.
Krieger, N. (2014). Discrimination and health inequities. *International Journal of Health Services, 44*(4), 643-710.
Kulis, S., Marsiglia, F. F., & Nieri, T. (2009). Perceived ethnic discrimination versus acculturation stress: Influences on substance use among Latino youth in the Southwest. *Journal of Health and Social Behavior, 50*(4), 443-459.
Lamont, M., & Molnár, V. (2001). How blacks use consumption to shape their collective identity evidence from marketing specialists. *Journal of Consumer Culture, 1*(1), 31-45.
Lantz, P. M., Viruell-Fuentes, E., Israel, B. A., Softley, D., & Guzman, R. (2001). Can communities and academia work together on public health research? Evaluation results from a community-based participatory research partnership in Detroit. *Journal of Urban Health, 78*(3), 495-507.
Laudens, F. (2013). Drugpreventie bij jongeren uit etnisch-culturele minderheden. Draaiboek voor het uitvoeren van een lokale verkenning en het opzetten van preventieve acties. (pp. 45). Brussel: Vereniging voor Alcohol en andere Drugproblemen (VAD).
Laurence, J. (2009). The Effect of Ethnic Diversity and Community Disadvantage on Social Cohesion: A Multi-Level Analysis of Social Capital and Interethnic Relations in UK Communities. *European Sociological Review, 27*(1), 70-89. doi: 10.1093/esr/jcp057
Leloup, X., & Radice, M. (2008). *Les nouveaux territoires de l'ethnicité*: 2305, rue de l'Université.
Lievens, J. (1999). Family-forming migration from Turkey and Morocco to Belgium: The demand for marriage partners from the countries of origin. *International migration review*, 717-744.
Lindert, J., Schouler-Ocak, M., Heinz, A., & Priebe, S. (2008). Mental health, health care utilisation of migrants in Europe. *European Psychiatry, 23*, 14-20.
Lodewijckx, E. (2014). Ouderen van vreemde herkomst anno 2011: Een korte demografische schets. In C. De Kock, E. Vens, & C. Van Kerckhove (Eds.), *Ouder worden in een veranderende samenleving*. Antwerpen: Garant.
Lodewyckx, I., Jansens, A., Ysabie, P., & Timmerman, C. (2005). Allochtone en Autochtone jongeren met psychische problemen en gedragsproblemen: verschillende trajecten naar de hulpverlening? : Steunpunt Gelijkekansenbeleid - Consortium Universiteit Antwerpen en Universiteit Hasselt.
Manço, A. (2004). *Reconnaissance et discrimination: présence de l'islam en Eruope occidentale et en Amérique du Nord.* . Paris: L'Harmattan.
Manço, A. (2012). *Approche sociodémographique de l'immigration turque en Belgique dans ses rapports aux autres populations*. IRFAM. Brussel.
Manco, A., Robert, M.-T., & Kalonji, B. (2013). Postcolonialisme et prise en charge institutionnelle des jeunes belgo-congolais en situation de rupture sociale (Anvers, Bruxelles). *African Diaspora, 6*(1), 21-45.

Marmot, M., Friel, S., Bell, R., Houweling, T. A., Taylor, S., & Health, C. o. S. D. o. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet, 372*(9650), 1661-1669.
Marmot, M., & Wilkinson, R. (2005). *Social determinants of health*: OUP Oxford.
Martiniello, M. (2013). Penser l'ethnicité. Identité, culture et relations sociales.
Martiniello, M., & Kagné, B. (2001). L'immigration subsaharienne en Belgique. *Courrier Hebdomadaire du CRISP, 1721*.
Maskens, M. (2013). Cheminer avec Dieu: Pentecôtismes et migrations à Bruxelles: Bruxelles, Editions de l'Université de Bruxelles.
Mazzocchetti, J., & Wayens, B. (2012). Gevoelens van onrechtvaardigheid en complottheorie. *Brussels Studies, 2012*(63).
Meys, E., Hermans, K., & Van Audenhove, C. (2014). Geestelijke gezondheidszorg en uitsluiting. In K. B. Stichting (Ed.). Leuvel: LUCAS Centrum voor zorgonderzoek & consultancy (KUL).
Minkler, M., Vasquez, V. B., Tajik, M., & Petersen, D. (2008). Promoting environmental justice through community-based participatory research: the role of community and partnership capacity. *Health Educ Behav, 35*(1), 119-137. doi: 10.1177/1090198106287692
Minsky, S., Vega, W., Miskimen, T., Gara, M., & Escobar, J. (2003). Diagnostic patterns in latino, african american, and european american psychiatric patients. *Archives of General Psychiatry, 60*(6), 637-644.
Missinne, S., & Bracke, P. (2012). Depressive symptoms among immigrants and ethnic minorities: a population based study in 23 European countries. *Social psychiatry and psychiatric epidemiology, 47*(1), 97-109.
Molina, K. M., Alegría, M., & Chen, C.-N. (2012). Neighborhood context and substance use disorders: a comparative analysis of racial and ethnic groups in the United States. *Drug and Alcohol Dependence, 125*, S35-S43.
Monshouwer, K. (2008). *Welcome to the house of fun: epidemiological findings on alcohol and cannabis use among Dutch adolescents*: Utrecht University.
Monshouwer, K., Smit, F., De Graaf, R., Van Os, J., & Vollebergh, W. (2005). First cannabis use: does onset shift to younger ages? Findings from 1988 to 2003 from the Dutch National School Survey on Substance Use. *Addiction, 100*(7), 963-970.
Mosavel, M., Simon, C., Van Stade, D., & Buchbinder, M. (2005). Community-based participatory research (CBPR) in South Africa: engaging multiple constituents to shape the research question. *Social Science & Medicine, 61*(12), 2577-2587.
Moselhy, H. F., & Telfer, I. (2002). The pattern of substance misuse among ethnic minorities in a community drug setting. *The European Journal of Psychiatry*.
Muhammad, M., Wallerstein, N., Sussman, A. L., Avila, M., Belone, L., & Duran, B. (2014). Reflections on Researcher Identity and Power: The Impact of Positionality on Community Based Participatory Research (CBPR) Processes and Outcomes. *Critical Sociology, 41*(7-8), 1045-1063. doi: 10.1177/0896920513516025
Muys, M. (2010). *Substance use among migrants: the case of Iranians in Belgium*. Brussels: VUBPRESS.
Negi, N. J. (2011). Identifying psychosocial stressors of well-being and factors related to substance use among Latino day laborers. *Journal of Immigrant and Minority Health, 13*(4), 748-755.
Nemoto, T., Aoki, B., Huang, K., Morris, A., Nguyen, H., & Wong, W. (1999). Drug use behaviors among Asian drug users in San Francisco. *Addictive Behaviors, 24*(6), 823-838.
Nieri, T., Kulis, S., Keith, V. M., & Hurdle, D. (2005). Body image, acculturation, and substance abuse among boys and girls in the southwest. *The American journal of drug and alcohol abuse, 31*(4), 617-639.
Noens, L., Soyez, V., & Thienpont, J. (2010). Bereiken, ondersteunen en begeleiden van familieleden van allochtone drugsgebruikers. *Verslaving, 6*(4), 72-83.
Oetting, E. (1994). Orthogonal cultural identification: Theoretical links between cultural identification and substance use. *NIDA research monograph, 130*, 32-32.

Oliemeulen, L., & Thung, F. H. (2007). *Ongehoord. Aansluitingsproblemen bij de behandeling van psychotische patiënten uit verschillende etnische groepen*. Antwerpen: Garant.
Otiniano Verissimo, A. D., Grella, C. E., Amaro, H., & Gee, G. C. (2014). Discrimination and substance use disorders among Latinos: the role of gender, nativity, and ethnicity. *American Journal of Public Health, 104*(8), 1421-1428.
Phinney, J. S. (1992). The multigroup ethnic identity measure a new scale for use with diverse groups. *Journal of adolescent research, 7*(2), 156-176.
Phinney, J. S., & Ong, A. D. (2007). Conceptualization and measurement of ethnic identity: Current status and future directions. *Journal of Counseling Psychology, 54*(3), 271-281. doi: 10.1037/0022-0167.54.3.271
Piérart, J., Bodeux, F., Francq, B., Snauwaert, B., Willems, S., & De Maeseneer, J. (2008). Stad en gezondheid. Een actieonderzoek in drie wijken (pp. 71). Brussel: Grootstedenbeleid.
Poirier, C. (2008). Peut-on encore parler de quartiers d'intégration ? Territoire et ethnicité à l'heure de mobilité. In M. Radice & X. Leloup (Eds.), *sous la dir., Les nouveaux territoires de l'ethnicité* (pp. 133-155). Québec: Les presses universitaires de Laval.
Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., Kluge, U., Krasnik, A., Lamkaddem, M., Lorant, V., Riera, R. P., Sarvary, A., Soares, J. J., Stankunas, M., Strassmayr, C., Wahlbeck, K., Welbel, M., & Bogic, M. (2011). Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. *BMC Public Health, 11*, 187. doi: 10.1186/1471-2458-11-187
Putnam, R. D. (1993). The prosperous community. *The american prospect, 4*(13), 35-42.
Putnam, R. D. (1995). Bowling alone: America's declining social capital. *Journal of democracy, 6*(1), 65-78.
Putnam, R. D. (2002). *Democracies in flux: The evolution of social capital in contemporary society*: Oxford University Press.
Rask, S., Suvisaari, J., Koskinen, S., Koponen, P., Molsa, M., Lehtisalo, R., Schubert, C., Pakaslahti, A., & Castaneda, A. E. (2015). The ethnic gap in mental health: A population-based study of Russian, Somali and Kurdish origin migrants in Finland. *Scand J Public Health*. doi: 10.1177/1403494815619256
Rassool, G. H. (2006). Substance abuse in black and minority ethnic communities in the United Kingdom: A neglected problem? *Journal of Addictions Nursing, 17*(2), 127-132.
Rastogi, M., & Wadhwa, S. (2006). Substance abuse among Asian Indians in the United States: A consideration of cultural factors in etiology and treatment. *Substance use & misuse, 41*(9), 1239-1249.
Reid, C. A., Lorraine Beyer, Nick Crofts, Gary. (2001). Ethnic communities' vulnerability to involvement with illicit drugs. *Drugs: education, prevention and policy, 8*(4), 359-374.
Rouws, G., Alleman, J., Gombault, B., Lisoir, H., Heyde, E. (2007). Beleidsaanbevelingen ongelijkheid in de gezondheidszorg. Brussel: Koning Boudewijstichting (KBS).
Sacré, C., Daumas, C., & Hogge, M. (2010). Usagers de drogues par injection en region Walonne.
Said, E. (1979). Orientalism. 1978. *New York: Vintage, 1994*.
Salganik, M. J., & Heckathorn, D. D. (2004). Sampling and estimation in hidden populations using respondent-driven sampling. *Sociological Methodology, 34*(1), 193-240.
Salsberg, J., Parry, D., Pluye, P., Macridis, S., Herbert, C. P., & Macaulay, A. C. (2015). Successful strategies to engage research partners for translating evidence into action in community health: a critical review. *J Environ Public Health, 2015*(2015), Article ID 191856, 191815 pp.
Sam, D. L., & Berry, J. W. (1995). Acculturative stress among young immigrants in Norway. *Scandinavian Journal of Psychology, 36*(1), 10-24.
Sangster, D., Shiner, M., Patel, K., & Sheikh, N. (2002). *Delivering drug services to black and minority ethnic communities*: Home Office.
Savage, J. E., & Mezuk, B. (2014). Psychosocial and contextual determinants of alcohol and drug use disorders in the National Latino and Asian American Study. *Drug Alcohol Depend, 139*, 71-78. doi: 10.1016/j.drugalcdep.2014.03.011

Scheppers, E., van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: a review. *Fam Pract, 23*(3), 325-348.
Schinkel, W. (2008). *De gedroomde samenleving*: Klement.
Schonlau, M., & Liebau, E. (2012). Respondent-driven sampling. *Stata Journal, 12*(1), 72-93.
Schoonvaere, Q. (2010). Etude de la migration congolaise et de son impact sur la présence congolaise en Belgique. *Analyse des principales données démographiques. Centre pour l'égalité des chances et la lutte contre le racisme, Bruxelles*.
Schoonvaere, Q. (2013). Etude Démographique de la Population Turque en Belgique: Bruxelles: Centre pour l'Egalité des Chances et la Lutte Contre le Racisme.
Schulz, A., House, J., Israel, B., Mentz, G., Dvonch, J., Miranda, P., Kannan, S., & Koch, M. (2008). Relational pathways between socioeconomic position and cardiovascular risk in a multiethnic urban sample: complexities and their implications for improving health in economically disadvantaged populations. *Journal of epidemiology and community health, 62*(7), 638-646.
Shattell, M. M., Hamilton, D., Starr, S. S., Jenkins, C. J., & Hinderliter, N. A. (2008). Mental health service needs of a Latino population: A community-based participatory research project. *Issues in mental health nursing, 29*(4), 351-370.
Simon, C., & Mosavel, M. (2010). Community members as recruiters of human subjects: Ethical considerations. *The American Journal of Bioethics, 10*(3), 3-11.
Sloboda, Z., Glantz, M. D., & Tarter, R. E. (2012). Revisiting the concepts of risk and protective factors for understanding the etiology and development of substance use and substance use disorders: Implications for prevention. *Substance use & misuse, 47*(8-9), 944-962.
Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in health care: Washington, DC: National Academies Press.
Suijkerbuijk, H. (2014). *Groenboek over de toegankelijkheid van de gezondheidszorg in België*. Waterloo: Wolters Kluwer Belgium SA.
Syme, S. L. (2004). Social determinants of health: the community as an empowered partner. *Prev Chronic Dis, 1*(1), A02.
Taïeb, O., Baubet, T., Ferradji, T., & Moro, M.-R. (2008). *Consommations d'alcool et de drogues, et migrations en Amérique du Nord: revue critique de la littérature.* Paper presented at the Annales Médico-psychologiques, revue psychiatrique.
Teunissen, E., Sherally, J., van den Muijsenbergh, M., Dowrick, C., van Weel-Baumgarten, E., & van Weel, C. (2014). Mental health problems of undocumented migrants (UMs) in the Netherlands: a qualitative exploration of help-seeking behaviour and experiences with primary care. *BMJ open, 4*(11), e005738.
Tieberghien, J., & Decorte, T. (2008). *Antwerpse Drug- en Alcoholmonitor. Een lokale drugscene in beeld*. Antwerpen: Acco.
Tonkiss, F. (2005). *Space, the city and social theory: Social relations and urban forms*: Polity.
Van buren, L., Beune, E., Kamperman, A., Nierkens, V., Stevens, G., Drogendijk, A., Hosper, K., Dotinga, A. (2010). Dataverzameling onder allochtone bevolkingsgroepen. In M. Foets, Schuster, J., Stronks, K. (Ed.), *Gezondheid(szorg)onderzoek onder allochtone bevolkingsgroepen: een praktische introductie*. Nederland: Aksant.
Van der Seypt, E. (2013). Het belang van interculturaliseren van de ouderenzorg. In C. De Kock, E. Vens, & C. Vankerckhove (Eds.), *Ouder worden in een veranderende samenleving*. Antwerpen Garant.
Van Kerckem, K., Van de Putte, B., & Stevens, P. (2013). On Becoming "Too Belgian": A Comparative Study of Ethnic Conformity Pressure through the City-as-Context Approach. *City & Community, 12*(4), 335-360. doi: 10.1111/cico.12041
Van Kerckem, K., Van de Putte, B., & Stevens, P. A. J. (2014). Pushing the Boundaries: Responses to Ethnic Conformity Pressure in Two Turkish Communities in Belgium. *Qualitative Sociology, 37*(3), 277-300. doi: 10.1007/s11133-014-9283-y

Vandevelde, S., Vanderplasschen, W., & Broekaert, E. (2003). Cultural responsiveness in substance-abuse treatment: a qualitative study using professionals' and clients' perspectives. *International Journal of Social Welfare, 12*(3), 221-228.
Vassart, C. (2005). Gezondheidszorg en diversiteit: het voorbeeld van de moslimpatiënten. Brussel: Koning Boudewijstichting (KBS).
Vega, W. A., Alderete, E., Kolody, B., & Aguilar-Gaxiola, S. (1998). Illicit drug use among Mexicans and Mexican Americans in California: the effects of gender and acculturation. *Addiction, 93*(12), 1839-1850.
Veling, W., Susser, E., van Os, J., Mackenbach, J. P., Selten, J. P., & Hoek, H. W. (2008). Ethnic density of neighborhoods and incidence of psychotic disorders among immigrants. *Am J Psychiatry, 165*(1), 66-73. doi: 10.1176/appi.ajp.2007.07030423
Verdurmen, J. E., Smit, F., Toet, J., Van Driel, H. F., & Van Ameijden, E. J. (2004). Under-utilisation of addiction treatment services by heroin users from ethnic minorities: results from a cohort study over four years. *Addiction Research & Theory, 12*(3), 285-298.
Verhaeghe, P.-P. (2013). Ruimtelijke segregatie van 'oude' en 'nieuwe' migrantengroepen in Gent. *Ruimte & Maatschappij, 4*(4), 7-35.
Verhaeghe, P.-P., Van der Bracht, K., & Van de Putte, B. (2012a). *Migrant zkt toekomst: Gent op een keerpunt tussen oude en nieuwe migratie*. Antwerpen: Garant.
Verhaeghe, P.-P., Van der Bracht, K., & Van de Putte, B. (2015). Inequalities in social capital and their longitudinal effects on the labour market entry. *Social Networks, 40*, 174-184. doi: 10.1016/j.socnet.2014.10.001
Verhaeghe, P.-P., Vanderbracht, K., & Van de Putte, B. (2012b). *Migrant zkt toekomst*. Antwerpen: Garant.
Vermeulen, H., & Governs, C. (2003). Antropologia da Etnicidade. Para além de. *Ethnic Groups and Boundaries, Lisboa, Fim de Século*.
Vertovec, S. (2007). Super-diversity and its implications. *Ethnic and Racial Studies, 30*(6), 1024-1054.
Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: structural racism, intersectionality theory, and immigrant health. *Soc Sci Med, 75*(12), 2099-2106.
Walleghem, P. (2013). Furor sanandi in psychotherapeutisch perspectief. *Ethiek en zorg in de hulpverlening: Over taboes gesproken*, 61.
Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. *American Journal of Public Health, 100*(S1), S40-S46.
Warnecke, R. B., Oh, A., Breen, N., Gehlert, S., Paskett, E., Tucker, K. L., Lurie, N., Rebbeck, T., Goodwin, J., & Flack, J. (2008). Approaching health disparities from a population perspective: the National Institutes of Health Centers for Population Health and Health Disparities. *American Journal of Public Health, 98*(9), 1608-1615.
Williams, D. R., & Collins, C. (2001). Racial residential segregation: a fundamental cause of racial disparities in health. *Public health reports, 116*(5), 404.
Wimmer, A. (2013). *Ethnic boundary making: Institutions, power, networks*: Oxford University Press.
Winchatz, M. R. (2006). Fieldworker or foreigner? Ethnographic interviewing in nonnative languages. *Field Methods, 18*(1), 83-97.
Woolcock, M., & Narayan, D. (2000). Social capital: Implications for development theory, research, and policy. *The world bank research observer, 15*(2), 225-249.
Young, J. (1971). *The drugtakers: The social meaning of drug use*: MacGibbon and Kee.
Zemni, S. (2009). *Het islamdebat*: EPO.