FEDERAL RESEARCH PROGRAMME ON DRUGS

MATREMI

MAPPING & ENHANCING SUBSTANCE USE TREATMENT FOR MIGRANTS AND ETHNIC MINORITIES

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Contract - DR/00/84

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The academic partners were responsible for the report. The professional partners were mainly responsible for disseminating and processing the national surveys and translating the survey results into a guidebook for use in substance use treatment (three months and support throughout the project). The identified inspiring practices are included in a 'Wegwijzer voor een toegankelijke en interculturele drughulpverlening / Recueil sur l'accessibilité et l'interculturalité des services pour usagers de drogues' (available online at www.belspo.be and in a book format via www.gompel-svacina.eu).

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The authors did their utmost best to analytically echo the voices of the consulted and interviewed experts and professionals. Nevertheless, the report is the sole responsibility of the authors. Finally, the recommendations were initially written in Dutch and translated into French and English. The texts may not be completely identical, but the spirit of the text and the recommendations are the same. Finally, we thank all the above mentioned experts and the interviewees (chapter 3, 7 and 8) for their contribution to this study as well as the Belgian Science Policy Office (Belspo) for giving us the opportunity to study these issues.

CONTENT

LIST OF ABBREVIATIONS

AMIF	Asylum, Migration and Integration Fund (EU)
BELSPO	Federal science policy office
CAD	*Centrum voor alcohol en andere drug* (centre for alcohol and other drugs)
CARUUD	*Centre accompagnement à la reduction des risques des usagers de drogue*
CAW	*Centrum algemeen welzijn* (general welbeing centre)
CBPR	Community-based participatory research
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CEOOR / UNIA	Centre for Equal Opportunities and Opposition to Racism / Belgian Equality Body
CERD	International Convention on the Elimination of all forms of Racial Discrimination
CGG / CSM	*Centrum geestelijke gezondheidszorg* (mental health care centre)
CIS	*Centraal informatiesysteem* (central information system)
CRPD	International Convention on the Rights of Persons with Disabilities
DPIA	Data Privacy Impact Assessment
DPO	Data Protection Officer
ECDC	European Centre for Disease Prevention and Control
ECRI	European Commission against Racism and Intolerance
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EPD	Electronic Patient File
ERDF	European Regional Development Fund
ERRC	European Roma Rights Centre
ESF	European Social Fund
EU	European Union
EU-MIDIS	European Union Minorities and Discrimination Survey
EU-SILC	European Union Statistics on Income and Living Conditions
FedAsil	Federal Agency for the reception of asylum seekers (Belgium)
FRA	European Union Agency for Fundamental Rights
GDPR	General Data Protection Regulation
HIV	Human Immunodeficiency Virus
HRDU	High risk drug use
ICCPR	Covenant on Civil and Political Rights (UN)
ICERD	Convention on the Elimination of All Forms of Racial Discrimination (UN)
ICESR	United Nations Covenant on Economic, Social and Cultural Rights
IDU	Injecting drug user(s)
INAMI / RIZIV	Federal Institute for Health Insurance
IOM	International Organization for Migration
KCE	Belgian Health Care Knowledge Centre (*Federaal Kenniscentrum voor de gezondheidszorg*)
MATREMI	Mapping and enhancing substance use treatment for migrants and ethnic
MEM	Migrants and ethnic minorities
MIPEX	Migrant Integration Policy Index
MPG / RPM	*Minimale Psychiatrische Gegevens* (minimum psychiatric data)
MSOC / MASS	*Medisch sociaal opvangcentrum (*Medico-social centre – heroin substitution)

NGO	Non-governmental organisation
NIN	National identification number
OCMW / PSCW	Public Centre for Social Welfare (CPAS in French)
OST	Opioid substitution treatment (e.g. methadone substitution)
PADUMI	Patterns of substance use among migrants and ethnic minorities (Belspo project)
PTSD	Post-Traumatic Stress Disorder
RCT	Randomised Controlled Trial
RIZIV / INAMI	National Institute for Health and Disability Insurance (*Rijksinstituut voor*
SES	Socio-economic status
SOCPREV	Social prevention of drug related crime (Belspo project)
SRAP	Addiction Prevention within Roma and Sinti Communities
STATBEL	Belgian statistical office
SUT	Substance use treatment
TDI	Treatment demand indicator
UN	United Nations
VAD	*Vlaams expertisecentrum Alcohol en andere Drugs* (Flemish expertise centre for alcohol and other drugs)
WHO	World Health Organisation

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1. INTRODUCTION

Charlotte De Kock, Tom Decorte

Migrants and ethnic minorities (MEM), especially refugees (Horyniak et al., 2016; Karl-Trummer et al., 2010) but also intra-European migrants and persons with a second, third and fourth generation migration background are often more exposed to trauma and social inequality (Marmot & Bell, 2016; Pickett & Wilkinson, 2010) when compared to non-MEM counterparts. These are important risk factors for mental health problems (Adler et al., 2016; Rechel et al., 2011; WHO, 2010a, 2010b). Nevertheless, significant disparities in the provision of (mental) health care and substance use treatment for MEM compared to non-MEM counterparts have been documented extensively across the continents (Margarita Alegría et al., 2008; Saloner & Lê Cook, 2013) and to a lesser extent in Europe (Dauvrin & Lorant, 2014; De Kock, 2019b; Devillé et al., 2011; Lemmens et al., 2017).

In Belgium, preliminary studies among migrants and ethnic minorities (MEM) demonstrate lower retention rates in substance use treatment, later first admittance, underrepresentation of females (Derluyn et al., 2008). Generalized inaccessibility to (mainly residential) substance use treatment for refugees and asylum applicants (Dauvrin et al., 2012; Derluyn et al., 2011; Matthei, 2007; Suijkerbuijk, 2014) and limited knowledge about substance use treatment among intra-European migrants, refugees and asylum applicants (De Kock & Decorte, 2017; De Kock, Decorte, Derluyn, et al., 2017; De Kock, Decorte, Schamp, et al., 2017).

1.1 First caveat: Insufficient migration & ethnicity related indicators in substance use treatment

A large caveat in literature and research consist of the fact that statistics about the presence of varying MEM populations in substance use treatment are not readily available in Belgium because scientifically sound migration and / or ethnicity related indicators – as studied in for example the educational (Agirdag & Korkmazer, 2015) and labour domain (Van der Bracht et al., 2015a) – are not standardized in substance use treatment data.

Jacobs and colleagues (2009) argue that, contrary to other European member states, ethnicity and migration related registration has become a taboo or even deemed 'inappropriate' in Belgium, resulting in a 'non-choice' concerning census registration since the nineties (Perrin et al., 2015). Since 2007, considering the propositions formulated by the High Council for Statistics, the Statistical Office does distinguish in population statistics between native and foreign-born Belgians by identifying people born as foreigners and Belgian nationals at birth. Additionally, recent efforts in analysing inequities in the labour market seem to signal that perspectives are shifting (UNIA, 2017).

In the substance use treatment domain – as is the case in the other EU member states, Turkey and Norway – Belgium uses the European Treatment Demand Indicator (TDI), a European registration instrument that allows to compare standardized data about service users entering substance use treatment across European member states (Antoine et al., 2016; Montanari et al., 2019; Van Baelen et al., 2018). However, in the third TDI protocol (2012), the 'nationality' indicator has been omitted.

Consequently, this indicator[1] was also omitted as an obligatory variable in Belgian national registries in 2015.

The nationality indicator is indeed a flawed proxy for ethnic or migration background because it does not capture the complexity of migrant generations or (multiple) self-identification (De Kock, Decorte, Vanderplasschen, et al., 2017; Hunt & Kolind, 2017). Moreover, the use of only this indicator does not allow for adequate intersectional analysis (Agirdag & Korkmazer, 2015), nor does it account for current and changing nationality legislation. Lastly, individuals that change their nationality over a lifetime cause bias in the resulting statistics (Perrin et al., 2015).

Nevertheless, European debate is unravelling about the necessity to include indicators that would allow to monitor ethnicity and / or migration background in the health domain (Farkas, 2017a) without stigmatizing specific groups. The European Commission on Racism and Intolerance (ECRI) for instance advocates for the collection of anonymized scientifically sound ethnicity related proxies, indicators and variables, based on the monitoring requirements mentioned in the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD in Simon, 2012).

A recent study on data collection in the field of ethnicity commissioned by the European Commission (Farkas, 2017a, 2017b, 2017c, 2017d) reports that Belgium has no specific legislation on the collection of 'ethnic equality data'. Additionally, the report signals issues related to data comparability between different institutional levels because the Belgian state, the governments, provinces and municipalities use different operationalisations of origin and/or migration background.

A need for finding midway solutions – in line with the current European General Data Protection Regulation (GDPR) – arises if we want to comply with ICERD in the domain of SUT. Contrary to census registration in countries such as the USA, Canada and Australia – that administer specific MEM groups by using respectively pre-defined census registration categories and multiple self-description (Perrin et al., 2015; Jacobs et al. 2009) – as well as Finland, the Netherlands and Norway no such relevant indicators are registered in Belgian substance use treatment. This type of data is essential to monitor substance use treatment for, and evaluate policies that target these populations.

1.2 Second caveat: Little targeted interventions to meet migration and ethnicity related needs in treatment

The 2019 EMCDDA programming document (EMCDDA, 2019, p. 9) states that:

> "Many migrants have lower rates of substance use than their host communities, but some may be more vulnerable to substance misuse for reasons such as trauma, unemployment and poverty, loss of family and social support, and the move to a normatively lenient setting; furthermore, these factors can be more severe in women and girls, as a result of experiences during migration (violence, sexual exploitation, loss of family members). These groups may be at risk of developing drug problems. There is a need therefore to increase awareness of vulnerabilities and reduce social exclusion of these people."

[1] The Belgian TDI protocol used to monitor client nationality and whether he or she had a EU or non-EU background.

Belgian substance use treatment services face complex questions regarding reach and retention of and accessibility for (potential) MEM service users, especially regarding intra-European (Blomme et al., 2017; De Kock, Decorte, Schamp, et al., 2017), female service users (De Kock, Blomme, et al., 2020; Derluyn et al., 2008) and asylum applicants and (recognized) refugees (Dauvrin et al., 2012; De Kock, Decorte, Schamp, et al., 2017). Targeted sensitizing initiatives about problem use and substance use treatment services have been recommended among intra-European migrants (De Kock, Decorte, Schamp, et al., 2017), asylum applicants and refugees but also persons with an 'older' second, third and fourth generation migration background (El Osri et al., 2012; Laudens, 2013). Furthermore, a focus on outreach work and mobile services for increasing the accessibility of substance use treatment for MEM injecting substance users as well as the monitoring of the 'urgent medical care' principle among refugees and asylum applicants in need of substance use treatment (Sacré et al., 2010, p. 212), have been recommended.

Nevertheless, streamlined action in SUT policy and practice within the framework of an integrated and integral drug policy have not been implemented in Belgium yet (Interministerial Conference on Drugs, 2011: 21446). Moreover, EMCDDA considered the availability of selective prevention interventions for 'ethnic minority groups' in Belgium to be 'rare' in 2015-2016. Additionally, an EMCDDA background study reports that substance use treatment is generally not prioritised in delivering healthcare to newly arrived asylum seekers (Lemmens et al., 2017, p. 13).

1.3 Research questions

In line with the above described double caveat in literature, MATREMI addresses a twofold research question:

Research question 1: How can we better register and monitor MEM service user presence in Belgian substance use treatment?

- Which migration and ethnicity related indicators are used in 1) TDI registration in the EU members states and 2) the domains of labour, integration and substance use treatment in Belgium?
- Can we use the identified registration methods to inform registration in Belgian substance use treatment, and more specifically TDI?

Research question 2: Which inspiring practices in the EU-28 member states and Belgium in particular, exist to increase substance use treatment reach and retention of and accessibility for specified (potential) MEM service users?

- How do SUT professionals experience service delivery among MEM?
- What are the main goals: reach, access and / or retention?
- Which are the targeted populations?
- In which domain are these practices located (prevention, treatment, harm reduction)?
    - (how) Are these practices evaluated?
    - Which caveats can be identified and translated into recommendations for research, policy and SUT practice?

1.4 Main research goals

The first objective of the MATREMI project is to inform Belgian substance use treatment policy on ethnicity and migration related indicators by mapping ethnicity and migration related TDI variations across the EU-28 member states as well as to map database coupling methods (census and other registers) aimed at insight in MEM presence and trajectories in substance use treatment.

The second MATREMI objective is to identify inspiring practices in or aimed at substance use treatment to increase reach and retention of and accessibility for (potential) MEM services users in Belgian substance use treatment.

1.5 Timeline, methods and work packages

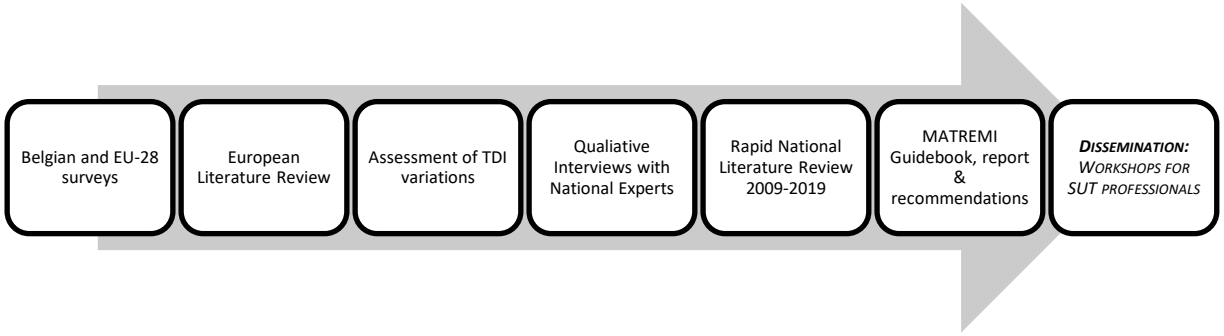


Figure 1: MATREMI Timeline and methods

The double objective of mapping (practices) and assessing (indicators) (see above: main goals) in the **European context** were reached by using three main methods:

- **A survey to the EU-28 Reitox National focal points** and stakeholders to identify inspiring practices;
- **A purposively targeted survey to European SUT services** to identify inspiring practices;
- **A synthesis of European review studies and Reitox national drug reports (2012, 2014).**

For the **national context**, the first objective included mapping existent indicators in other domains (work, education, integration) as well as indicators in substance use treatment datasets, other than the TDI register. The second national objective included mapping inspiring practices in Belgium. The following methods were used:

- **Qualitative semi-structured interviews with Belgian professionals** in SUT and mental health;
- **A rapid national literature review** of academic and grey literature on 1) ethnicity and migration related indicators and 2) substance use treatment for MEM (2009-2019);
- **A survey to all specific SUT services** to identify migration and ethnicity related registration methods in SUT.

These methods are elaborated upon throughout this report (see 'methods' sections).

2. THE STATE OF HEALTH AND SUBSTANCE USE AMONG MEM IN THE EU

Charlotte De Kock

Monitoring the state of health of migrants and ethnic minorities (MEM) compared to non-MEM counterparts is difficult in Europe because of varying definitions and poor disaggregation of data by migrant type across the member states (WHO, 2018, p. 12). Some studies document a higher susceptibility for bad health (e.g. higher admission rates for schizophrenia compared to 'native' populations, Selten and Sijben, 1994 in Rechel et al., 2011 p. 170) whereas others document lower susceptibility for specific health issues (e.g. 'the healthy migrant effect' and mental disorders among migrants, Carta et al., 2005 in Rechel et al., 2011 p. 170). Similarly, there is very little and dispersed data available concerning the prevalence of (the spectrum from recreational to harmful) substance use in these populations.

Indeed, investments are needed in the European Health Surveys to guide member states in gathering more knowledgeable and representative data among these populations. For good prevalence estimates it is necessary to include valid indicators, to distinguish between recreational and harmful substance and to have representative (sub) population samples. However, population prevalence alone, as stated by Ritter et al. (2019, p. 22) "*is limited in its usefulness unless it is matched with consideration of different treatment types and their relative intensity, and/or explored as a function of geography and subpopulation*".

Consequently, we will not attempt to give an exhaustive overview of substance use prevalence rates across the EU-28 member states but will refer to previous studies on this matter. In what follows, we intend to sketch the broader health context of harmful substance use and SUT for MEM in the EU-28 member states to set the scene for this research project.

We start out by briefly introducing and explaining the importance of an ecosocial perspective on substance use and treatment (2.1). We proceed by analysing treatment demand trends among MEM in the EU-28 member states by analysing the 2012 and 2014 Reitox national drug reports (2.2). Finally, the discussion section focusses on the vulnerable MEM populations identified in the Reitox national drug reports (2.3).

2.1 An ecosocial perspective on substance use and treatment[2]

Zinberg's drugs-set-setting trilogy (1984) traces **the reasons for different degrees of substance use** (ranging from recreational to problem use) back to characteristics related to the substance, the individual and the environment. This trilogy of reasons for substance use can be supplemented with an socio-ecological framework that traces back the interrelated mechanisms of both **substance use and disparities in treatment** among MEM[3] (Alegría, Pescosolido, et al., 2011; Krieger, 2011). It allows for understanding the individual (micro), environmental (meso) and societal (macro) factors

[2] Part of this subsection was published De Kock, C. (2020). Risk factors and dangerous classes in a European context: The consequences of ethnic framing of and among Turkish drug users in Ghent, Belgium. In B. Thom & S. MacGregor (Eds.), Alcohol, drugs and risk in historical and cross-cultural perspective: Framing dangerous classes and dangerous spaces. Oxfordshire: Routledge.

[3] based on Alegria's socio-cultural framework (Alegría, Pescosolido, Williams, & Canino, 2011) and Krieger's view on the epidemiology of the people's health (Krieger, 2011)

at both substance user / client and provider level that can conjointly influence both substance use and treatment (De Kock, 2019a).

Similarily, Martiniello (2013) proposes studying 'ethnicity' at a micro-level (subjective feeling of belonging), meso-social level (ethnic group) and macro-level (policy and structural constraints). Similarly, the eco-social health perspective (Krieger, 2012) posits that treatment barriers and causes of disease are located at the micro-level (client and provider), meso-level (service provision) and macro-level (health care policy and dominant theoretical scope) (see e.g. Andrade et al., 2014; Scheppers et al., 2006). This framework has been elaborated upon by Alegria who hypothesises that "*disparities in substance use services arise when disadvantages in the health care system interact with those in the community system*" (Alegria et al., 2011, p. 377).

I add to the eco-social perspective of both ethnicity and health inequities the claim that access barriers as well as root causes for problem use are not only located at one or the other level but that the same 'barrier' and root cause should also be considered intersectionally at all three levels and both among (potential) clients and among providers. It follows that root causes for problem use will be located at intersections of client micro-, meso- and macro-levels and that access and quality in treatment can be located in these same intertwinements adding the actor of the treatment provider (micro), treatment service (meso) and broader health system (macro) (see Figure 2).

It goes without saying that the intertwinement of micro-, meso- and macro-levels is co-produced by subjective self-understanding and external framing of actors at all levels. In other words, the framing of ethnic minority and migrant clients among providers (as citizens), services and health systems will influence problem use, access and quality of care among (potential) clients.

We depart from Weber's notion of ethnicity as the social construction of differences in social relations instead of objective differences between groups. This is in line with the idea that ethnicity is a means to create boundaries that enable groups to distance themselves from one another (Barth, 1969/1998). Consequently, the boundaries that define ethnicity and the actors that are most persuasive or influential in creating and framing these boundaries are more significant to us than the 'cultural stuff' perceived to be enclosed within them (Wimmer, 2013).

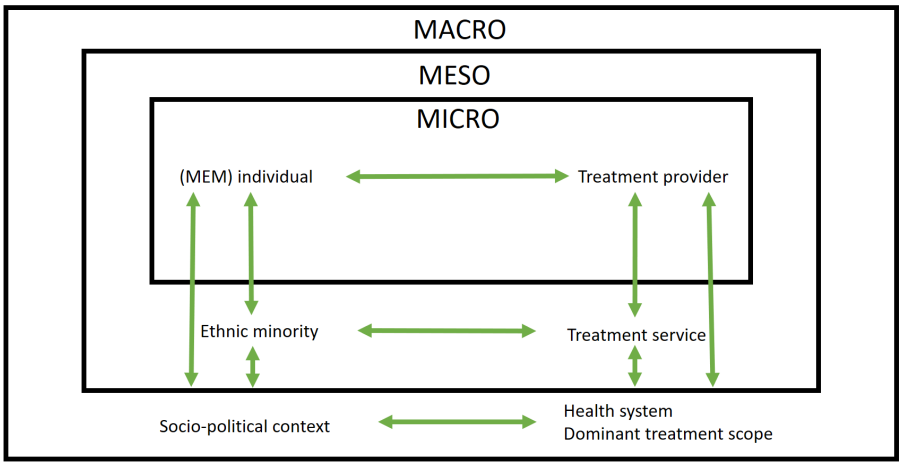


Figure 2: An ecosocial perspective on problem substance use and treatment among MEM: adaptation from Krieger and colleagues *2013 (Epidemiology and the People's Health)* (De Kock, 2020)

2.1.1 Macro: Lower access to general health care

Universal health coverage is endorsed by both the WHO and the UN as a core component of sustainable development and as a priority of every health system (Abiiro & De Allegri, 2015). The UN's 'AAAQ framework' states that "*all [health] services, goods and facilities must be available, accessible, acceptable and of good quality*" (UN, 2008, p. 3).

Equitable health care in turn is achieved when "*people with equal needs receive similar care (horizontal equity) or when people with greater needs are provided with specific care that meets these needs (vertical equity)"* (Starfield, 2001). Dauvrin and colleagues (2019, p. 41) operationalised this definition by adding that equitable health care consists of (i) equal access for equal needs, (ii) equal treatment of equal needs, (iii) equal outcomes for equal needs.

The MIPEX questionnaire (IOM, 2016) – disseminated within the framework of the EQUI-HEALTH project – ranked European countries by their degree of equitability of health policies for migrants by means of four indicators:

- Migrants' **entitlements** to health services;
- **Accessibility** of health services for migrants;
- **Responsiveness** to migrants' needs;
- **Measures** to achieve change.

Figure 3 demonstrates that the Baltic States, Poland, Greece, Slovenia and the Czech Republic score lowest whereas Norway, UK, Italy and Switzerland score highest using these indicators.

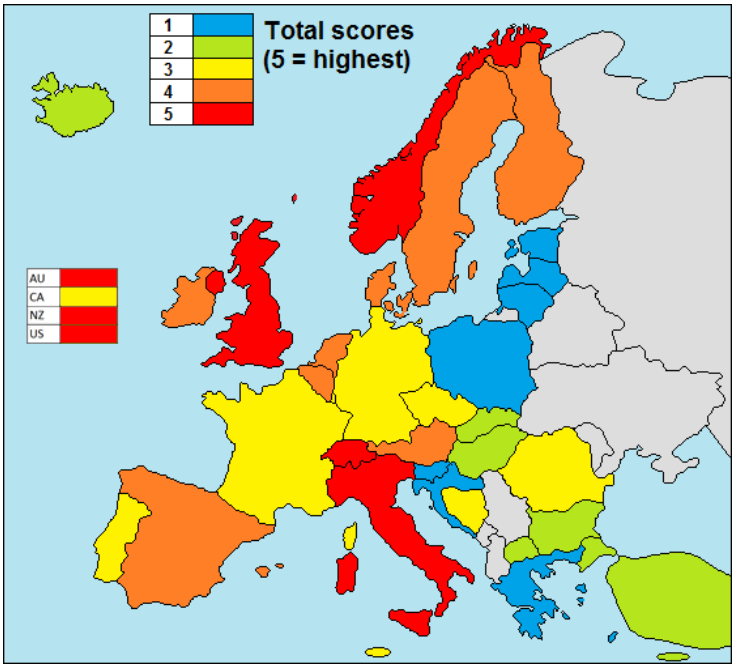


Figure 3: Map showing total scores on the MIPEX health strand (divided according to rank order into 5 groups of roughly equal size) (IOM, 2016, p. 2)

A comparative study of the right of **access to health care for undocumented migrants**[4] in 27 EU member states (Cuadra, 2012) demonstrated that in 2011, only 5 countries granted undocumented migrants a right to access care that is more extensive than emergency care. In 12 countries they could only access emergency care and in 10 countries even emergency care was inaccessible for this population. Some scholars argue that this limited access to national health care systems is used as 'a weapon' in immigration control, urging to detach health care from immigration control (Karl-Trummer et al., 2010).

Detollenaere and colleagues (2017) found that in European countries income inequality, primary care work force development as well as accessibility of primary care are significantly related to **inequity in unmet healthcare needs**. The authors subsequently hypothesise that reducing income inequality reduces access inequities and that strengthening primary care systems by means of workforce development reduces inequity in unmet need. These are important findings considering that primary care in many European countries is the first entry-point to the health system while vulnerable groups experience most barriers in accessing healthcare (Dahlgren & Whitehead, 1991).

Lastly, Dauvrin and colleagues (2019) identified the following inequities at the micro level in Belgian health care that are inextricably related to the above mentioned macro issues:

- Inequity in access caused by geographical availability and accessibility, cultural, linguistic and administrative barriers as well as the heterogeneity in the freedom of choice of a professional.
- Inequity in treatment caused by a lack of uniform health coverage, a lack of evaluation of the health status upon arrival and departure in asylum facilities, poor implementation of guidelines and a lack of access to mental health care.

Even though most high-income countries have invested – be it with limited success – considerably in nationwide (mental) health equity programmes, the European Union is lagging behind when it comes to its research and political agenda to analyse and reduce health (care) and SUT disparities among MEM. Nevertheless, the 2010 World Health Organisation report on the health of migrants identified migrants as a group particularly at risk of mental disorders in Europe (IOM, 2010).

2.1.2 Meso: Organisational issues and barriers

Barriers at the health service level may reduce the willingness of professionals to treat patients with a migration background and can also influence the quality of care provided to them (at the micro level). Very little research has been conducted concerning the organisation of substance use treatment services for the broad group of migrants and ethnic minorities. What is known from large scale service studies in the United States is that a combined focus on the following aspects are of importance at the service level: **knowledge (about MEM), outreach, personnel involvement, resources, policies and procedures, hiring and retention of MEM personnel. This combined set of knowledge, service practices and personnel practices can only work to reduce service level disparities in the presence of what Guerrero and colleagues defined as transformational leadership that is open to diversity (Guerrero et al., 2017).**

[4] Undocumented migrants are those third-country nationals without a valid permit authorising them to reside in EU member states, including asylum applicants that have been unsuccessful or those in violation of the terms of their visa ('overstayers'), an estimated 7 to 13% of the total EU foreign population in 2008. (Vogel, D. Size and development of irregular migration to the EU CLANDESTSINO Research project.)

Dauvrin and colleagues (2019) in a report on equitable health for asylum applicants in Belgium, discern the following hindering service issues (in Belgium):

- **Unclear administrative system** (e.g. for Urgent Medical Care);
- **Differences in health systems dependent on the residence** (e.g. difference between OCMW / CPAS);
- **Lack of professionals qualified** to interact with these populations;
- **High turnover** of health professionals in asylum centres;
- **Reluctance and / or overburdening** of (some) health professionals;
- **Unclear collaboration** between actors involved in asylum seekers health;
- Tensions regarding **confidentiality**;
- Lack of appropriate **health information**.

2.1.3 Micro: Risk factors and inequities in access, treatment and outcomes

At the individual micro-level, we distinguish between inequities in access, treatment and outcomes, on the one hand (Dauvrin et al., 2019) and the reasons for substance use and risk factors on the other hand.

Reasons for substance use

Genetic, neurobiological, and behavioural individual risk and protective factors as identified and studied extensively in general populations (e.g. Hawkins et al., 2008; Sloboda, Glantz, & Tarter, 2012) are of course equally important among MEM. However, as pointed out in the WHO European Region report on the Health of Refugees and Migrants (2018), different subgroups (e.g. asylum applicants, undocumented migrants, disadvantaged ethnic minorities, labour migrants, female sex workers etc.) live in different circumstances that correspond to varying vulnerabilities.

There is strong evidence that some MEM populations are more exposed to **structural inequalities** (IOM, 2010; Marmot, 2016; Marmot & Bell, 2016; Puchner et al., 2018; Rechel et al., 2011). A 2008 EMCCDA report (2008) on drugs and vulnerable groups of young people for instance notes that a group's exposure to social disadvantage or inequality may result in limited individual choice and lead to earlier, more frequent or more problem substance use.

Migrants and ethnic minorities, especially refugees and asylum applicants but also intra-European migrants and persons with a second, third and fourth generation migration background are for example often more exposed to **trauma** (Karl-Trummer, Novak-Zezula and Metzler 2010; Horyniak, 2016) and **social inequality** (Marmot and Bell 2016; Pickett and Wilkinson 2010; Verhaeghe et al. 2014; Boone et al. 2016) when compared to non-MEM counterparts.

The WHO report on migrant health in Europe (WHO, 2018) sums up the following risk factors that are considered as morbidogenic conditions related to migrant health (Lindert & Schimina, 2011; Puchner et al., 2018; WHO, 2010b): **transit and travel conditions, mode and duration of travel, loss of family and friendship networks, (Acculturation and / or post-traumatic) stress.**

The WHO European report on migrant sensitive health (WHO, 2010b) notes that the assumption that **socio-economic status** (SES) is a confounder among MEM when describing health and treatment inequities in general populations, has large consequences on policy making in Europe. Most importantly, this presumption results in a lack of targeted health interventions. The WHO report notes that socio-economic status (SES) could well be considered a mediator instead of simply a confounder.

SES is considered in this WHO report to be part of the causal chain between migration status or ethnicity and health. A common mistake is to assume that if health differences in MEM disappear when socio-economic status (SES) is controlled for, the 'real' determinants of health are socioeconomic ones and consequently do not require MEM targeted interventions. The report consequently argues that *"policies to reduce health inequalities which do not take migrant status and ethnicity into account can only have limited success in countries where these groups are numerically significant and are not treated equitably"* (p. 9).

Inequities in access, treatment and outcomes

The most common way to measure health access at client level is 'self-assessed unmet need'[5] (Carr & Wolf in Detollenaere et al., 2017, p. 2). An analysis within the framework of the QUALICOPT project (Hanssens et al., 2016) demonstrated that in 31 European countries, people with a migration background[6] were disadvantaged during the **health care process**. This study indicates that satisfaction with the health care process improved for second-generation migrants in comparison with first-generation migrants although it remained significantly lower compared to non-migrant counterparts. These authors used **opening hours, distance to practice, patient-GP interaction and continuity of care** as indicators for respectively access and quality of health care.

Moreover, a systematic review (Norredam et al., 2009) demonstrated differential **utilization of somatic healthcare services** by first generation migrants compared to non-migrants in Europe. Relevant to the MATREMI study is that migrants tended to have more contacts per patient with general practitioners but less use of consultation by telephone, and same or higher levels of use of specialist care compared to non-migrants. Emergency room utilization analysis had dispersed results in this study, demonstrating both higher, equal and lower use compared to non-migrants across the member states. Hospitalisation rates in turn were higher or equal to non-migrant hospitalisation rates. Interestingly, several of the included studies demonstrated that, nor socio-economic status nor health status could account for the reported differences, implying that other issues (e.g. discrimination) confound these results.

Asylum applicants, refugees, undocumented migrants

Little studies have been conducted in Europe concerning (problem) substance use among asylum applicants, refugees and undocumented migrants (Priebe et al., 2016). A study identified by Priebe and colleagues (2016) (Bogic et al., 2012) found substantial differences between receiving countries concerning the rates of substance use disorders among resettled refugees: 11.8% of refugees in Germany had any substance use disorder, compared with 1.7% in England and 0.7% in Italy; 4.7% of refugees in Germany had alcohol dependency, compared with 0.7% in England and 0.3% in Italy.

[5] Defined as 'the differences, between those services judged necessary to deal appropriately with defined health problems and those services actually being received'

[6] Defined as birthplace of the patient or mother (Rumbaut, 2006)

The authors suggest that substance use patterns may be influenced by social norms in the host country (Priebe et al., 2016).

An earlier review that was not included in Priebe and colleagues' study (Horyniak et al., 2016) among **refugees, internally displaced people and asylum seekers** concluded that there is a limited understanding of substance use among forced migrants, particularly regarding persons displaced due to disasters and deportation. They further found that prevalence estimates of hazardous/harmful alcohol use ranged from 17%-36% in camp settings and 4%-7% in community settings and that **male sex, trauma exposure and symptoms of mental illness** were commonly identified correlates of substance use (Horyniak et al., 2016, p. 1).

The seminal '*Migration and health in the European Union*' report (Lindert and Schinina in Rechel et al., 2011) indicates that asylum applicants and refugees **are more likely to be exposed to risk factors for mental health disorders such as exclusion and discrimination** (Stillman et al., 2009 in Rechel et al., 2011), on top of the higher stress levels due to uncertainty of living conditions and acculturation (the so-called **migration morbidity hypothesis**) and post-traumatic stress. Lindert (2011) further specifies that being exposed to political violence prior to migration, is an extra risk factor for psychopathology.

The WHO European Region report on the Health of Refugees and Migrants (2018) remarks that apart from post-traumatic stress disorder (PTSD), the rates of psychotic, mood and substance use disorders among refugees, asylum seekers and irregular migrants appear to be similar to those found in host countries. Indeed, a systematic review of post-traumatic stress disorder among **resettled refugees** in western countries reports an overall high prevalence of 9% of PTSD, but hypothesises that substance use prevalence can be supposed to approximate prevalence in general populations with time (Priebe et al., 2016).

A large scale Dutch study nuances that it may rather be current stress and lack of resources in the host country on top of traumatic stress that leads to PTSD and depression among **mental healthcare-seeking refugees** (Knipscheer et al., 2015). Moreover a study among 270 **return migrants** concluded that criminalisation of migration in policy and public discourse has detrimental effects among these populations (Kubal, 2014). Lindert and colleagues too, stress that **post-migration experiences including formal access to health care, needs matching and competence in the health system influence both the development of psychopathology as well as help seeking behaviour.**

As mentioned above, only a minority of member states offers full access to health services to **undocumented migrants** (Cuadra, 2012). Kuchner and colleagues (2018, p. 3) argue that

> "the EU health response [to peak influx of refugees and migrants] is predominantly emergency-driven. (…) The policies and operations remain-short-term financed, short-sighed, and essentially unharmonized with the international obligations of the EU".

A systematic review on the **use of healthcare services by undocumented migrants in Europe** (Winters et al., 2018) cautiously identifies a low utilisation of primary healthcare services, a high prevalence of PTSD and subsequent reception of individual or group psychotherapy. The study also indicates that in many countries undocumented migrants **rather visit hospital services instead of general practitioners**. Finally, almost all included studies point out an **implementation gap: a discrepancy between formal entitlement to health care and actual utilisation of services.**

This implementation gap is also confirmed in a scoping review on **refugees' and asylum applicants'** experiences of health care (Mangrio & Forss, 2017). Mainly communication barriers in the broad sense, are discussed: low communication of health rights, concrete language barriers between client and provider, lack of trust in interpreters or unavailability of interpreters, not being asked or really listened to (sufficiently) and perceiving discrimination in the health care setting. **Moreover, these communication barriers result in a lack of knowledge and trust and contribute to underutilisation, lower care continuity, lower satisfaction and subsequent treatment success rates.**

Roma[7]

In a communication to the European Parliament, The European Commission estimated that about 10 to 12 million European citizens are Roma, and notes that many of them face **prejudice, intolerance, discrimination and social exclusion** in their daily lives (COM(2011) 173 final). Indeed, Roma are often disadvantaged EU citizens both in their native countries and in the member states they migrate to.

Roma in many eastern European countries do not have (sufficient) access to health services due to structural discrimination as will be documented below. The existence of institutional discrimination in for example Romania has recently been corroborated by the European Court of Human Rights (ERRC, 2019). Roma in France[8], Hungary[9] and Slovakia[10] have been documented to have insufficient access to safe and affordable drinking water and sanitation and many Romani households do not have access to water and sewerage due to discrimination (ERRC, 2017, p. 37), resulting in subsequent health problems. In Bulgaria, about 30% of Roma are reported not to be registered at a general practitioner. Moreover, the ERRC documents involuntary sterilisation of Roma women in Czechia, Slovakia and Hungary as well as the existence of segregated hospital units with poor services (ERRC, 2016).

The second European Union Minorities and Discrimination report (FRA, 2017) observes that Roma respondents experience the highest rates of discrimination in access to health compared to other national and ethnic minorities. The highest rates were recorded in Greece, Romania, Slovakia and

[7] The Council of Europe uses 'Roma' as an umbrella term. It refers to Roma, Sinti, Kale and related groups in Europe, including Travellers and the Eastern groups (Dom and Lom), and covers the wide diversity of the groups concerned, including persons who identify themselves as Gypsies (FRA, 2017, p. 12).

[8] According to interviews the ERRC conducted with gens de voyage, water access is cut if people miss paying the fee. Despite the fact that since 2015, French law forbids disconnecting people from water due to paying arrears,80 our research indicates that managers of halting sites for Travellers across France continue cutting the water regardless (ERRC 2017, p. 27).

[9] In Krásnohorské Podhradie, there was a water leak under the public road in summer 2015 (which the water company fixed only after some weeks) which led to a large invoice of several thousand Euro for the Roma association. Neither municipality nor the water supplier assumed any responsibility for this situation. The association could not pay the unusually large bill, and ultimately all Romani houses were cut off from water. In a similar situation to Krásnohorské Podhradie, the Roma association in Szeged is held fully accountable for water distribution complications in the settlement (ERRC 2017, p. 26).

[10] ERRC submitted water from the well to a certified water lab in Košice in May 2014 and the test results revealed that the quality of the water was poor and significantly contaminated by nitrogen. The mayor does not consider the settlement a part of her municipality (she declared to the ERRC and UNDP researchers that there was 100% water pipe coverage in her town) (ERRC 2017, p. 26).

Croatia[11]. The SRAP report (2012) identifies three main types of barriers to health services for Roma: **administrative barriers** (lack of entitlement), **barriers related to orientation to the health system** (continuity of care and finding the right services) and **lack of access to information**.

Concerning substance use, international and domestic data are quoted to be inconsistent mainly because of underreporting in large scale samples, low comparability and / or methodological quality (Rácz et al., 2012). The SRAP report (2012) on 'addiction prevention' in Roma and Sinti communities alerts that:

> "The few studies concerning the health and addiction problems among (…) Roma, are quite alarming regarding the health disparities and differences in levels and incidence of substance consumption. Research conducted on drug consumption in Roma groups in Ireland (EMCCDA, 2008), Hungary (Gerevich, Bacskai, Czobor, & Szabo, 2010), Bulgaria (EMCCDA, 2009), Finland, Spain, Portugal (EMCCDA, 2002) have indicated worrying tendencies such as early ages for the initiation of tobacco and alcohol consumption, higher lifetime prevalence for all types of drugs, stigma and concealment of consumption. Fundación Secretariado Gitano's research on the health of the Roma pointed out that there are high percentages of households where at least one member has an alcohol and/or drug problem, especially in Bulgaria, Greece and Czech Republic, with an average of 11.4 % of the households in all contexts." (SRAP, 2012, p. 4).

A review of research on Roma substance use in Czechia and Slovakia (Kajanová & Hajduchová, 2014), cited in the 2013 Czech Reitox national drug report (Mravčík et al., 2014) notes that the most commonly used drugs are reported to include **buprenorphine, cannabis, toluene and other inhalants, heroin, and methamphetamine.**

Moreover, the 2012 Roma Minority Report (in SRAP, 2012) suggests that substance use and gambling are among the negative phenomena which accompany **social exclusion**. In the report, substance use was described as an escape strategy from a hopeless situation but also as a trigger for criminal behaviour. The authors of SRAP observe that Roma respondent beliefs and values about substance use **were not strictly 'ethnic' or specific to Roma culture and that patterns of consumption varied considerably between and within the studied communities.**

Moreover, worrying trends identified among Roma adolescents were the early onset of tobacco consumption (11-12 years old), exposure to binge drinking or alcoholism by adults, underestimation of the consequences of substances such as cannabis, amphetamines and cocaine, presence of injecting substance use of heroin and open drug scenes in specified neighbourhoods (SRAP, 2012). Additionally, in some closed communities, drug phenomena were reported to be taboo.

Nevertheless, knowledge about the prevalence of substance use among Roma (sub)populations remains limited.

2.2 State of substance use and treatment among MEM in the EU-28

2.2.1 Methods

To identify trends concerning SUT and substance use prevalence among MEM in the EU-28 member states we screened both the 2012 and 2014 Reitox national drug reports submitted by the EU-28

[11] Apart from 10 % of the respondents with Turkish background in the Netherlands and 9 % of the respondents with South Asian background in Greece, no other groups indicated having experiences with discrimination when accessing healthcare services in the 12 months before the survey.

member states[12] to the EMCDDA by means of the following queries: ethn*, minorit*, migra*, nationali*, foreign, roma, asylum, refugee. The publicly available versions of the 2017 reports contained little to no information on treatment demand trends among MEM whereas not all 2015 and 2016 reports were online available. We subsequently focused on the 2012 and 2014 reports for in depth analysis. Full paragraphs including the search terms were listed and read per country. Lastly, inspiring practices (in the 2014 reports) related to SUT for MEM were listed and included in chapter 5.

When information was scarce or incomplete in the Reitox national drug reports, the researcher searched for additional studies. These additional studies are only included in the results section when they are needed to contextualise information from the 2012 and 2014 reports. Subsequently, most additional studies have been included in the discussion section of this chapter. The methods used for data registration and analysis in the Reitox national drug reports (e.g. indicators) are not reported here but discussed in-depth in chapter 3.

For the readability of this report we only include references to the year and country of the reports. The reports are fully available in the online EMCDDA repository (consulted in May 2019). The results are presented per geographical region: The Baltic (2.2.2), Eastern and Central European (2.2.3), Nordic (2.2.4), Western (2.2.5) and Southern member states (2.2.6) and UK and Ireland (2.2.7). The reader should consider that throughout these results we have copied the wording and denominations that were used in the reports.

2.2.2 The Baltic states[13]

The 2012 and 2014 **Estonian** Reitox national drug reports observe that the population in treatment demand data mainly has the 'Russian nationality', accounting for over 80% in the years 2011, 2012, 2013. 10% had another nationality. In these same years, over 70% of overdose deaths involved Russian nationals. In 2013, the percentage of Estonians seeking treatment for the first time increased to almost 20% of the total population in treatment.

The 2014 **Latvian** report observes that approximately half (50.6%) of the population seeking treatment was Russian, one third (35.2%) was Latvian, one in ten (10.2%) did not provide information on their nationality and 7.6% reported another nationality. The 2012 Reitox national drug report only mentions this population in the context of criminal records.

The only MEM related trend reported in the 2012 and 2014 **Lithuanian** drug reports is a Vilnius Police and treatment collaboration aimed at Roma in three Vilnius based Roma encampments. An older study (Subatta, 1997 in Rácz et al., 2012) observed that Roma substance users made less use of an OST service in the capital due to geographic distance and a lack of trust. The mobility and substance use report (Company, 2005) in turn observed that Roma faced prejudice, disadvantage and discrimination in many areas of life, including access to health services. Health conditions were reported to be markedly worse among Roma. Roma in a Vilnius encampment were also reported to be involved in 'homemade' opioid trade in both the national reports and in the mobility and drug

[12] The reader should that the 2012 reports refer to 2011 country data and that the 2014 reports refer to 2013 data.
[13] Estonia, Latvia, Lithuania

use report. This report also mentions but does not further document the existence of a Russian speaking substance user population in Vilnius.

2.2.3 Eastern and Central European member states[14]

The 2012 **Bulgarian** report outlines that 14% of the treatment clients were reported as being Roma (2012, p. 67). A 2005 report (Bezlov, 2005) additionally estimates that in 2003 18% of the injecting users were Roma and 3% had a Turkish nationality, whereas in 2005 these numbers were respectively 13 and 10%. The 2014 report additionally mentions that the relative share of individuals demanding treatment and "who do not belong to the main ethnos of the country" has doubled comparing 2013 to 2007 data (2014, p. 63). Moreover, in 2013 12% of all newly-registered HIV positive clients were foreign citizens. Lyubenova (2007) additionally alerted that HIV services were insufficiently adapted to these populations (in 2007).

Concerning trends, Bulgarian SUT services are reported to have a growing number of Roma in OST and growing inhalant use among "the group of Roma origin" in 2011 and 2013 (2014, p. 83). The 2014 Reitox national drug report indicates a change in Roma housing situations (more "ghetto formation") which makes it harder to reach these populations. Lyubenova (2007, p. 25) corroborated that there was a lack of low threshold services for these populations, especially for IDU's living in isolated communities.

The 2014 **Czech** drug report quotes a qualitative study on migrant substance use trends (Nepustil, 2007). Substance use among Vietnamese nationals is described. The same study described harmful substance use among Albanians and former Yugoslavia nationals. These users are described to mostly engage with their own social network when attempting recovery. Lastly, Ukrainian users are described as mainly using stimulants.

In regions with an otherwise low prevalence of heroin, Czech SUT services reported that clients were more often Roma. The 2014 report (p. 6) also mentioned that the most often recorded substance among Roma were methamphetamine ("pervitin"), cannabis, and inhalants and to a lesser extent heroin and buprenorphine (recorded in Prague, Brno, and North Bohemia). The 2014 report (p. 180) in turn related "ethnic Albanians" (Kosovar, Macedonian, Turkish nationals) to the trafficking and distribution of heroin. An included governmental report indicates that the number of substance users in the populations living in socially excluded areas – mostly inhabited by Roma – is estimated to be between 10 and 70%.

The 2012 and 2014 **Czech** reports also extensively report about higher prevalence of social correlates for substance use among minority populations, especially Roma, and that social exclusion tends to be related with areas inhabited by Roma. It is noted that the low availability of OST creates a treatment gap in Czechia (2014, p. 6). A Belgian study explains that after the fall of communism the threshold to visit a doctor was increased for Roma. Many Roma are fully self-reliant because they have little opportunity to obtain legitimate care in health systems (Člověk v tísni [People in Need], personal communication, 1 December 2015 in De Kock, Decorte, Schamp, et al., 2017).

The **Romanian** national drug reports do not mention prevalence rates and observe little trends among MEM. The 2014 report does alert an increase in HIV prevalence among injecting users and

[14] Austria, Bulgaria, Croatia, Czech Republic, Hungary, Poland, Romania and Slovakia

reports on subsequent prevention initiatives of several NGO's and the Romanian Harm Reduction Network

(see inspiring practices). Also, involvement of Turkish nationals and Roma in drug supply networks are reported.

A presentation at EMCDDA by the national antidrug agency (Iliescu et al., 2015) does report on a study of Roma drug users without treatment. In a small sample (14% of 400 respondents) the presentation characterises those respondents as follows: use of cannabis, heroin and NPS as main substances, lower economic and educational status, higher prevalence of criminal records and absence of identity documents compared to non-Roma counterparts. Furthermore, an analysis of data on people requesting treatment, attending emergency rooms for substance use and accessing needle exchange programs in 2013 demonstrated that 18% reported to be Roma (n=2223) while 27% did not specify ethnicity and 1% was Hungarian. Roma most often presented at needle exchange programmes compared to the other two treatment types.

Of all substance users who have received treatment in 2013, registered in Romanian TDI data, 7% were reported to be Roma and use heroin as the primary substance (Iliescu et al., 2015). Consequently, 40% of the total clientele of NEP were Roma in 2013. Another report (Company, 2005, p. 52) contextualises that Roma were one of first main groups that transported heroin from Turkey to Hungarian borders through Romania and that they subsequently were the first Romanian population group affected by injecting heroin.

The 2012 **Slovakian** drug report observes that asylum seekers in Slovakia[15] in certain asylum centres have problems with accessing specialized health care, especially regarding harmful substance use and mental disorders. Marihuana use (2012) and production (2014) by Vietnamese nationals is also reported as well as involvement of Albanian and Turkish nationals in methamphetamine trafficking. The 2014 report in turn notes that most heroin consumers were Roma, involved in its distribution, and/or long-term heroin dependence.

The **Croatian** reports do not mention MEM prevalence rates or presence in treatment. "ethnic Albanians" are reported to be involved in drug smuggling via de Balkan route. One Zagreb based association is mentioned to target prevention at young Roma. The **Hungarian** and **Polish** reports also do not report MEM related trends nor prevalence rates of use or treatment demand. A study on the barriers to treatment among Roma and non-Roma counterparts in Budapest (Rácz et al., 2012) affirms that no comprehensive Hungarian studies exist that uncover patterns of substance use among Roma. In this study on help-seeking among high risk injecting Roma users, Rácz concludes that Roma, compared to high risk non-Roma injecting drug users are not at higher risk of not obtaining treatment. The author hypothesises that high risk substance use and social situation rather than ethnicity are an explanatory factor for treatment demand in this population.

The **Austrian** 2012 and 2014 Reitox national drug reports do not mention treatment demand among MEM. The 2014 report (p. 14) does mention issues of social exclusion among non-Austrians, alerting that they were particularly affected by unemployment in 2013. The specific situation of people with

[15] The Correlation report on substance use and mobility in central Europe (2005) mentions that there is a big number of undocumented migrants in Slovakia: in 2002 large numbers of people from Afghanistan, China, India, Iraq, Russia, Moldova, Poland and Vietnam tried to cross the Slovak border.

a migration background may be connected to an elevated risk of developing an addiction, because immigration can be an event in life that is traumatising and subsequently triggers addiction (p. 7).

2.2.4 The Nordic member states[16]

The **Swedish** 2014 report observes that substance use among "foreign-born" (p. 71) is lower compared to the general population. Both the 2012 and 2014 reports mention that although long-term poverty is in decline in the general population, it is more common among immigrant populations (2014, p. 67). The 2014 report mentions that when "foreign-borns" are homeless, this is mainly due to not finding housing in the housing market and family related problems (2014, p. 71). Lastly, both the 2012 and 2014 report mention involvement of "foreign-born" citizens in drug markets.

Both the 2012 and 2014 **Danish** national reports mention that treatment demand among foreign citizens was 6% in 2011 and that this corresponds to the proportion of foreign nationals in the general population. The 2014 report also mentions that the installed heroin 'smoking boots' in the city of Skyen are mostly frequented by men of "other than Danish ethnic origins" (2014, p. 68).

The 2012 **Finish** report only mentions that 24% of those suspected of committing aggravated narcotic offences where foreign, mainly Russians living in Estonia (p. 80). No social correlates are reported.

A 2011 Finnish national health survey study found that socio-economic disadvantage increased the odds for daily smoking in Russian, Somali and Kurdish migrant men. Furthermore, several migration-related factors, such as age at migration and language proficiency, were associated with substance use. Binge drinking in turn was found to be less prevalent among all migrant studied groups (Russian, Kurdish, Somali) compared to the Finnish population (Salama et al., 2018).

2.2.5 The Western member states[17]

The **Belgian** Reitox national drug report refers to research on substance use and help seeking behaviour among MEM (Derluyn et al., 2008; Muys, 2010) but does not report on nationality of clients. The 2012 report (p. 29) notes that data on substance use among these populations is not available at population level but stresses that these populations experience SUT access problems. The 2014 report adds that specific actions for ethnic groups are mainly implemented in the Flemish Community (p. 43). Derluyn and colleagues found that MEM in treatment were more often male, less educated and more often referred to ambulant (instead of residential) services compared to non-MEM counterparts. Moreover, analysis of the EuropAsi data demonstrated that clients were significantly more often unemployed, and that this contributed to mental distress and substance use. Additional Belgian studies are presented in chapter 6, 7 and 8.

The 2012 **French** report observes a growing population of socially marginalised young poli-substance users with mainly Central and Eastern European[18], Asian and African backgrounds without family nor institutional support in the past decade. A study is cited (Rahis et al., 2010) that observed higher prevalence of needle sharing, prostitution and cumulative health risk among these populations. For

[16] Denmark, Finland and Sweden

[17] Belgium, France, The Netherlands, Germany Luxemburg

[18] Russia, Bulgaria, Georgia, Ukraine, Belarus, Romania, Moldavia and countries making up the former Yugoslavia)

economically disadvantaged populations, access to treatment thanks to the Universal Medical Coverage (CMU) is reported. The report also notes that among OST clients in 2010 about 6% lived in France illegally. The 2014 report largely repeats these findings.

The 2012 **Dutch** report alerts that the 70's heroin epidemic disproportionately affected persons with a Surinam background due to among other factors the economic recession and bad housing. The 2014 report in turn alerts that migrants and especially "non-Western migrants" are documented as having high unemployment rates, experience discrimination in the job market and are at higher risk of poverty (p. 83). Additionally, the proportion of migrants among the homeless was 40% in 2012 and public nuisance involving psychiatric patients rose due to the reduction of inpatient units (p. 83), implying higher criminalisation of these populations.

The report mentions that most likely, the social exclusion of substance users with a migration background will have increased, but that there is no information available on this topic. Quoting a study on high-risk characteristics of injecting drug users (Havinga et al. 2014) including unstable housing situations, **this is one of the few Reitox national drug reports that does not only endorse higher prevalence of social correlates of harmful substance use among some MEM populations but also documents the mechanism that explain this higher vulnerability.**

The 2012 **Luxembourg** report only mentions that some asylum applicants from Ivory Coast have been implicated in illicit cocaine trafficking. The 2014 report is more elaborate concerning trends among MEM. Both the 2012 and 2014 reports mention that among heroin users no predominant nationalities can be discerned. The 2014 report indicates an increase in non-national clients that largely consists of Portuguese clients. Additionally, 27% of the overdose victims were observed to have another nationality (p. 98).

The 2012 **German** report observes an increasingly diverse population of problem substance users. The 2014 report in turn indicates that 'drug dependence' has a higher incidence compared to PTSD and psychosis among migrants. The report also states that persons with a migration background make less use of health services compared to German counterparts (p. 43). A study quoted in the 2014 report (Piontek et al., 2014) found that non-national problem users were more likely to present with comorbid disorders.

Both the 2012 and 2014 **German** reports observe that among the TDI registered SUT clients: 3% had a European nationality and over 8% "came from non-EU countries such as Turkey or the former Soviet Union" (2014, p. 104). It further describes adolescents with a Russian background as a specific social risk group exhibiting disproportionately high prevalence of substance "abuse and deviance", which was already established in the 2012 report.

2.2.6 The Southern member states[19]

For **Cyprus**, the national drug reports observed 7% foreign, mainly Greek, clients in 2011 and 18% (p. 52) in 2013. Foreign nationals accounted for most high-risk opiate users (estimated at about 60% of all opiate HRDUs in 2013). The 2014 drug report observed overrepresentation of foreign nationals among identified high risk injecting and sharing practices and HCV infections (p. 61). Furthermore, there was a slight increase in 'illegal migrant' involvement in drug offences in 2013 (p. 82). The

[19] Spain, Portugal, Italy, Greece, Malta, Cyprus, Slovenia

national substance use treatment strategy is reported to have invested considerably in the accessibility of OST for migrants (2012, p. 12).

The 2012 **Greek** drug report mentions that no differences were observed in terms of gender, age, nationality, educational status, use of cocaine and sharing syringes. Ethnic Greeks ('Rossopontioi' or Pontian Greeks) accounted for the majority of 'non-EU nationals'. Furthermore, foreign nationals accounted for nearly 40% of OST service clients. The 2014 report in turn mentions that 7% of users in therapeutic services in 2013 had a foreign nationality (p. 80). Lastly, between 2011 and 2012 the total number of foreigner arrestees increased with 8.3% (p. 87).

In **Malta**, most of all treated clients in 2011-2013 were Maltese nationals (97%) and clients from EU countries remained stable at 2% (National report 2012 and 2014) (p. 37). A Maltese study on asylum seekers and persons with international protection additionally suggests that they have substantially more social support and healthcare rights compared to other third country nationals but that in practice they remain more vulnerable to discrimination and are less likely to access their rights (Fsadni & Pisani, 2012).

The **Slovenian** 2012 and 2014 reports focus on Roma as vulnerable MEM populations. Although none of the reports mention prevalence or trend data, the 2012 report (p. 62) stresses that *"substance abuse among Roma people is usually addressed through safety measures and law enforcement, while their health problems remain ignored".*

The 2012 **Italian** report only reports that 50.7% of "drug-addicted prison inmates" are Italian citizens; in 33.8% of cases, nationality data is not available, and the remaining 15.4% are foreigners (of whom 85% come from outside of the EU). The 2014 report (p. 184) in turn observes an increase in "foreigners" among "incarcerated adult drug addicts": 17.3% (3,257 subjects) has a foreign nationality (of whom 81% come from outside of the EU). Although we find no clear treatment demand numbers or prevalence rates of MEM groups, the Italian report does alert that a large-scale municipality survey revealed that municipalities alert that accessibility of substance use treatment for migrants with problems of high-risk substance use are low (p. 117) and that there is a need for targeted interventions.

Additionally, a conference paper on migrant access to health adds that the main migrant groups have eastern and central European nationalities and that they migrated mainly for employment (Di Palma, 2010). A cross-national study among 297 Italian long-settled war-affected refugees from former Yugoslavia demonstrated that although over 40% suffered from mental disorders, less than 1% suffered from substance misuse which is significantly less compared to similar populations in Germany and UK (Bogic et al., 2012). Younger age, male gender and not living with a partner were associated with "substance use disorders" in this study. War-related factors explained substance use disorder variance rates.

The 2014 **Portuguese** report identifies that most registered clients ('97 to 100%') are Portuguese clients (p. 73). 28% of those detained for drug-related crimes were non-nationals (p. 120). An analysis of 2012-2014 TDI data (De Kock et al., 2018) further nuances that about 2% had a European nationality and over 5% had a non-EU nationality. Educational levels were reported to be relatively high among these clients in treatment. Unemployment rates were similar comparing national to non-national clients although non-nationals were less often employed steadily. Lastly, non-national

clients were less often referred by GPs, health services and governmental programmes and more often reported to be opioid users compared to national clients.

Lastly, the 2012 **Spanish** report indicates a rising population of foreign prisoners, accounting for 35.6% detained for drug-related crime, with an exceptionally high number of female prisoners. This number seems to have remained stable in 2013 (p. 171). 1% of the IDU population in prison is reported to be 'foreign' (p. 177). A study among natives and immigrants in a large sample of IDUs involved in harm reduction programmes in Catalonia (Saigí et al., 2014) additionally found that IDUs with a migration background lived alone more frequently, started injection at later ages, inject more frequently and make less use of treatment compared to non-migrant counterparts.

The study concluded that migration could be a risk factor for initiation, increase of consumption and lower access to substance use treatment. Lastly, research in a Spanish SUT service sample studied the likelihood that Roma and non-Roma would remain in treatment. The results showed that remaining in treatment was less likely for Roma, although the result was not statistically significant (Rácz et al., 2012) and the reasons for this result remained unstudied.

2.2.7 UK and Ireland

The 2014 **Irish** national drug report is the only of all European drug reports that argues for the inclusion of ethnic identifiers in routine data collection for planning health services (p. 60). Based on these identifiers, a 2013 study (Carew et al., 2013) reported that treatment demand was three times higher among clients registered as "travellers" compared to the general population in 2010. Alcohol was reported as the primary substance and a rise in treatment demand concerning opioids, benzodiazepines and cannabis was also recorded, opioids being the main substance among women. Also, higher rates of poli-substance use and earlier onset of use were recorded in this population. Sharing paraphernalia was reported to be lower in this population. Furthermore, a Migrant Rights Centre report (2014) reported that potential victims of human trafficking for forced labour in cannabis plantations – mainly identified as Vietnamese – are currently being prosecuted for crimes they may have been forced to commit – while their traffickers enjoy impunity.

A small scale qualitative study found that persons with African Caribbean, Romanian, Russian, Georgian and Ukrainian background were well reached by OST services, but that Somalis, Congolese and Georgians mainly relied on street methadone (Corr, 2004). Africans among the respondents were more likely to smoke cocaine (although some were smoking heroin and there was some evidence of injecting heroin), while Eastern Europeans were more likely to inject heroin. The study concluded that the social situation of new communities, coupled with other stressors such as displacement and seeking asylum, constituted a risk for engagement in problem substance use.

The 2012 **UK** report mentions that even large household surveys, such as the Crime Survey for England and Wales, have insufficient sample sizes to properly consider prevalence of substance use by ethnicity considering the variety of ethnic groups and the different age structures of the populations. It also mentions that ad-hoc studies or one-off studies of particular ethnic groups are sometimes undertaken but there were none reported in 2012. Although the 2014 report does not report on specific trends among MEM, it does report that the National Institute for Health and Care Excellence has alerted that marginalised groups such as homeless, drug users and vulnerable migrants, children from some unreached groups, for example travellers or those from families that don't speak English as a first language should be targeted specifically. A recent report identifies

barriers to mainly alcohol-related treatment among persons with a Polish background in London (Herring et al., 2019).

2.3 Identified populations

2.3.1 Roma and national minorities in need of treatment across the EU-28 member states

First, at least ten reports identify what could be considered as national minorities. Pontic Greeks are identified in Greek treatment and 'travellers' in Ireland. Furthermore, Lithuania, Bulgaria, Czechia, Romania, Slovakia, Croatia, Slovenia and Spain stress the significant representation of Roma in low threshold OST services. Most of these reports additionally stress the social and economic vulnerability of these populations and / or involvement in illegal drug markets such as involvement in Balkan route trafficking e.g. in Croatia. Moreover, risky substance use and lower health statuses are reported in the Roma populations seeking or identified as needing treatment.

Interestingly, none of the national drug reports in the Western European countries mention Roma as a specifically vulnerable population. Nevertheless, studies identify mobile drugs users in Western and Southern European countries (Company, 2005; De Kock, Decorte, Schamp, et al., 2017; López et al., 2018). In a study on mobile drug users (Company, 2005) Romanian mobile drug users reported to be mainly in need of NEP, night shelters, laundry, social assistance and employment, assistance in prisons and language mediators. None of the Western European countries seem to have implemented consequent drug policies concerning these populations.

2.3.2 Russian speakers and former USSR citizens

Several country reports and additional studies observe considerable numbers of Russian speakers in SUT. Most notably, Russian speakers appear to seek treatment in the neighbouring Baltic states (Estonia, Latvia), France, Germany and UK. This could be the result of the Russian government's intolerance toward substance use and the subsequent occurrence of systematic human rights violations among people who use substances in this country (Golichenko & Chu, 2018; Rhodes et al., 2006) but is also a result of the existence of long-settled Russian national minorities across Europe.

A 2017 study in a large sample of 2013 substance users (Jauffret-Roustide et al., 2017) corroborates that about one third of Paris and surroundings' SUT clients come from Eastern European, mainly Russian speaking countries and especially Georgia. The seroprevalence of hepatitis C is reported to be two times higher among these clients compared to French speaking clients (nine in ten). Furthermore, these clients are characterised by higher educational levels, higher precarious living conditions and similar needle sharing practices, compared to French speaking clients. The study also mentions that the higher seroprevalence is likely related to repressive drug policies in the native countries.

A 2015 French study among OST clients (CARUUD) (Cadet-Taïrou et al., 2018), surprisingly, does not account for clients migration backgrounds but does include some interesting trends such as the rise in mobile drug users (about one third of the clients), possibly including the population described by Jauffret-Roustide and colleagues. More recently, social workers as well as the director of France terre d'asile (Pierre Henri) alerted that the closure of both a first reception centre for undocumented migrants service and the closure of a CARUUD OST service (in the 18th district, Paris) led locally to a steep increase of crack use among undocumented migrants. Treatment providers alert that not attending to undocumented migrants basic needs contributes to these vulnerable populations

joining other vulnerable substance using populations[20]. Subsequently, the *National Plan for Mobilisation against drug addiction* has recently prioritised the contact with vulnerable individuals including migrants in general and especially drug dependent unaccompanied minors.

2.3.3 Mobile drug user treatment demand

Over a decade ago a report on Mobility and substance use in Central Europe alerted that "*the number of registered drug users / foreigners do not reflect the prevalence of substance use among foreigners, but how public health services are prepared to provide treatment to them*." (Company, 2005, p. 10).

The Czech, Croatian and Slovakian reports mention Balkan route related treatment demand trends among Albanian citizens. Mobile drug users are described as the most hidden subgroup of substance users and require specific interventions. The report identified the following vulnerable groups of mobile drugs users:

- **In Czechia:** Russian speaking low-paid workers, Russian speaking individuals involved in drug trafficking, hidden groups of Vietnamese users, Slovak users;
- **In Poland:** Russian speaking users (e.g. Ukrainian), 'drug-refugees' (migrated because of better quality, low prices);
- **In Romania**: big communities of Chinese and Arab IDU, smaller groups of sex workers.

Additionally, central and eastern European clients are observed in the Reitox national drug reports to reach SUT services in UK and France.

2.3.4 A focus on 'non-nationals' in Northern and Western European treatment

Reitox national drug reports of the western member states mainly describe non-nationals denominated as for example non-Austrians (Austria), foreign-born (Sweden), foreign citizens (Denmark), people with a migration background (Belgium, Germany) and non-western migrants (The Netherlands). Additionally, the 2014 Slovakian and Czech reports observe that non-nationals are most often recorded as not insured compared to nationals whereas most of the Western European member states (excluding France) do not consider this issue in the drug reports. The majority of the reports as well as more recent studies demonstrate that non-nationals in treatment often have lower SES compared to national counterparts.

The Italian, Portuguese and Spanish reports do not mention nationalities in treatment but do identify nationalities when it comes to drug-related crime. The Cyprus, Greek, Maltese reports in turn report on treatment demand among non-national populations (respectively Greeks, Pontian Greeks and European citizens). It should be noted that little information on MEM substance use and treatment demand trends were found in the Italian, Portuguese, Maltese, Hungarian and Polish reports.

2.3.5 No focus on asylum applicants, refugees and undocumented migrants

No information on asylum applicants, refugees or undocumented migrants is mentioned in any of the reports besides in the 2012 Slovakian and 2014 French report. For the Eastern and Central European member states this could be attributed to their lower presence. These countries are rather

[20] France 24 documentary of 14th of December 2018 https://www.france24.com/fr/20181214-reportage-paris-nord-migrants-toxicomanie-chapelle-crack

transit and emigration countries than immigration countries (Company, 2005). Nevertheless, the countries should be observed because of the use of the Balkan route by more recent refugee populations. Concerning, the Western, Southern and Nordic member states it could be argued that the influx of 2015 had not occurred at the time of writing the Reitox national reports. However, these countries have received considerable numbers of asylum applicants long before 2015.

A study among long-settled war refugees in Germany from mainly Bosnia and Herzegovina, Kosovo and Serbia reported a 12% prevalence of any substance use related disorder (Bogic et al., 2012). This number is significantly higher compared to similar populations in Italy and UK. Moreover, compared to these countries, refugees in Germany reported much higher rates of experiences of interpersonal assaults, including torture. Also, post-migration circumstances were much poorer for refugees in Germany, with the large majority failing to obtain a work permit. Additionally, a challenge reported in several major cities are undocumented migrants experiencing homelessness (Köhnlein, 2018).

A recent Swedish study among newly arrived migrants observed that this population did not seek care to the same extent as the general population, mainly due to high costs, long waiting times and language difficulties (Mangrio et al., 2018).

2.4 Intermediate conclusion

Even though the research domain of substance use and treatment among MEM is still limited in the European context there are clear indications of disparities in these populations across the EU-28 member states. The results demonstrate that over half of the 2012 and 2014 national drug reports observe trends in treatment demand and highlight social correlates to problem substance use and treatment demand among MEM. Nevertheless, **the reports insufficiently contextualise specific numbers or substantiate and explain trends clearly to be able to act upon them**.

Moreover, the description of specific populations could possibly harm persons identifying with these respective subpopulations (De Kock, 2019b; De Kock, Decorte, Vanderplasschen, et al., 2017; Hunt et al., 2018). For instance, many of the reports identify numbers or characteristics of non-nationals in relation to drug-related crime (e.g. Balkan route related trafficking) but most of the reports describe insufficiently how and why this information was gathered or how it is used for policy making. These methodological issues and the apparent lack of purpose specification (e.g. registration of 'pontic greeks', 'Russian nationals', 'Roma' etc.) are elaborated upon in chapter 3 below.

3. Ethnicity and migration related monitoring in the EU

Charlotte De Kock

This section contextualises ethnicity and migration related monitoring in the European context. We introduce this chapter with discussing the relevance of such monitoring to enable the identification of treatment gaps and subsequent policy planning (3.1). We briefly discuss the international context of ethnic and migration related monitoring (3.2). We continue by discussing the European context of this type of data collection (3.3). In section 3.4 we distinguish between administrative, census and survey data, describe the legal requirements and harmful use of this type of data collection as well as the state of data collection in the European health domain.

In subchapter 3.5 we discuss the use of migration and ethnicity related indicators in the national treatment demand indicator (TDI) protocols. The discussion (3.6) and conclusion (3.7) of this chapter focus in-depth on the nature and necessary requirements for including migration and ethnicity related indicators in the European Treatment Demand Indicator (TDI) registries.

3.1 Modelling treatment gaps in potentially vulnerable populations

Planning substance use treatment in national health settings is ideally based on the availability of accurate data on at least treatment need and treatment demand. Modelled analysis of this type of data allows to identify 'treatment gaps'. Montanari and colleagues (Montanari et al., 2011) for example hypothesised a treatment gap of women compared to men in European substance use treatment.

Treatment need is defined as the presence of a diagnosis for which treatment is available whereas treatment demand numbers reflect the population that wants treatment (Ritter et al., 2019). However, these datasets are per definition troubled by conceptual and methodological issues. **Treatment need** is often based on substance use prevalence rates as identified in national health surveys. Use of illicit substances is the only drug-related indicator in the European Core Health Indicators (ECHI) and subsequently replicated most frequently in the European national health surveys, be it to varying extents (e.g. daily use, monthly use etc.).

National health surveys are often not representative for (vulnerable) subpopulations and often insufficiently distinguish between varying types of substance use to represent real treatment need in a given population. In the Belgian health survey (2013) and the EU-SILC survey (2016) for instance, there were no specific measures to prevent low response rates among non-national populations (Noppe & Vanweddingen 2018, p. 272). Also, this type of treatment need estimation does not account for the phenomenon of natural recovery without treatment (Ritter et al., 2019).

Treatment demand in turn represents the intention to seek treatment (Ritter et al., 2019) or in the European context 'presenting to a treatment facility' (Antoine, 2016) and thus 'met' treatment need. Dependent on which interpretation is used, the resultant data can additionally be troubled by for instance issues of problem awareness in case of self-reporting (Ritter et al., 2019).

Database linkage or comparisons of treatment need and demand are necessary to gain insight in and understand treatment gaps among specific populations. Alison Ritter argues for the deployment of models when estimating real treatment gaps with the eye on local treatment planning. These models should include data on need ánd demand but should also allow to distinguish between types

of substances, age groups, substance use severity (Ritter et al., 2019, p. 25) and focus on subsequent 'tiered' modelling for targeted service planning.

The example of Montanari and colleagues' study demonstrates that when data is available (in this case on gender), treatment gaps and other population disparities can be identified. However, concerning migrants and ethnic minorities[21] there are little sound indicators available in the European continent that allow to monitor MEM in substance use treatment. This 'statistical blindness' is reported to be a legacy of the strategy to dismiss race and ethnicity from all legal texts and collective representations since the post-war period in Europe (Escafré-Dublet & Simon, 2011). Nevertheless, the implementation of equality policies since the 2000's, require that data about MEM is available to assess and monitor disparities and to design subsequent policies to act on these disparities. This type of monitoring should of course avoid stigmatising specific groups and always consider rigorously ethical and privacy considerations (see below).

In what follows, we make the case for this type of registration of migration and ethnicity related indicators in substance use treatment. We start out by critically discussing equality data collection and 'migration and ethnic monitoring' in the international (chapter 3.2) and the European (chapter 3.4) context. We also discuss this type of registration and monitoring in health (chapter 3.4.3). We than review legal grounds (chapter 3.4.4) and subsequent prerequisites and guidelines for this type of registration (chapter 3.4.5) in Europe. Lastly, we report on how ethnicity and migration related variables are currently (not) registered in the European Treatment Demand Indicator registries (chapter 3.5). We subsequently conclude by identifying discrepancies between legal requirements and current practices (3.6) and formulate possible ways forward for the Belgian TDI registry.

3.2 International treaties and regulations

The main argument in favour of data collection concerning ethnicity and migration at the individual level is based on an equality perspective: to monitor equal treatment of migrants and ethnic minorities data should be made available. However, privacy issues are often juxtaposed to the responsibility of states to gather migrant and ethnicity related data. This argumentation will be reviewed below.

[21] The use of the combined terminology 'migrants and ethnic minorities' is proposed by the European Regional Office of the World Health Organisation (WHO EU, 2010) and is equally used in the European ETHEALTH report for equal health and health care (Derluyn et al., 2011) and the EMCDDA's review of drug prevention targeting these populations (2013). We have argued elsewhere that this combined terminology allows to consider 1) the individual history of migration, 2) the feeling of belonging to an ethnic group as well as 3) the societal denomination and categorization of belonging to such minorities (De Kock, Decorte et. al. 2017). This conceptualisation takes Ford and colleagues' (2010, p. 3) proposition to define 'ethnicity' as "a two-dimensional, context-specific, social construct with an attributional dimension that describes group characteristics (e.g., culture, nativity) and a relational dimension that indexes a group's location within a social hierarchy (e.g., minority vs. majority status)" a step further in proposing three instead of two dimensions.
These three aspects (individual migration experiences, subjective belongingness, societal denomination) are especially important in studying problem substance use in these target groups because they allow for a layered understanding of the aetiology of problem use and help-seeking behaviour.

The right to equality and protection against discrimination for all constitutes a universal human right that is endorsed by (among others) the following internationally agreed human rights instruments:

- the Universal Declaration of Human Rights,
- the United Nations Convention on the Elimination of all forms of Discrimination Against Women (CEDAW),
- the International Convention on the Elimination of all forms of Racial Discrimination (CERD)
- the International Convention on the Rights of Persons with Disabilities (CRPD)
- the United Nations Covenants on Civil and Political Rights (ICCPR) and on Economic, Social and Cultural Rights (ICESCR)

The World Conference against Racism (2001) called upon states to develop systems of data collection that uphold the right to privacy and the principle of self-identification. United Nations statisticians subsequently made recommendations to promote census data collection based on racial and ethnic origin (UN, 2006). The authors note that "*identification of the ethno-cultural characteristics of a country's population has increasing importance in the context of migration, integration and policies affecting minority groups*." (in Farkas, 2017a, p. 21). The report further mentions that:

> "Ethnicity can be measured using a variety of concepts, including ethnic ancestry or origin, ethnic identity, cultural origins, nationality, race, colour, minority status, tribe, language, religion or various combinations of these concepts. (…) The method and the format of the question used to measure ethnicity can influence the choices that respondents make regarding their ethnic backgrounds and current ethnic identification." (in Farkas, 2017a, p. 21).

3.3 Data collection regimes and their context

The United Nations found that in the 2000 global census about 65% of all countries enumerated their population using national and ethnic group categorisations (Morning, 2015). However, countries do so in very different ways and for different reasons. For a comprehensive review of global categories, we refer to Morning (2008).

Canada was the first country to identify racial / ethnic origins in the 1767 census (Aspinall, 2017). Registering 'ethnic minorities' by means of predefined categories has since been criticised for being based on 'ethnic absolutism' (Girloy 2004 in Aspinall, 2017). Consequently, many countries have opted during the last decade for 'multi-ticking' categories, exact combinations in duplex categories (e.g. white ánd Asian in the 2001 England and Wales census) and open ended write in options that allow for self-definition.

Indeed, the use of predefined categories could be considered not to be in line with the idea that group identities such as ethnic identities are mutually implicated and feedback upon each other (Jenkins, 2011) and conflicts with the right to self-determination. The above-mentioned UN recommendations subsequently notes that:

> "the subjective nature of the term [ethnicity] requires that information on ethnicity be acquired through self-declaration of a respondent and also that respondents have the option of indicating multiple ethnic affiliations." (in Farkas 2017, p. 21).

Departing from the logic that mixed ethnicity is one of the fastest growing census categories in the UK and North America, Aspinall (2017) reviewed how countries across the globe capture this 'mixedness'. He concluded that only "tick all that apply", specific combinations of interest, and "mixed" open response possibilities allow for providing enough information on the composition of a person's 'mixedness'. **He notes that these types of registration face some problems in terms of validity and comparability but that trade-offs between comparability and increased capture of specific populations should be made.**

The types of nomenclature used are always a reflection of a particular history, geography and population composition and tend to 'fix' certain groups in certain categories (Hunt et al., 2018). Moreover, the very origin of ethnic data-gathering in for example census questionnaires is argued to be rooted in (nation) states' desire to classify populations, to identify majorities and minorities and even to create group identities (Benedict, 1987).

This type of classification for political purposes in 'multiculturally organised' societies is exemplified in the United State categorisations of citizens as White American, Black or African American, Native American and Alaska Native, Asian American, and Native Hawaiian and Other Pacific Islander, people of two or more races and Hispanic or Latino ethnicity.

Rallu (2006, in Escafré-Dublet & Simon, 2011) distinguishes between four types of data collection regimes across the continents:

1. counting to dominate (e.g. in colonial or imperial states);
2. not counting in the name of national integration (where the nation's rationale is one of homogenisation);
3. counting in the name of multiculturalism (identifying groups from a symbolical and organisational point of view);
4. counting to implement positive action in the name of equality (most recent, in the light of equality regulations).

3.4 Types and interpretations of migration and ethnic data collection

General recommendation 32 of the Committee on the Elimination of all Forms of Racial Discrimination (CERD) states that "*the principle of non-discrimination requires that the characteristics of groups be taken into consideration*". Moreover, the European Commission against Racism and Intolerance (ECRI) (in Escafré-Dublet, 2012) further mentions that "*it is difficult to develop and effectively implement policies without good data". ECRI defines equality data as "statistics broken down by citizenship, national/ethnic origin, language and religion*" (Farkas, 2017, p. 36).

These are the arguments most often cited by proponents of ethnic and migration monitoring in the EU. Nevertheless, there is a discrepancy between this ideal and the political realities in Europe. Escafré-Dublet and Simon (2012) note that only two countries in Western Europe - namely UK and Ireland - collect data on ethnicity with the aim to implement positive action (as described in Rallu's type 4 data collection regime above). Furthermore, ethnicity and migration related data collection is not included in the EU statistical planning (Farkas, 2017a, p. 43).

3.4.1 Administrative, census and survey data

Censuses, as ways of national 'stocktaking' are one of the oldest and most reliable sources of information about the characteristics, composition and conditions of the population in a country. Population censuses are intended to provide a representative population or subpopulation picture (in the case of a micro census) of all individuals in the population at a certain time. Many countries perform a census each decade. The 2011 Census was held across all EU Member States and was carried out conform the Census Act of 1948 and Regulation 763/2008 of the European Parliament and of the Council.

Population statistics on the other hand change constantly. Some countries (e.g. Belgium, Denmark, Latvia, Finland, Sweden, The Netherlands, Spain, Austria, Norway) rely mostly on population registries whereas others produce estimates (mostly based on census data and other information) (Jacobs et al., 2009) made public by means of aggregated datasets. Also, there are **surveys** that depend on sampling and target smaller (sub) populations.

An important observation made by Farkas (2017) is that most European countries do not inscribe a definition of the equality grounds of migration or ethnicity backgrounds in their legislation, hampering their registration. In Europe only Finland, Ireland, Norway and United Kingdom place a duty of ethnic equality data collection on public bodies as part of their equality planning (Farkas, 2017, p. 15). In these four countries migration and ethnicity related data collection is included in national legislation.

Review studies (Farkas, 2017b; Jacobs et al., 2009; Simon, 2007, 2012) identified that citizenship or nationality is registered in all censuses or population registries. Based on these reviews, the second most registered variable used as a proxy for migration background appears to be country of birth or country of origin (13 countries). Eleven EU member states register an ethnicity-based indicator in their census. The interpretation of this indicator varies, and its registration is often of low quality. **Religion or belief** is (voluntarily) registered in no less than fifteen member states in censusses or large-scale surveys. Nine countries register language related variables be it **mother tongue or language most often used**. Finally, four countries capture birth country or **country of origin of one or both parents** in censuses. In most countries data is collected on a voluntary basis, especially concerning religion or belief.[22]

For some countries it is unclear how data is registered and some country reports included in Farkas' review study on equality data gathering (2017c) explicitly mention that these indicators are registered without informed consent or by making use of unreliable proxies (e.g. language to identify Roma in Czech republic, 'optional' nationality in Cyprus resulting in undercount of Roma, Russian nationality in Latvia etc.).

3.4.2 Interpreting migration and ethnicity related indicators

It should be noted that most EU population registries only record legal nationals. Kupiszewska and colleagues within the framework of the PROMISTAT project (2010) reported that Spain was the only country with a population register where the current legislation allows inscription of the entire population regardless of their legal status. Other countries such as Belgium and Germany record asylum applicants in a 'waiting register' (Perrin et al., 2015).

[22] A table with this information is available upon request to the author.

Ethnic minorities?

Ethnicity is a concept with fuzzy boundaries because of its ambiguous criteria of group membership. Moreover, ethnicity can change depending on situation, context, and interpretation of underlying concepts (Aspinall, 2017). Whereas most of the Baltic states and former Soviet states record language and religion as ethnic proxies, Western and Nordic states that are more geographic origin oriented, rarely consider language and religious differences that may exist within certain minorities (Farkas, 2017).

The England and Wales census contains questions on exact combinations of two ethnic groups. Some argue that these combinations are not consistent and lack efficacy in capturing multiplicity (three or more groups) (Aspinall, 2017). Another critique is that the current options favour minorities that have an association with Britain's colonial past whereas 2015 data on country of birth reveal that a substantial part of migrant communities are not related to ex-colonies. The same author argues that the Scotland and Northern Ireland Census 'mixed' options are more satisfactory because they allow for write-in 'other' options. Table 1 identifies the largest national and other minority groups as defined by the FRA in its EU-MIDIS II report (FRA, 2017, p. 4).

When public authorities use the 'minorities' concept, they often focus on historical and linguistic 'national minorities'. The Baltic states (Estonia, Latvia, Lithuania) and other central and eastern European countries (e.g. Bulgaria, Croatia, Czech Republic, Hungary, Poland, Romania and Slovakia among the EU countries) traditionally monitor the presence of 'national minorities' and 'language groups' through open or multiple-choice census questions (Jacobs et al., 2009).

Escafré-Dublet and Simon (2012) defined these member states as 'mosaic' countries in the sense that the legacy of the national minorities characterises these empires' regions. This explains the larger attention to national minorities compared to most Western European and Nordic countries. In many Western European and to a lesser extent the Nordic member states 'minorities' are more often related to migration (Simon, 2017) (see below: migration background).

Country code	EU Member State	Country target group code	Target group
AT	Austria	AT – TUR	Immigrants and descendants of immigrants from **Turkey**
		AT – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
BE	Belgium	BE – TUR	Immigrants and descendants of immigrants from **Turkey**
		BE – NOAFR	Immigrants and descendants of immigrants from **North Africa**
BG	Bulgaria	BG – Roma	Roma
CY	Cyprus	CY – ASIA	Immigrants and descendants of immigrants from **Asia**
CZ	Czech Republic	CZ – Roma	Roma
DE	Germany	DE – TUR	Immigrants and descendants of immigrants from **Turkey**
		DE – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
DK	Denmark	DK – TUR	Immigrants and descendants of immigrants from **Turkey**
		DK – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
EE	Estonia	EE – RUSMIN	Russian minority
EL	Greece	EL – Roma	Roma
		EL – SASIA	Immigrants and descendants of immigrants from **South Asia**
ES	Spain	ES – Roma	Roma
		ES – NOAFR	Immigrants and descendants of immigrants from **North Africa**
FI	Finland	FI – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
FR	France	FR – NOAFR	Immigrants and descendants of immigrants from **North Africa**
		FR – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
HR	Croatia	HR – Roma	Roma
HU	Hungary	HU – Roma	Roma
IE	Ireland	IE – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
IT	Italy	IT – SASIA	Immigrants and descendants of immigrants from **South Asia**
		IT – NOAFR	Immigrants and descendants of immigrants from **North Africa**
		IT – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
LT	Lithuania	LT – RUSMIN	Russian minority
LU	Luxembourg	LU – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
LV	Latvia	LV – RUSMIN	Russian minority
MT	Malta	MT – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
NL	Netherlands	NL – TUR	Immigrants and descendants of immigrants from **Turkey**
		NL – NOAFR	Immigrants and descendants of immigrants from **North Africa**
PL	Poland	PL – RIMGR	Recent immigrants
PT	Portugal	PT – Roma	Roma
		PT – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
RO	Romania	RO – Roma	Roma
SE	Sweden	SE – TUR	Immigrants and descendants of immigrants from **Turkey**
		SE – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**
SI	Slovenia	SI – RIMGR	Recent immigrants
SK	Slovakia	SK – Roma	Roma
UK	United Kingdom	UK – SASIA	Immigrants and descendants of immigrants from **South Asia** (Pakistan and Bangladesh)
		UK – SSAFR	Immigrants and descendants of immigrants from **Sub-Saharan Africa**

Table 1: Country and target groups codes in the EU survey on migrants and minorities (EU-MIDIS II)

The only European minority that is recognised and subsequently monitored to different degrees in surveys (Farkas, 2017a) across Europe, are Roma. Roma are considered a national minority in Bulgaria, Romania and Slovenia. Countries such as France and Spain however, do not have specific legislation dealing with this minority, while in for instance Italy there is only regional level legislation. Roma sometimes do not have a strictly defined legal status. Slovenian law for instance only protects Roma with Slovenian citizenship and Eastern-European Roma in Italy are sometimes categorised as "*irregular migrants*" instead of belonging to a "*regional minorities*'. (SRAP, 2012, p. 12)

Migration background?

Countries such as Belgium, France, Spain, The Netherlands, Germany, Ireland, Portugal, the UK and the Scandinavian countries interpret 'migration background' in terms of **citizenship or nationality at birth** and **place of birth of one or both parents**. The rationale is that some people (e.g. Turkish and Moroccan descendants of labour migration in Belgium and France) cannot be made visible in statistics once they acquired citizenship (Simon, 2012). Based on citizenship regulations for instance

in Belgium, the Netherlands and Greece it is much more likely for a person with a migration background to have acquired the nationality in these countries compared to for instance Austria or Switzerland (Jacobs et al. 2009).

3.4.3 Migration and ethnic monitoring in health

In the available literature on ethnic and migration monitoring there is surprisingly little reference to the health domain, as opposed to references to this type of monitoring in education, housing and employment domains. Farkas' review (2017a) only mentions one largely scale study in Sweden that inquired among five recognised national minorities - Jews, Roma, Sami, the Swedish Finns and Tornedalers – about their experiences in health (2008 and 2010).

Consequently, Farkas (2017c, p. 20) mentions that across member states "*major data gaps emerge in the area on social inclusion*" including health. The Roma health report (Matrix, 2014, p. 127) for instance observes that this data appears to have shortcomings in terms of quality, timeliness, collection methods and reporting.

A large-scale European study funded within the framework of Horizon 2020 (ADAPT: Adapting European health systems to diversity) recommended the "*collection of data on MEM [migrants and ethnic minorities] (…) and epidemiological and clinical monitoring of their state of health*" (COST 4134/11).

A 2009 review of registry data on migration related indicators in health (Nielsen et al., 2009) reports that only 11 EU countries register citizenship and / or country of birth (see figure 4 below) in the health domain. In the framework of a European project on migrant health (EUGATE) Kluge and colleagues (2012) found that in 16 EU member states only 15% of health services recorded data on service users with a migration background. Additionally, most of the country reports in Farkas' study reveal that data are rarely disaggregated or cover the health domain, with 17 countries providing 'comprehensive' data on ethnicity and health (Farkas, 2017c, p. 54).

All the member states do report to allow an exemption of the sensitive data regulation (as per Directive 95/46/EC) in the domain of health (Farkas, 2017c, p. 63) (see below).

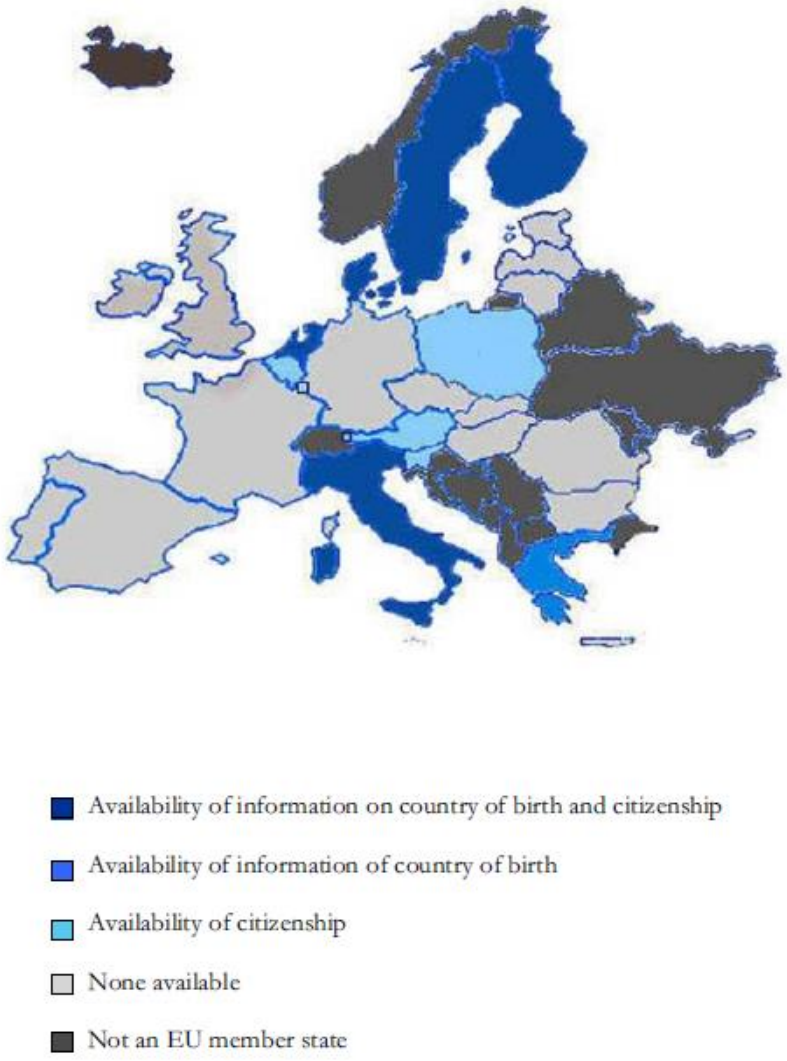


Figure 4: Availability of registry information allowing the identification of migrants in the EU (Nielsen 2010, p. 9)

The European PROMINSTAT project (2010) identified the following broad necessities and difficulties in ethnic and migration related data collection and analysis in the health domain:

- Medical research uses **homogenous samples**, where the specificity of ethnic minorities and migrants does not appear;
- migrants may have **lower response rates in epidemiological and social surveys**;
- **monitoring undocumented immigrants is difficult** or even impossible;
- **measuring equity and the impact of migrant's** situation in the quality of care is complicated;
- recording ethnicity in clinical records can be illegal or **politically sensitive** and perceived as a discriminatory practice;
- the language and terminology used in surveys may have **different meaning for groups** of migrants.

The Roma Health report (2017, p. 129) in turn identified five countries that produce specific data on Roma Health (Latvia, Slovakia, Denmark, Sweden, Spain)[23]. Nevertheless, in the health domain, the Roma Health Report (Matrix, 2014) identified that 40.7 % of the questioned member states do not dispose of disaggregated data on Roma health and 25.5 % rely mainly on administrative registers or existing international surveys to provide partly disaggregated data.

Table 2 lists the advantages and disadvantages of the categorisations that are most often used in European countries in the domain of health, namely: **country of birth, country of origin, country of nationality, ethnicity, immigration status and length of stay in the countries** (as used in studies within the framework of HIV related surveillance). It is unclear why the category 'birth place of one or both parents' was not included in this list.

Definition/ proxy indicator	Advantages	Disadvantages	Comment
Immigration status	• Secure immigration status important for defining rights, access to care • Information may be important for defining service needs	• Information about status extremely sensitive, difficult to collect reliably and may negatively affect definition of service needs • Highly subject to abuse • May cover diverse sub-groups and may change rapidly	• Requires assurance of confidentiality, and trust between interviewer and interviewee
Length of stay in current country	• Denominator available in census data (recommended) • Distinguishes between newly-arrived and well-established migrants whose needs will be different • Less intrusive than questions about legal status	• As with immigration status, may be sensitive and subject to abuse, although less so • May not be asked consistently, especially of those who appear to be autochthonous	• Date of arrival more specific, though subject to ambiguity when migration is circular or progressive • Year of arrival is sufficient

[23] Latvia: Roma Register on Drug and Substance Users, Slovenia: Regional Office for Public Health, Denmark: Danish National Health Board, Sweden: Swedish National Institute of Public Health, Spain: Spanish ministry of Health

Definition/ proxy indicator	Advantages	Disadvantages	Comment
Country of birth	• Relatively easy to define • Will be made available by age and sex in Eurostat data on migrants • Denominator available in EU and UN migration data, and census data (recommended)	• Information missing in several major datasets • Provides no information about mobility between birth and current place of residence • Does not allow for country nationals born abroad • Provides no information about second and subsequent generation migrants or ethnic minorities • Provides no information about sub-groups and can mask important differences (e.g. ethnic, religious, language, socio-economic status, lifestyle, self-perception)	ECDC prefers this over 'region of origin' for epidemiological HIV surveillance
Country of origin	• Widely used, thus comparable from study to study • Second most important category used in statistical datasets for indicating migration background • Allows respondents to define where they consider themselves to be 'from', thus reflecting some of the advantages of 'ethnicity'	Not precisely defined: could be interpreted as country of birth or country of citizenship or in some other way	• In the past more often defined as 'region of origin' • Some datasets also try to capture the country of previous residence
Country of nationality	• Easy to define (e.g. passport) • Will be made available by age and sex in Eurostat data on migrants • Denominator available in EU and UN migration data (citizenship of resident population is used in statistical sources in almost all PROMINSTAT countries), and census data (recommended)	• Policies for granting nationality vary from country to country, thus comparability difficult • Many people (migrants and non-migrants) have more than one nationality • Provides no information about second and subsequent generation migrants or ethnic minorities • Provides no information about sub-groups and can mask important differences	• ECDC prefers this over 'region of origin' for epidemiological surveillance • Key issue is how to classify people with several nationalities
Ethnicity or ethnic origin	• Reflects significant differences in health indices, access to healthcare, discrimination • Often used in some countries, thus comparable from study to study • Self-defined, thus presumably reflects cultural traditions that may be relevant • May be helpful for mobilising communities	• Not possible to measure accurately or with validity and may change over time • Highly influenced by ideology and may be euphemism for 'race' • Does not allow for people of mixed origin • Classification categories vary widely and covers diverse sub-groups • Difficult to compare between countries • Provides no information about how long an individual has been in a country • Provides no information about sub-groups and can mask important differences	• Important in some countries, considered unacceptable in others • More of a process than a static concept, and a sociological than a biological category • Should be self-defined, not assigned

Table 2: Advantages and disadvantages of most commonly used definitions for migration and HIV related surveillance and research (ECDC 2011, p. 20)

Table 3 below identifies the number of countries where inclusion of such information in migrant health data is (not) mandatory or optional in research on migrant health and identified their availability for research purposes across the researched EU countries. (IOM, 2016)

19	**Collection of data on migrant health** Data on migrant status, country of origin or ethnicity is included in medical databases or clinical records. Choose Option 1 if linkage between medical databases and national databases containing the above personal information is practically possible.	*Inclusion of such information is mandatory* **11** BG, BH, CH, DK, IT, MT, NL, NO, SE, SK, UK	*Inclusion of such information is optional* **15** AT, BE, CY, DE, ES, FI, GR, HU, IE, LT, LU, LV, MK, PT, RO	*Such information is never included* **8** CZ, EE, FR, HR, IS, PL, SI, TU
20	**Support for research on migrant health** Funding bodies have in the past five years supported research on the following topics: A. occurrence of health problems among migrant or ethnic minority groups B. social determinants of migrant and ethnic minority health C. issues concerning service provision for migrants or ethnic minorities D. evaluation of methods for reducing inequalities in health or health care affecting migrants or ethnic minorities	*Three or four topics (please specify)* **17** AT, BE, BG, CH, CZ, DE, DK, ES, FI, IT, MK, MT, NL, NO, PT, SE, UK	*One or two topics (please specify)* **12** BH, CY, EE, FR, GR, HU, IE, LT, RO, SI, SK, TU	*None of these topics* **5** HR, IS, LU, LV, PL

Table 3: MIPEX measures taken to stimulate and coordinate improvements in policies on migrant health and with 'flanking measures' necessary to support good policies - data collection and research (IOM 2016, p. 65)

3.4.4 Legal requirements in Europe[24]

Monitoring minority populations is endorsed by the implementation of the '*Framework Convention for the Protection of National Minorities*' (1995), which encourages the use of migration or ethnicity related indicators (Escafré-Dublet, 2012; Ringelheim, 2011). For a comprehensive description of data protection laws in each member state we refer to Farkas (2017d) and Simon (2007).

General recommendation 32 of the *Committee on the Elimination of all Forms of Racial Discrimination* (CERD) states that "*the principle of non-discrimination requires that the characteristics of groups be taken into consideration*". Moreover, the European Commission against Racism and Intolerance (ECRI) (in Escafré-Dublet, 2012) specifies that "*it is difficult to develop and effectively implement policies without good data*". ECRI defines equality data as "*statistics broken down by citizenship, national/ethnic origin, language and religion"* (Farkas, 2017, p. 36).

In the context of HIV-related surveillance among migrants, a report of the European Centre for Disease Prevention and Control (ECDC) (2011, p. 13) cautions that this type of data gathering:

[24] Parts of sections 3.4.1 to 3.6 have been published in the article '*Monitoring migration and ethnicity related indicators in European Drug Treatment Demand (TDI) Registries*'. The version of record is available in the Journal of Ethnicity in Substance Abuse, published in November 2019, DOI: 10.1080/15332640.2019.1664962. **Acknowledgements**: Many individuals have contributed to this work and helped in conceptualizing the discussed issues, although they may not agree with all the views, interpretations and conclusions in this paper. Lies Gremeaux and Jerome Antoine (Sciensano, Belgian National Focal Point) provided input and comments to the early and advanced versions of this paper and were key in disseminating the survey to National Reitox Focal Points. Hannah Vermaut (UNIA, Belgian Equality Body) provided comments on an early version of this paper based on her insight and expertise.

> *"should 'do no harm' (…). This means that if data are collected about 'migrants' it should be done with the intention of benefiting migrants and it should be possible to provide evidence that this is the case or, at least, that no harm befalls them as a result of this data collection."*

To protect European citizens from these potential harms, the General Data Protection Regulation (GDPR) regulates the collection and processing of personal data. GDPR explicitly prohibits the collection of ethnicity related data but also provides quite an array of exceptions including 'substantial public interest', 'vital interests of the data subject' and 'public health' relevance (art. 9). Furthermore, the collection and processing of (pseudo)anonymised data (Custers et al. 2012, p. 345; Hall et al. 2011) is not prohibited when working with unidentifiable unique encrypted personal numbers (Van Baelen et al., 2018) and if the 'purpose specification principle' (and subsequent informed consent) is respected.

Processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation shall be prohibited.
Paragraph 1 shall not apply if one of the following applies:

*(a) the data subject has given **explicit consent** to the processing of those personal data for one or more specified purposes, except where Union or Member State law provide that the prohibition referred to in paragraph 1 may not be lifted by the data subject;*

(b) processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the controller or of the data subject in the field of employment and social security and social protection law in so far as it is authorised by Union or Member State law or a collective agreement pursuant to Member State law providing for appropriate safeguards for the fundamental rights and the interests of the data subject;

*(c) processing is necessary to **protect the vital interests** of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent;*

*(d) processing is carried out in the course of its legitimate activities with **appropriate safeguards** by a foundation, association or any other not-for-profit body with a political, philosophical, religious or trade union aim and on condition that the processing relates solely to the members or to former members of the body or to persons who have regular contact with it in connection with its purposes and that the personal data are not disclosed outside that body without the consent of the data subjects;*

*(e) processing relates to personal data which are **manifestly made public** by the data subject;*

*(f) processing is necessary for the establishment, **exercise or defence of legal claims** or whenever courts are acting in their judicial capacity;*

*(g) processing is necessary for reasons of **substantial public interest**, on the basis of Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject;*

*(h) processing is necessary for the purposes of **preventive or occupational medicine**, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3;*

*(i) processing is necessary for reasons of **public interest in the area of public health**, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices, on the basis of Union or Member State law which provides for suitable and specific measures to safeguard the rights and freedoms of the data subject, in particular professional secrecy;*

*(j) processing is necessary for **archiving purposes in the public interest**, scientific or historical research purposes or statistical purposes in accordance with Article 89(1) based on Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject.*

Personal data referred to in paragraph 1 may be processed for the purposes referred to in point (h) of paragraph 2 when those data are processed by or under the responsibility of a professional subject to the obligation of professional secrecy under Union or Member State law or rules established by national competent bodies or by another person also subject to an obligation of secrecy under Union or Member State law or rules established by national competent bodies.
Member States may maintain or introduce further conditions, including limitations, with regard to the processing of genetic data, biometric data or data concerning health.

Table 4: General Data Protection Regulation Article 9

Farkas – in a report on equality data gathering commissioned by the European Commission – argues that "*no Member State imposes an absolute prohibition of ethnic data collection. In all Member*

States, the collection of ethnic data takes place in accordance with the Data Protection Directive." (2017, p. 14)[25]. Farkas rated the EU-28 member states equality data gathering (including but not limited to ethnicity related data) as presented in Table 5. At least eighteen of the EU-28 member states regulate equality data gathering in their privacy legislation insufficiently, resulting in dispersed interpretation and adding to the taboo of this type of data gathering. Farkas (2017a) further specifies that ethnicity data gathering is not absolutely prohibited in any of the member states and that even in France – often cited as a member state with absolute prohibition of this type of data gathering – ethnicity data-gathering is possible by means of the exceptions in privacy legislation[26].

	Equality data gathering score (Farkas 2017)				
Country	regulated	valid	reliable	comprehensive	Used
Austria	red	red	orange	yellow	red
Belgium	red	yellow		yellow	yellow
Bulgaria	orange	orange	red	green	red
Croatia	yellow	orange	orange	light green	red
Republic of Cyprus	red	red	red	orange	red
Czechia	red	orange	orange	yellow	red
Denmark	red	red	yellow	yellow	orange
Estonia	orange	orange	orange	orange	red
Finland	green	green	green	green	light green
France	red	orange	yellow	yellow	red
Germany	red	red	yellow	yellow	orange
Greece	red	red	orange	yellow	red
Hungary	light green	orange	orange	orange	orange
Ireland	yellow	light green	yellow	yellow	yellow
Italy	red	yellow	orange	yellow	orange
Latvia	red	orange	orange	orange	red
Lithuania	red	orange	orange	orange	red
Luxembourg	red	orange	orange	yellow	red
Malta	red	red	orange	orange	red
Netherlands	light green	green	green	green	yellow
Poland	red	orange	orange	yellow	red
Portugal	orange		yellow	yellow	red
Romania	red	orange	orange	orange	yellow
Slovakia Republic	red	orange	red	red	red
Slovenia	red	orange	red	orange	red
Spain	orange	orange	orange	orange	red
Sweden	red		orange	light green	red
UK	green	green	green	green	green

[25] For detailed country information we refer to the full country reports (Farkas, 2017d).

[26] A French constitutional decision did indeed forbid the inclusion of variables on race and religion in administrative files but it did not rule on the de facto inclusion of geographic origin or previous citizenship (available in public statistics) and language related indicators. Farkas concludes that "*It is conceivable that as a result of the Constitutional Council decision, French judicial interpretation is not compliant with the EU Data Protection Directive concerning the collection of ethnic data, inasmuch as it denies the right to individuals to consent to the processing of data concerning their ethnic origin while providing a mechanism that generates such data without their explicit consent*" (2017a, p. 14).

Explanatory note:
The grey scale represents respectively from black to light grey the following colours (Farkas, 2017b, p. 5-6):
Red (Score 01-19): Major weaknesses;
Orange (Score 20-39): Areas of Weaknesses;
Yellow (Score 40-60): Mixed Areas of Strengths & Weaknesses;
Light green (Score 61-80): Areas of Strengths;
Green (Score 81-100): Major strengths.
Farkas (Farkas, 2017c, pp. 12-21) rated equality data gathering by means of a fixed set of indicators as:
regulated (in sensitive data exemptions allowed as per Directive 95/46/EC and in anti-discrimination legislation and
the existence of equality data legislation or guidance);
valid (consultation of populations, coverage of groups, use of self-definition);
reliable (nationally comparable, regular data collection, number of actors collecting data, controls and disaggregation);
comprehensive (presence of population estimation and data on employment, education, housing, health, poverty
/ social exclusion, crime victimisation, discrimination complaints, discrimination cases, outcomes of discrimination
cases), **use** of equality data to promote equality in practice (official national monitors (discrimination, equality, integration), official local monitors (discrimination, equality, integration, proof in discrimination cases, use of remedies & sanctions, planning for equality or positive actions, law- and policy-making, evaluation of anti discrimination legislation).

Table 5: Equality data score as presented in Farkas (2017c)

Health-related data enjoys an even higher level of protection in the EU (Convention 108, Article 6). As is the case in GDPR, the 2019 Recommendation on the protection of health-related data (CM/Rec(2019)2) stresses in its preamble that data gathering should always "aim to serve the data subject, enhance the quality and efficiency of care, and to enhance health systems where possible".

This recommendation subsequently advises member states to ensure that its principles are enshrined in law and brought to the attention of the authorities responsible for healthcare systems with the main aim of developing secure and interoperable information systems. The recommendation aims at limiting data processing for specified purposes. As is the case for GDPR, it includes exceptions related to

> "*reasons of public health, such as the protection against health hazards, humanitarian action or in order to ensure a high standard of quality and safety for medical treatment, health products and medical devices, subject to the conditions provided for by law*" and "*reasons of substantial public interest*" (2019, p. 5).

A report on 'ethnic statistics' and data protection commissioned by the Council of Europe (Simon, 2007, p. 21) specifies that:

> *"The concept of public interest applies to all areas of public action, and so leaves legislators relatively substantial scope for removing certain sensitive data from the protection authorities' control. It also specifies that scientific research and public statistics are areas where reasons of public interest apply. This opens the way to the collection of data which might seem to be prohibited."*

Indeed, 'public interest' in GDPR and the health-related data recommendation are broad and open to interpretation. Nevertheless, although 'public interest' theoretically opens the way to secondary use of migration and ethnicity related data for research or official purposes, it is rarely invoked by the member states to register or process this data.

3.4.5 The risks of harmful data use: overcoming ethical and methodological issues

The main ethical and methodological challenges identified in a report on the analysis of equality data collection[27] across the EU members are: **regulation, validity, reliability, comprehensiveness and use**. As reflected in table 5, there is little information available on migration and ethnic monitoring in countries such as Bulgaria, Croatia, Cyprus, Greece, Latvia, Malta and Poland. Not surprisingly, equality data gathering in six out seven of these countries is reported to have major weaknesses by Farkas (2017a) (see table 6).

INDICATORS	Evaluation of EU countries equality data gathering by Farkas, 2017, p. 7-8
Regulation	• Limited mandate and resources for equality bodies & employers to collect equality data beyond the ground of disability • Little official guidance provided on how to collect valid, reliable and comprehensive equality data
Validity	• Little-to-no community consultations with the groups concerned to set the national definitions for equality data on all grounds • Few options are given to people for self-definition in the national census or surveys on any grounds of disability, racial or ethnic origin, religion/belief, sexual orientation and gender identity
Reliability	• Few national surveys & few initiatives conducted by a wide variety of methods and actors (e.g. NGOs, researchers, equality bodies, local and regional statistical bodies) • National surveys or administrative data often are not disaggregated due to small sample sizes or incomplete datasets European sources (e.g. FRA surveys, European Social Survey, LFS/SILC ad hoc modules) are often the only major source on disability, ethnic/racial origin, religion, sexual orientation & gender identity
Comprehensiveness	• Social inclusion and living conditions are a major gap for many equality grounds • Targeted comprehensive surveys may be the necessary solution for the under-sampling of small or under sampled groups (e.g. LGBTI, immigrants, religions) in mainstream surveys • The number and outcomes of discrimination cases are rarely collected or disaggregated
Use	• On most grounds, available equality data is usually not a systematic or obligatory part of policymaking, planning, implementation and evaluation • Few national and local equality monitors have been created on equality grounds in order to raise awareness and use of equality data • Equality data is rarely used in discrimination cases and the design of remedies, sanctions and positive actions

Table 6: Overview of equality data gathering weaknesses following Farkas, 2017a

As exemplified in Bulgaria, The Netherland and Germany by Farkas (2017, p. 31) the wrongful use of ethnic data can indeed cause harm (see Table 7). In the context of studying substance use, Reinarman and Levine (1997, in Hunt et al., 2018, p. 4) argued that "*investigations of ethnicity in alcohol and drug research have typically taken the form, whether intentionally or not, of linking "a scapegoated substance to a troubling subordinate group—working-class immigrants, racial or ethnic minorities, or rebellious youth*". Hunt and Kolind (2018) extensively exemplify that research across the continents has largely ignored the injustices of drug laws and high rates of imprisonment caused by singling out specific migrant and ethnic minority populations, for instance in the USA's 'war on drugs' discourse.

[27] Note that Farkas' evaluation (2017) includes indicators concerning all equality grounds (e.g. gender and disability).

Moreover, we have argued elsewhere (De Kock, 2020; De Kock, Decorte, Vanderplasschen, et al., 2017), that ethnicity and migration related variables should not be equated to risk factors when studying substance use and treatment among individuals with an ethnic or migration background because it can inverse causal relations (studying the reasons for differences among MEM versus characterising MEM by means of the identified differences).

Bulgaria: In 2015, the Ministry on Regional Development published an official statement regarding the number of unlawfully built constructions subject to demolition under final demolition orders. According to the statement, 530 out of 6080 buildings were Roma-owned. It is not known how the information was collected. The Bulgarian Regional Inspectorates on education collect information regarding the ethnic origin of the students in every school. This information is only available for the respective Educational departments within the municipalities and would not be revealed upon official request. On occasions, concerns arise even in relation to the collection of census data on ethnic origin.
Germany: Housing companies have developed their own strategies in dealing with the emerging diversity: there is a commonly held view – the so called 25 % myth – among urban planners, according to which with more than 25 % foreigners, a block becomes a problem area and often falls under special local urban development plans. In order to learn about the ethnic composition, housing cooperatives and companies purchase a program, the so-called ethno-variable (onomastic procedures), which categorises their tenants according to names and related regions.
The Netherlands: A recent publication on the housing of asylum seekers and their integration in Dutch society led to a heated public debate on the use, validity, and interpretation of research findings based on ethnicity. The debate focused on one research question: to what extent asylum seekers were involved in criminality. Contrary to the research findings, various national (online) media published the hasty conclusion that asylum seekers were more likely to commit criminal acts.

Table 7: Examples of wrongful use of ethnicity related data collection in Bulgaria, Germany and The Netherlands

Varcoe and colleagues (2009) in their study on collecting ethnicity data in a clinical context argue that most proponents of this type of data gathering envision benefits associated with having this data, but that these benefits are contingent upon action being taken to ameliorate inequities (see also Rallu 2006). Moreover, from the viewpoint of the (potential) client, significant downsides of ethnicity data gathering have also been identified in literature (Aspinall, 2017; Baker et al., 2005; Varcoe et al., 2009):

- Discomfort in reporting race / ethnicity;
- Concerns that the information will be used to discriminate;
- Being judged by the clinician based on stereotypes;
- Defining ethnicity as a 'risk factor' and not considering intersectional axes;
- Reluctance of accessing care because of this type of ethnicity data gathering.

Additionally, evidence is needed concerning the benefits of migration and ethnicity data collection (Varcoe et al. 2009). However, positive action based on migration and ethnic monitoring and the subsequent positive results of these actions have been documented – be it to a limited extent – in the domain of housing and the labour market, more specifically for instance by means of the use 'practice tests' (Van der Bracht et al., 2015b). Although, the health domain significantly differs from the afore mentioned domains, it is worth considering these efforts in the housing and labour domain in the absence of evidence in the health domain. Furthermore, and as mentioned in GDPR ruling, protocols and training for registering need to be available (Varcoe et al., 2009). Additionally, administrative data gathering should not be confounded with data gathering for clinical purposes (see chapter 4).

Lastly, Kriszán (2001), in her review of ethnic monitoring in mainly Central and Eastern European ethnic monitoring as well as Germany, Spain and Latvia reported the following real life examples of harmful use of ethnic data that affects everyday lives of individuals (p. 279):

- Categorising Bulgarian-speaking Muslims as Turks in Bulgarian census makes census data unreliable (p. 275);
- The creation of criminal 'ethnic categories' in criminal statistics by means of external registration by the police goes against the right to self-determination (p. 276) (reported in 2001 in the Czech Republique in the Ministry of Interior suspect registration, Bavarian police in Germany on persons involved in investigations, ethnic data on suspicious people by local Spanish Police, Bulgarian secret services and Hungarian state employment offices on Romani ethnicity);
- Institutionalisation of ethnicity among resettled 'ethnic Russians' in Latvia (p. 277) by means of determining nationality based on ethnicity, obliging citizens to have an 'ethnic' record in the population register, which contradicts the right to self-determination.

We will consider in 3.6 how the wrongful use of data can be prevented by applying the GDPR principles and rules.

3.5 Treatment demand indicator registration in the EU[28]

The European Reitox national drug reports are the only comparable sources across all European member states that describe the overall picture of the drug phenomenon of the most recent year. They are commissioned on a yearly basis by EMCDDA, submitted by the Reitox National Focal Points and predominantly based on the registration of the European Treatment Demand Indicator (Antoine et al., 2016; Montanari et al., 2019). Although this indicator is subject to some limitations[29], it is the only sound, reliable, standardised and thus comparable treatment indicator in Europe (Montanari et al., 2019).

The nationality variable was the only sub indicator that allowed to identify non-national clients in the registries. However, the indicator was suppressed in the third European TDI protocol in 2013. The reason for excluding this variable was that there are no international standards for this type of data collection, that differing European privacy legislations limit this type of data collection and the fact that the variable had only resulted in identifying that most non-national clients have a European nationality (PV CocoTDI 23/11/2012, Sciensano). Furthermore, treatment services indicated that registering nationality is a sensitive topic among some clients.

[28] In this chapter we only retained information of drug phenomena among MEM and registration of their presence in treatment and prevalence surveys. Information on inspiring practices (or reasons for their absence) are not discussed here but in chapter 5. Large parts of this subsection have been published in De Kock, C. (2019c). Migration and ethnicity related indicators in European treatment demand (TDI) registries. Journal of Ethnicity in Substance Abuse, Advance online publication. doi:10.1080/15332640.2019.1664962

[29] such as applying a too narrow definition of treatment (e.g. excluding general practitioners and harm reduction) as well as overestimating the total client number because of doubles.

3.5.1 Method[30]

Reitox National report analysis

To identify trends concerning substance use treatment demand among MEM in the EU-28 member states we screened both the 2014 Reitox national drug reports submitted by the EU-28 member states to the EMCDDA by means of the following queries: ethn*, minorit*, migra*, nationali*, foreign, roma, asylum, refugee. The 2017 reports that are available online contained little to no information on treatment demand trends6 among MEM whereas not all 2015 and 2016 reports were available online, as the result of large changes in the reporting system in 2015[31].

I subsequently focused on the 2014 reports[32] for in-depth analysis and disseminated a survey to identify the indicators that were used in 2017 (see below). Full paragraphs including the search terms were listed and read per country. The information was then coded with the intent of framework analysis (Gale et al., 2013). The framework codes emerged from the gathered data and are used for the subheadings of this paper: vulnerable populations, treatment demand, drug-related crime, prison populations, health/risk behaviour data, social correlates and accessibility.

Survey on migration and ethnicity related variables in TDI Registries

To identify how EU-28 member states monitor migration and ethnicity related variables, an online survey[33] was distributed to the EU-28 member states via the Reitox National Focal Points by means of a request of the Belgian National Focal Point (Sciensano). The European Reitox National Focal Points (NFP) are responsible for submitting the yearly treatment-based (including TDI data) drug reports to EMCDDA on a yearly basis.

The survey questions aimed at identifying ethnicity and / or migration related variables registered by means of the 2017 national TDI protocols. The full survey is available upon request to the author. The survey was open from 10th to 31st of April 2019. Two reminders were sent by the Belgian National Focal Point. Two days before closing the survey, the researcher sent an extra reminder and called all heads of the national focal points that had not completed the survey to provide the relevant data.

3.5.2 2014 Reitox European Drug Reports

Identified vulnerable populations

20 out of the 28 national drug reports of 2014 identify MEM populations that they describe as specifically vulnerable for problem use or remarkably prevalent in treatment demand registries. Eight country reports[34] did not single out a specifically vulnerable MEM population. At least three

[30] Parts of sections 3.4.1 to 3.6 have been published in the article '*Monitoring migration and ethnicity related indicators in European Drug Treatment Demand (TDI) Registries*'. The version of record is available in the Journal of Ethnicity in Substance Abuse, published in November 2019, DOI: 10.1080/15332640.2019.1664962. **Acknowledgements**: Many individuals have contributed to this work and helped in conceptualizing the discussed issues, although they may not agree with all the views, interpretations and conclusions in this paper. Lies Gremeaux and Jerome Antoine (Sciensano, Belgian National Focal Point) provided very useful input and comments to the early and advanced versions of this paper and were key in disseminating the survey to National Reitox Focal Points. Hannah Vermaut (UNIA, Belgian Equality Body) provided comments on an early version of this paper based on her insight and expertise.

[31] The reporting guidelines of EMCDDA are re-discussed year by year.

[32] All 2014 reports are based on 2013 data. Subsequently, if no year is mentioned in the results section, data refer to 2013.

[33] The full questionnaire is available upon request to the author. The relevant wording of the questions is reported in the results section.

[34] UK, Poland, Denmark, Greece, Portugal, France, Finland, Malta

(France, Malta, UK) of those countries are reported to explicitly mention the inclusion of MEM populations in social exclusion policies. The UK report explains that there are no statistically representative samples available to report about these populations whereas the Polish report explains that no data is available. The German report in turn indicates that "data on the prevalence of addiction behaviour among people with a migration background is generally insufficient" (p. 71[35]).

Populations denominated as 'not having the nationality of the member state' are most prevalent, including but not limited to Greek nationals in Cyprus, Vietnamese and Chinese nationals in Ireland (in addition to traveller populations), Portuguese nationals in Luxembourg, homeless non-nationals in Hungary, and undefined non-nationals in Austria and Italy. Roma populations are the second most mentioned across the reports, mainly in Central and Eastern European but also in the Baltic member states[36].

Problem users with a Russian background (identified by means of their language or as a 'former USSR national') are the third most mentioned population, more specifically in the Baltic states and Germany.[37]

Besides these three categories, the Dutch report highlighted vulnerabilities among non-western migrants, the Swedish report speaks of 'foreign-born', the German and Belgian reports identify populations with a (mainly Turkish and Moroccan) migration background. The German report is in fact the only report that includes a clear definition of 'migration background'[38].

[35] In the results section we only refer to pages in the 28 national reports. These reports are fully available and were consulted via http://www.emcdda.europa.eu/publications-database_en?f%25255B0%25255D=field_series_type%253Aname%3ANational%20reports&f%5B0%5D=field_pub_date%3A2014

[36] Lithuania, Slovakia, Slovenia, Czechia, Romania, Bulgaria

[37] Note that MEM that were only reported about in drug-related crime or judicial statistics are not accounted for in this section.

[38] p. 156 "*Definition of people with migration background: The term, "People with migration background" includes people who came to Germany after 1950 and foreign nationals born in Germany (including refugees), late repatriates and naturalised persons as well as their children* (Ruf & Walter-Hamann 2014)."

Treatment demand

Half (n=14) of the 2014 national drug reports observe numerical trends in treatment demand among MEM mainly based on nationality registration. Table 8 presents the full paragraphs that include MEM related TDI data.

BG	The general characteristics of the persons demanding drug-related treatment in 2013 can be expressed as follows: predominantly male (81.1 %), **predominantly Bulgarian (81.8 %),** General average age – 29.5 years of age, predominantly secondary education (56.2 %), predominantly heroin (70.1 %), predominantly daily use (56.4 %), predominantly injecting (64.4 %), average age at the time of first use of primary drug – 19.6 years of age. (p. 60) The relative share of the individuals who have demanded treatment and who do not belong to the main ethnos of the country has increased more than twice since 2007 and over the past 3 years remained within the 17-18 % break, which can be explained by the fact of the addition of the persons who demanded treatment in the prisons, where the percentage of the minority groups is much higher. (p. 63)
CY	In 2008, a remarkable decrease of opiate HRDUs occurred, partly attributable to some significant changes in the population used for the estimate, such as a lower number of demands for treatment, a lack of prison data and a significant decrease of foreign nationals recorded in treatment. (p. 39) In particular, as in previous years, foreign nationals accounted for the majority of high risk opiate users (estimated at about 60% of all opiate HRDUs in 2013) (p. 42). Regarding the nationality of clients recorded in treatment in 2013, 879 out of 1092 were Cypriot nationals**. Nationals of other countries amounted to 205, the majority of whom were EU nationals (135), mainly Greek nationals**. (p. 52). As in previous years, **significant differences occur in risk behaviour prevalence when stratified by nationality**. As in the case of heroin as primary drug, both injecting and sharing practices are more prevalent among foreign nationals (27.5% of Cyprus nationals with heroin as primary drug reported ever shared, as compared to 41% of EU nationals). (p. 61)
DA	**A minor proportion of the drug users receiving treatment are foreign citizens, amounting to a little over 6% in 2011**. The proportion of clients of foreign nationality receiving treatment almost corresponds to the proportion of foreign nationals in the population as a whole. (p. 39)
DE	Data from the various recent studies (MoSyD, SCHULBUS, JDH-Study Berlin) confirms that in a comparison of adolescents from Muslim parent households with other adolescents of the same age, those with a Muslim background use cannabis and illegal drugs much more rarely. (p. 43) The data available on the prevalence of addiction behaviour amongst people with a migration background is generally insufficient. In addition, this population group is too heterogeneous to enable generally applicable statements to be made as to the addictive behaviour of its members. Rather, the group must be further differentiated into specific sub-categories. Individual study results are available for the addictive behaviour of migrant adolescents. In a cross-sectional study, Bermejo and Frank (2014) collected data on alcohol consumption amongst older persons with Turkish, Spanish and Italian migration backgrounds, as well as amongst repatriates. Overall risky consumption was reported by 9% of respondents. Repatriates had the highest level (11.4%) and the Turkish group - in which most people, namely 70.2% are abstinent - had the lowest level (5.3%). Looking at persons who consume alcohol, the highest value for risky consumption was recorded in the Turkish group (17.6%). Alcohol consumption of older persons with a migration background is below the average values for Germans. The findings indicate that persons who consume alcohol from abstinence-based cultures are more likely to develop problem consumption patterns. (p. 71) In 2013, 78.2% (2012: 78.7%) of all outpatient clients N=67,03059 with drug problems recorded within the framework of the German Statistical Report on Treatment Centres for Substance Use Disorders were male. 50.2% (2012: 50.3%) of all treated patients were between 15 and 29 years of age. 83.3% (2012: 83.2%) of them were of German nationality**, 3.2% (2012: 3.0%) were from other countries of the European Union (EU), 8.4% (2012: 8.6%) from non-EU countries such as Turkey or the former Soviet Union (unknown nationality: 5.1%).** Since living conditions of the clients vary considerably depending on the main diagnosis or the drugs used, the characteristics presented in Table 5.4 are broken down by main drugs. (p. 104) in outpatient and inpatient addiction treatment (Künzel et al. 2013), the proportion of these people in outpatient treatment was most recently estimated at 16.8% and the proportion of those in inpatient treatment was estimated at 13.0%. These figures, however, are not only related to persons addicted to illegal drugs but also, for example, to alcohol and tobacco dependent persons (p. 156)
EE	**Most of the persons receiving drug addiction treatment (over 80%), just like in the previous year, were Russians, the percentage of other nationalities was less than 10%.** In 2013, the percentage of Estonians who sought treatment for the first time was somewhat larger amounting to almost 20%. 38% of all people who sought treatment lived in Tallinn and Harju County and 59% in Ida-Viru County. However, among the persons who sought treatment for the first time, the percentages of patients living in Tallinn or Harju County and the Ida-Viru Country were reversed - 59% of the people who sought treatment lived in Tallinn or Harju County while 38% lived in Ida-Viru County (p. 38)
GR	In 2013 unemployed users comprise 64.3% of all users who approached drug services. 8.8% of all users approaching treatment services were homeless users at the reporting year**. 7% of users approaching various therapeutic services in 2013 have foreign nationality**. (p. 80)
GR	According to the data from two low threshold services run by OKANA and KETHEA, the profile of their clients (n=2 552) is as follows: The vast majority were men (80%), The mean age of those approaching KETHEA low threshold service (n= 379) was 37

	years, on average, about one out of three were immigrants, more than half (55%) were homeless and 77.5% were unemployed. (p. 78) **In 2013 unemployed users comprise 64.3% of all users who approached drug services. 8.8% of all users approaching treatment services were homeless users at the reporting year. 7% of users approaching various therapeutic services in 2013 have foreign nationality. (p. 80)**
IE	**The incidence of treated problem substance use among the Traveller community was three times that among the general population in 2010** (523 per 100,000 vs 173 per 100,000). [elaborate study of types and trends] (p. 61)
LU	The male/female ratio of the PDU population is stable at 4:1. **During the last ten years the proportion of indexed non-native PDU has shown strong variations but a clearly increasing tendency since 2003. The population of non-native drug users largely consists of Portuguese nationals, whose proportion is not consistently lower than the one observed in general population**. (p. 74)
LV	**Approximately one third (35.2%) of drug users treated in 2013 are Latvians, about one half (50.6%) are Russian speaking, one in ten (10.2%) drug users have not provided information on their nationality, but 7.6% of drug users treated in 2013 represent other nationalities**. Among those first-treated patients whose nationality has been indicated, the proportion of Latvians is bigger than among previously treated patients (44.6% and 30.8% respectively). (p. 58)
MA	**The majority of all treated clients were Maltese Nationals during 2013 (97%),** the same as that for 2011 and 2012. The number of Maltese first treated clients was reported at 94%, the same percentage as in 2012 and a slight decrease of 3% from 2011 (97%). Treated clients coming from other EU countries in 2013 remained stable at 2% of the entire service using population as in 2011 and 2012. (p. 49)
PT	The analysis of socio-demographic characteristics of patients who went in 2013 to the different drug addiction treatment structures continue to be mostly male (74% to 88%), aged 35-44 years (22% to 52%) and 25-34 years (18% to 44%), middle age varying between 30 and 40 years. **Continue to be predominantly individuals of Portuguese nationality (93% to 100%)** and singles (48% to 71%). (p. 73)
RO	Data for HIV infection show double prevalence among IDUs, compared to the previous year. In terms of the socio-demographic indicators, these define, both for IDUs benefitting from treatment services and for IDUs benefitting from needle exchange programmes, an extremely vulnerable population, in terms of lack of subsistence means, low level of education, **ethnical component (high prevalence of Roma sub-population in the needle exchange programmes) and anomic behaviours (commercial sex, drug related crimes etc.).** (p. 6)
SK	Heroin was mainly distributed from suppliers to consumers through Roma families that apply a similar modus operandi as Albanian organised crime groups. In Central and Eastern Slovakia, heroin continued to be sold in minimum quantities to relatively closed groups of consumers. **A majority of heroin consumers were individuals of Roma origin involved in its distribution, and/or long-term heroin addicts.** (p. 145)

Table 8: Treatment demand MEM-trends in the EU-28 national drug reports of 2014

Notwithstanding the fact that half of the countries report numerical treatment demand trends among varying MEM, these numbers are often left insufficiently contextualised because they report inconsistently concerning comparisons with general population presence (other than the Danish, Cyprus and German reports) and whether the numbers represent over- or underrepresentation. The majority of the data is not aggregated per treatment type nor at other levels (except for the Estonian report).

Most importantly the migration or ethnicity related variables are not analysed in relation to other correlates (e.g. employment, gender, education, housing) and countries do not always identify longitudinal trends. The 'Social exclusion and drug use' parts of the 2014 reports often include a break-down by employment and education but this is not related to ethnicity or migration related indicators in the TDI data. Reports do identify specific socio-economic vulnerabilities in these populations (e.g. the Swedish report concerning nationalities of homeless populations and low employment among third country nationals in the Dutch report) by means of references to other studies.

Only the Irish report specifically identifies and in-depth study of treatment demand among a MEM (sub)populations concerning the above-mentioned contexts: it documents treatment demand in a specific population, comparing trends among traveller clients to trends in the general population.

Drug related crime and prison populations

Whereas only half of the country reports include data and trends about MEM substance use treatment demand, more (n=18) reports include information about drug-related crime or nationalities in judicial statistics. The type of data reproduced includes foreign arrestees, convictions of non-nationals, non-nationals detained with drugs, prison population data, drug-related crime and aggravated narcotic offences. Some countries reported quite high non-national prison populations (Cyprus: 50%) or non-national involvement in drug-related crime as reflected in prison populations (Finland: 39%, Spain: 1/3, Portugal: 28%) while other countries report that these numbers decline and / or have always been quite low (Czechia: 9%, Italy: 17% [but also over 30% unknown], Greece: 8%, Bulgaria [no numbers]).

However, no real trends can be discerned because country reports do not report uniformly, and numbers are rarely presented in relation to a broader context. It is for example unclear whether the populations included in these drug related crime or judicial statistics do or do not overlap or are related to trends in treatment demand data. This is for instance particularly the case for the populations denominated as 'ethnic Albanian' in the reports of Slovakia, Czechia and Croatia as well as the Russian population in Finland, ethnic Vietnamese in Slovakia and non-EU nationals in Italy, Spain and Luxemburg.

Only the Romanian and Lithuanian reports mention that Roma populations in the capital are involved in both drug markets and problematic use of heroin, but this is not documented with numbers. Similarly, the Irish report gives insight in a prison subpopulation with Asian backgrounds, detained for involvement in cannabis cultivation but identified as having been lured by human traffickers and forcedly involved in cannabis cultivation. Lastly, the Slovakian report notes that "distribution of heroin to users is obviously provided by Roma families" (p. 19) but does not include references to numbers, observations or the relation of this statement to treatment demand.

Some country reports (e.g. Luxemburg, Sweden) emphasise that no real trends among non-nationals involved in drug related crime can be discerned. The French report does not include numbers but does report that data is available per nationality about different types of offences, convictions, types of procedures, nature and duration of the sentences (p. 147).

Health correlates and high-risk drug using behaviours

Those country reports that include MEM numerical substance use treatment demand trends[39] more often also included specific information on correlated health risks and risky drug use, compared to countries that did not observe these trends. Some country reports observe that among persons newly registered with infectious diseases a certain proportion consists of non-nationals. Concerning HIV in Sweden, 12 of 14 newly registered HIV cases among persons who inject drugs (PWID) in 2013 were reported to have been infected abroad. But the total number is low and declining. In Bulgaria and Slovakia these numbers were similarly low, respectively 12 and 5%. In Greece, between 2011-2013, 23% of newly infected HIV were non-nationals (p. 60). Concerning HCV (Hepatitis C) in Cyprus, the majority of HCV positives (23 out of 39 cases) were non-nationals (1/2 Greek, 1/4 other EU, 1/4 non-EU).

[39] Greece, Denmark, Bulgaria, Cyprus, Germany, Estonia, Slovakia, Latvia, Lithuania, Luxemburg, Romania, Portugal, Ireland, Malta

Additionally, in Estonia, the prevalence of infectious diseases in 2013 among Tallinn PWID was higher among those with a Russian nationality. Also, in Estonia, 70.2% of the overdose victims (mainly fentanyl-related) were ethnic Russians (n=78). However, overdose deaths were generally declining. In Italy, 9% of the overdose deaths involved non-nationals. This was the case for 27% of the overdose deaths in Luxemburg. Additionally, a decreasing number of victims of Portuguese nationality was observed in Luxemburg.

High risk drug use related behaviour was also accounted for in some of the reports. A lower starting age for illegal substance use was reported among Roma in Czechia. In Cyprus, most high-risk drug users were non-nationals and in 2013 injecting and sharing practices became more prevalent in this population. In Estonia too, injecting drug users mainly had a Russian nationality. Higher injecting prevalence was also observed among female travellers compared to male travellers in Ireland, while when leaving gender unaccounted for, injecting practices were similar to those in the general population.

Social correlates

Half of the countries that report on treatment demand[40] in varying MEM populations, mention social correlates to problem drug use among MEM populations. Homelessness, unemployment, low education and being undocumented are the social correlates that are most mentioned in these country reports. The Dutch report for instance reports that "the proportion of non-Western migrants among the homeless people was 40%" (p. 83) whereas the Swedish report notes that among homeless non-nationals "one fourth had no other known problem besides their lack of housing, compared to 14% of the Swedish-born. The most usual reason for being homeless in the foreign-born group is not being approved on the regular housing market" (p. 71) and "the income gap has increased. Poverty is increasingly more common among immigrants" (p. 67). These correlates are equally mentioned in nine country reports that did not include an analysis of treatment demand among MEM[41].

Four country reports quote survey data that indicates higher unemployment among non-Western migrants (Netherlands), concurrence of risk factors (substance use, homelessness) (Spain) and higher unemployment among non-nationals compared to nationals (Austria, Latvia). However, as mentioned above, none of the reports study these issues as correlates in the available TDI data (see Table 8).

Access

All EU-28 2014 country reports refer to national strategies intended to increase the accessibility of SUT services. Countries such as Czechia, Austria, Poland, Estonia and Romania mainly focus on increasing the geographical availability of opioid substitution treatment to assure equitable access. Country reports also focus on targeting especially vulnerable populations such as drug using prison populations (e.g. Bulgaria, Spain, Denmark) and HIV positive substance users (e.g. Lithuania, Greece, Latvia, Luxemburg, Slovakia).

[40] Greece, Denmark, Bulgaria, Cyprus, Germany, Estonia, Slovakia, Latvia, Lithuania, Luxembourg, Romania, Portugal, Ireland, Malta

[41] Austria, Czechia, Lithuania, Netherlands, Poland, Slovenia, Sweden, Croatia, Spain

Moreover, country reports mention universal health coverage for all citizens (e.g. France, Denmark, Bulgaria, Slovakia, Portugal) enabling access to SUT. Nevertheless, not all citizens have access to SUT, especially not when persons demanding treatment do not have a national identification number or social security number (e.g. Croatia). However, only the German, Luxemburg, Irish and UK reports specifically mention MEM populations when discussing accessibility. None of the country reports (except for the French) make reference to the degree of access to substance use treatment for undocumented MEM.

3.5.3 Survey on migration and ethnicity related variables in TDI

The survey had a response rate of 68%, including two additional respondents who provided information via telephone and sent documentation to the researcher. Data was collected about 19[42] of the EU-28 member states. Respondents all were staff members and researchers, mainly and as intended of the Reitox National Focal Points.

Concerning the **indicators used**, all respondents answered the question "which migration / ethnicity / nationality related indicators were registered in the 2017 national TDI protocol?". Considering that only two respondents chose the 'other' option (see below) we presume that the answer options[43] had enough coverage. The used indicators are listed in Table 9.

Nationality (n=10)
Birthplace (n=6)
European-Union / not-European-Union (n=5)
Ethnicity (n=5)
Nationality at birth (n=4)

Table 9: The five most often registered indicators in the 2017 national TDI protocols identified by survey respondents

Two respondents answered that they did not record migration or ethnicity related variables. One respondent answered that this data is not available and that "only the number for foreigners is available". Five respondents only ticked one option whereas the other respondents indicated that their TDI protocol covers two to three indicators. Only one respondent indicated recording 'birthplace / nationality mother or father' and the one respondent reported to record a language related question.

Concerning the **methods of registration**[44], the majority of the respondents (n=12) indicate that 'providers tick one or several predefined categories'. Three respondents indicate that open answers by the provider are also available in addition to predefined ticking. One respondent reported that only an open-ended registration is possible.

[42] Belgium, Bulgaria, Cyprus, Czechia, Finland, France, Greece, Ireland, Italy, Latvia, Lithuania, Luxemburg, Poland, Portugal, Slovakia, Spain, Sweden, The Netherlands United Kingdom (England), Poland. No data available on Denmark, Germany, Estonia, Hungary, Croatia, Malta, Austria, Romania.

[43] "Birthplace, European / not-European choice, Nationality at birth, Nationality, Language related question, Birthplace / nationality of mother, Birthplace / nationality of grandmother, Birthplace / nationality of father Birthplace / nationality of grandfather, Ethnicity, I don't know, None, Other (Please specify)"

[44] Based on the question "*Can you specify how migration / nationality / ethnicity related indicators were mainly registered in the 2017 national TDI protocol*?"

All respondents reported insufficient **coverage** of the ethnicity and migration related indicators[45] because of a low number of services that register TDI or a low number of identifiable clients in TDI registries. In some countries, most government funded SUT services register TDI. In most countries, SUT services consist partly of private services that often do not register TDI. Furthermore, TDI registration is often not mandatory which is why services sometimes do not register it. Respondents also observe that many clients are not registered with a national identification number (NIN), especially those clients with a migration background and those who do not have a NIN such as undocumented migrants. A respondent specified for example that:

> *Registering ethnicity is illegal in [member state]. Our TDI data is pseudo-anonymised and cannot be linked to other register data. Birthplace, Nationality at birth, Nationality, Mother tongue, Birthplace / nationality of mother and Birthplace / nationality of father are available in the national population register and by applying data permissions for specific studies, it would be possible to link this data to general health care registers. They are not, however, very useful for assessing drug-disorders because of under-reporting.*

Lastly, we asked respondents in an open-ended question how they believe monitoring MEM presence and trajectories in substance use treatment could be **enhanced** in their country. Clearly, the registration of these types of indicators is considered sensitive or even prohibited in some countries, as demonstrated in the quote below.

It is very difficult in [member state] to get data through studies on migrants, non-nationals, not to speak of ethnicity which is a taboo subject. To any attempt to do so will be opposed the fear of discrimination. The only possible approach for these subjects seems to carry out qualitative studies.

Answers to this question are very diverse but complement one another. Four respondents did not provide answers on how to enhance registration or data processing. Respondents answers were categorised and are summarised in Table 10. These answer categories are used to structure the discussion. The discussion is based on these survey responses because of the importance of proportionality and subsidiarity in the European Union. This means that in areas in which the European Union does not have exclusive competence, member states are expected to initialise change and that EU action shall not exceed what is necessary to achieve the objectives of the Treaties. In other words, a discussion on how to enhance TDI registration and data processing, can only be initiated based on the perspectives of national experts in the field.

Reliable indicators and registration in TDI (n=5)
It is sensitive and / or prohibited by law (n=3)
Use of unique identifiers in the TDI dataset (n=3)
([pseudo]anonymous) database linkage (n=2)
Stratify available TDI data (n=2)

Table 10: Summary of how survey respondents believe monitoring migrant and ethnic minority presence in substance use treatment could be enhanced

[45] Based on the question *"Please name the (types of) services of which (you think) registered nationality / migration / ethnicity related in 2017."* And *"Are clients registered with a national identification number in drug treatment in your country?"*

3.6 Discussion: a heated debate

In light of public interest, our results demonstrate that over half of the 2014 national drug reports observe trends in treatment demand and highlight important social correlates to harmful substance use and treatment demand among MEM. Nevertheless, the reports insufficiently contextualise specific numbers or substantiate and explain trends clearly to be able to act upon them. Eastern and Central European countries clearly observe disparities among Roma and general populations but cannot pinpoint reasons and ways forward because of inconsistent data and a lack of harmonised processing guidelines. This is similarly the case for Russian speakers in Latvia, Estonia, Germany and more recently in France (Jauffret-Roustide et al., 2017) as well as non-nationals in Cyprus, Ireland, Luxembourg, Hungary, Austria, Sweden and Italy.

Moreover, persons defined as having a migration background (at least one parent with other nationality / birthplace) are identified as specifically vulnerable in Belgium and Germany. Lastly, it should be mentioned that trends in treatment demand among the growing group of intra-European migrants, asylum applicants and undocumented migrants in Western, Northern and Southern European countries are left unstudied in the 2014 country reports. Indeed, the data used in these reports dates back about five years at the moment of writing. Nevertheless, new (intra-European) migration movements had already initiated due to the accession of Central and Eastern-European countries in the EU in 2007. Although irregular third country arrivals in the EU only peaked in 2015, the number was already growing in 2013.

Even though the research domain of SUT among MEM is still limited in the European context there are clear indications of disparities in these populations across the EU-28 member states. Subsequently, ethnicity and migration related data gathering in TDI could be argued for on the basis of public interest if privacy regulations are respected. In what follows, we first elaborate on the ways survey respondents believe monitoring MEM presence and trajectories in substance use treatment could be enhanced and then discuss the importance of purpose specification and subsequent informed consent.

3.6.1 Sensitive and prohibited?

Three respondents indicated in the survey that this type of data collection is sensitive or prohibited in their country. This type of data collection is indeed the subject of heated debate in Europe, mainly because of its ethical implications for the populations being registered and 'categorised' (Jacobs et al. 2009). The main argument of proponents of migration and ethnicity related data gathering is based on a perceived need for documenting (in)equalities related to (health) rights of population groups (Krizsán, 2001) whereas opponents mainly refer to concerns about privacy (should treatment data aggregated at migration or ethnic background level be made available and if so to whom?) and self-determination (What will be the consequences of lumping individuals together in categories of persons with a migration background?) (Varcoe et al., 2009).

Especially in the health domain it has been argued that it can "work to reify, perpetuate and spread into the area of healthcare politically driven notions and categories of nationalism which exclude certain groups" (Helberg-Proctor et al., 2017).[46] We have argued elsewhere that the analysis of static

[46] In the Netherlands for instance some argue that while ethnicity is included in the health domain to combat disparities, it might be intertwined with and contribute to these very societal dynamics which produce health inequalities. This was similarly argued for by Epstein (2007) in stating that the political context in the US

ethnicity related categories in epidemiological research that lacks the consideration of correlates and consequent analysis of cross-categories can indeed work to reify and stigmatise subpopulations (De Kock, Decorte, Vanderplasschen, et al., 2017).

However, it appears that European member states interpret the GDPR and its predecessors very differently and as a result only a minority registers such data in health, census or other registries. The main problem appears to be that national legislation and resultant regulations do not contain specified definitions of the equality grounds (e.g. 'race', 'ethnicity'). Consequently, member states insufficiently regulate the registration and use of equality data in the light of public interest. It should be noted that in the EU-28 only two countries - UK and Ireland - collect data on ethnicity with the aim to implement positive action (Escafré-Dublet & Simon, 2011).

In any case and in conformity with the GDPR, National Data Protection Authorities should regulate and control compliance with the lawfulness of data processing and should supervise that "processing is necessary in order to protect the vital interests of the data subject or of another natural person" (GDPR, art. 5). Furthermore, the GDPR requires that before data registration and processing take place, a Data Privacy Impact Assessment be made and that Data Protection Officers at the organisational level secure that no direct or indirect harm is inflicted upon data subjects as a result of data registration or processing.

This implies that advocates of minority rights and anti-discrimination policy on the one hand and proponents of personal data protection on the other hand should not per definition take opposite stands. Moreover, protecting individual privacy and the right to equal treatment can be considered two sides of the same coin: pursuing the integrity of all individuals (including privacy and equal treatment) in society in line with the Universal Declaration of Human Rights.

3.6.2 Reliable indicators in TDI

Five respondents indicated that more reliable registration could enhance monitoring MEM in European SUT. The fact that nationality was most reported by survey respondents to be registered in national TDI registries is a direct result of its inclusion in the second TDI protocol. The strength of already having the nationality variable integrated in at least one third of the EU-28 national TDI protocols should not be underestimated, considering the compatibility needs when making changes in a registration protocol in the interest of longitudinal analysis (Krizsán, 2001). With sufficient coverage (both in terms of client totals as in terms of treatment services covered) it can give insight in the specific group of first-generation migrants in SUT (e.g. an estimated half of the 2018 MEM population in Belgium). Even if coverage is limited, member states could choose to monitor registration shortcomings scrupulously in order to report on parts of their TDI datasets. The nationality indicator does need rewording in specific national contexts (and with answer options conforming to ISO 3166 including a 'none' option) because in some EU countries 'nationality' could be interpreted as an ethnicity related indicator (e.g. Cyprus, Romania, Estonia).

Nevertheless, the nationality variable is indeed a flawed proxy to cover all migration and ethnic backgrounds because it does not capture the complexity of migrant generations or (multiple) self-definitions (Hunt, 2017; Kolind & Hunt, 2017). Additionally, the 'European / non-European' indicator

shaped scientific practices related to ethnicity and race in health, as exemplified in US based epidemiological studies (De Kock, Decorte, Vanderplasschen, Derluyn, & Sacco, 2017).

reported to be used in at least three member states is insufficiently valid considering the changing composition of the EU member states and the difference between countries pertaining to the EU on the one hand and European countries on the other hand.

A way forward concerning monitoring second generation migrants could be the inclusion of an indicator concerning birthplace of mother to the example of European surveys (e.g. European Labour force, health and social surveys, EU-SILC) and a language related question (mother tongue, home language [e.g. International PISA questionnaire]) and possibly a third language related questionnaire). The use and processing of these indicators in European surveys and their acceptance in the EU-28 member states that partake in the surveys, indicates validity and conformity vis-à-vis current national privacy regulations. Additionally, the use of these indicators could be generalised to other registries (e.g. national health surveys) which could contribute to data comparability and multi-indicator analysis. These indicators are not intended to capture self-identification but rather to capture the situation of objectifiable social groups. It should be noted that self-identification (see below) is an added value for qualitative understanding but has been described in literature to be insufficiently discriminatory to capture migration backgrounds (Perrin et al., 2015). A minimum, medium and in-depth registration scenario for TDI is subsequently proposed in Table 11 below.

Type of registration	Number of Indicators	Indicators	Analytical capacity
Minimum	2	Nationality country of birth	National / non-national specifiable per country First migration generation
Medium	3 or 4	country of birth mother (country of birth father)	Second migration generation
In-depth	5, 6 or 7	Mother Tongue Home Language A third language related question	Integration / health access Ethnicity related language use

Table 11: Proposal for minimum, medium and in-depth registration

A second way forward is the consultation of Eastern and Central European member states to collaboratively (with member state representatives and targeted populations) consider the inclusion of ethnicity related (in combination with other) indicators. This issue will become increasingly important because inequalities among Roma populations are no longer only a concern in Central, Eastern and Baltic European countries but increasingly require attention in Western, Northern and Southern European countries too (Company, 2005; ERRC, 2017).

Concerning registration of the indicators, **self-definition** is considered to do most justice to the right of self-determination and to define ethnicity and migration background (Aspinall, 2017; Krizsán, 2001; Varcoe et al., 2009). The definition of ethnicity and migration background by thirds such as the police and justice actors should therefore be evaluated critically because the resulting numbers may not be correct and possibly harm the data subject and / or depicted populations (Krizsán, 2001). However, self-definition complicates data collection and analysis (lack of uniform and exclusionary units of analysis), especially in the SUT context. Also, it has been argued that strict self-definition is arguably the best method or sufficiently valid when the purpose is to analyse the impact of perception by others (e.g. perceived and structural discrimination) (Ringelheim & De Schutter, 2010, p. 135).

Our results demonstrate that the majority of TDI data is registered by means of the provider ticking predefined categories. The option of open-ended self-identification alongside the choice of predefined categories, is a valuable addition to ticking predefined categories, in line with the right to self-determination.

3.6.3 Multivariate analysis in TDI datasets

Two respondents indicated that the in-depth analysis of current TDI datasets will be sufficient to gain more insight in treatment demand among MEM populations. Indeed, some current TDI datasets already hold the potential FOR informing positive action towards certain MEM populations. However, identifying complex patterns and trends in treatment demand and nuancing the identification by means of migration and ethnicity related indicators, requires intersectional analysis (Agirdag & Korkmazer, 2015; De Kock, Decorte, Vanderplasschen, et al., 2017). Indeed, only relating identified populations in one-on-one relations to health risks, risky drug use behaviour, drug-related crime or prison-populations is insufficient because it provides little information on real treatment demand trends. Furthermore, it could in fact harm the population being described by adding to stigma or discrimination. Madeira and colleagues (2018) for instance found that perceiving MEM as a threat or risk to public health (e.g. concerning HIV among high drug users as mentioned in some reports) is indicative for health providers self-reported bias in treatment, a bias directly related to lower quality treatment.

This implies the analysis of two sets of combined variables. First, the processing of at least two and preferably more reliable migration and ethnicity related variables (see Table 11) will allow for contextualising the seemingly static categorisation of individuals in groups or populations. Indeed, individual data should not be used only to characterise a group but also to identify combined characteristics as well as longitudinal trends and subgroup changes.

Second, migration and ethnicity related variable analysis should be studied intersectionally in combination with covariates such as living situation, education, employment and gender in relation to treatment demand (Giritli Nygren & Olofsson, 2014). This combined study will give in-depth insight inTO both the construct of ethnicity, the impact of migration / ethnicity and might broaden micro-centred epidemiological studies by explaining treatment demand trends (Carliner et al., 2016; Kapilashrami et al., 2015). The ‘guide for assessing health needs and health protection resources’ developed with the support of the European Health programme (2016) could be a valuable resource in addition to the EMCDDA processing and reporting guidelines.

Moreover, it should be noted that none of the 2014 national drug reports compare treatment demand to population-based prevalence rates among MEM besides the German and the Swedish reports. In this context, Ritter (2019) argues for the deployment of models that include treatment demand and need (substance use prevalence) when estimating real treatment gaps for the purpose of local treatment planning. These models should also allow us to distinguish between drug types, age groups and drug use severity (Ritter et al., 2019, p. 25) and focus on subsequent ‘tiered’ modelling based on multi-indicator analysis for targeted service planning.

A way forward in the European context could be to a priori add additional purposive sampling strategies to the National Health Surveys in order to routinely collect data in representative MEM samples that include (spectra from harmful to recreational) substance use prevalence or setting up targeted surveys that complement general population studies, to be included in the national drug

reports. Furthermore, the currently used indicators (i.e. nationality, birthplace, EU/not-EU) should always be contextualised by means of representation in the general population or other population-based studies. It would also be informative if country reports could inform consequently on why specific information is not provided (e.g. the UK report mentioned that representative datasets were not available).

3.6.4 The use of unique identifiers in the TDI datasets

The use of unique identifiers in the TDI datasets was suggested by three survey respondents to better monitor treatment demand among MEM. If a unique identifier is not available (e.g. first letters of name and first two numbers of birthday), data cannot be analysed at the individual disaggregated level (disabling the study of correlates). The growing group of undocumented migrants for instance that do not possess NIN (yet) are not identifiable in datasets if NIN is the only identifier used. A last way forward in order to not rely on NIN, could thus be the consideration to create unique (pseudo)anonymised TDI identifiers for each client as for example in Finland.

Lastly, database linkage (e.g. TDI and population registries) for gaining insight in treatment demand, as suggested by two respondents, could be problematic and holds the risk of harmful use of datasets (e.g. small and identifiable subsets, opening the possibility for linkage to judicial databases in insufficiently regulated data environments). Database linkage is reported to be rare in the domain of ethnic data collection in Europe (Farkas, 2017) and to our knowledge limited in the substance use treatment domain (Van Baelen et al., 2018). Moreover, linkage of population-based administrative data is limited by many methodological challenges such as bias from linkage errors located in the data linkage environment, privacy preservation procedures in data preparation and the choices of linkage methods (Harron et al., 2017).

Additionally, in the niche domain of MEM in substance use treatment, database linkage is likely to be unreliable because it requires clients to be registered with a unique identifier that is equally identifiable in other databases such as a national identification number (NIN). Persons with a different nationality have been reported to be more often registered without a NIN (i.e. 40.72% non-identifiable third country and 37.51% European clients in 2012-2014 datasets compared to 23.86% of Belgian clients) (De Kock, Blomme, et al., 2020).

Although database linkage could offer insights in high quality subsets of data, it would be advisable at this moment to limit data analysis on this specific topic only to TDI datasets. Only member states that have both high-quality datasets (valid indicators, coverage etc.) and that provide sufficient safeguards for the privacy of data subjects should consider linkage of TDI to other datasets for further analysis[47].

3.6.5 'Do no harm': Purpose specification and informed consent

Rallu and colleauges (2004) argues in favour of data collection regimes that do not simply aim to document and count but that clearly and explicitly aim at implementing positive action in the light of equality regulations (in Escafré-Dublet, 2011). Indeed, the raw data can be misleading if the data are not considered in relation to other characteristics such as age, sex and SES (WHO, 2010b, p. 8). Subsequently, it is essential to consider **purpose specification** scrupulously.

[47] More information on TDI database linkage in other domains can be found in Van Baelen, De Ridder, Antoine and Gremeaux (2018)

The TDI protocol 3.0 describes the purpose of data collection as follows: "gain insights into the characteristics, risk behaviours and drug use patterns of people with drug problems in the community, and to help to estimate trends in the extent (prevalence and incidence) and patterns of problem drug use" (2012, p. 17). One could however argue to take this a step further and include, to the benefit of (and to explicitly protect) the populations involved (and their subsequent willingness to provide data) the purpose of combatting inequities and disparities. The 2018 UK 'National Drug Treatment Monitoring System' protocol for instance, introduces with the following sentence: "Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities". This addition to the protocol could be decided upon on the level of a member state or the EU level.

Purpose specification in turn is closely intertwined with **voluntary informed consent**[48] by the data subject. Studies do indeed observe that persons identifying with stigmatised populations are often 'reluctant' to identify as such out of fear of stigmatisation (Varcoe et al., 2009). This in turn results in their underrepresentation in statistics. However, the nature of data collection methods and use of data without proper purpose specification (e.g. invalid proxy by interpreting only language to identify 'ethnicity', 'choosing' nationality in census contexts, involuntary ethnicity registration in police statistics etc.) are likely to influence this suspicion.

Moreover, the 2015 Eurobarometer asked whether individuals would support providing personal details on an anonymous basis if it could help to combat discrimination in their country and 72% were in support regarding data on 'ethnic origin' (Makkonen, 2016). Although individuals with a Roma background were less favourable, still over half of the surveyed respondents with this background, were in favour. Although it can be time intensive for service providers, it is advisable for the national TDI protocols to include a clear statement on purpose specification to support the service provider responsible for registration, in explaining it to the client.

Purpose specification and informed consent could thus be translated in 1) specifying the purpose of TDI (at member state or EU level) and 2) involvement of target populations in defining variables and subsequent involvement of, for instance, the ombudspersons for Minority Rights in the member states. Indeed, the quality of the data highly depends on the data supplier's interest in the produced data (Krizsán, 2001, p. 281).

3.7 Conclusion

Treatment demand trends and socio-economic contexts of MEM populations are very diverse across the EU-28 member states and consequently do not always allow for comparisons. However, the current study demonstrates that the TDI dataset – as a result of the efforts of standardisation initialised by the Pompidou group over two decades ago and continuously sustained by EMCDDA

[48] GDPR (31) "The processing of special categories of personal data may be necessary for reasons of public interest in the areas of public health without consent of the data subject. Such processing should be subject to suitable and specific measures so as to protect the rights and freedoms of natural persons. In that context, 'public health' should be interpreted as defined in Regulation (EC) No 1338/2008 of the European Parliament and of the Council (1), namely all elements related to health, namely health status, including morbidity and disability, the determinants having an effect on that health status, healthcare needs, resources allocated to healthcare, the provision of, and universal access to, healthcare as well as healthcare expenditure and financing, and the causes of mortality. Such processing of data concerning health for reasons of public interest should not result in personal data being processed for other purposes."

and the National Reitox Focal Points – provides a valuable tool when it comes to identifying treatment demand trends across the EU-28 countries. The existence of this dataset enables knowledge transfer across the countries and could inform joint policy planning without interfering with the principles of subsidiarity and proportionality.

Although some respondents expressed legitimate concerns related to privacy legislation, the majority of survey respondents formulated complementary measures to enhance trend monitoring concerning MEM substance use treatment demand. Because of the importance of the principles of subsidiarity and proportionality in the European Union, I focussed the discussion of the results on the suggestions made by survey responses of Reitox National Focal point staff members. Departing from the idea that drug (treatment) policy is best based on 'tiered modelling' (Ritter et al., 2019) this analysis suggests to focus prioritarily on the use of reliable migration and ethnicity related indicators in TDI and other drug related indicator protocols, multivariate and cross-category TDI analysis, the use of unique identifiers and purpose specification in the TDI protocol.

Providing guidelines and support on how the existent data can be enhanced, processed and safeguarded as well as continuously improving the quality and coverage of the dataset can allow the member states to relate prevalence rates (health surveys), treatment demand and data on social correlates to identify meaningful trends and inform targeted service planning.

Processing TDI data should always comply with the GDPR, thereby avoiding increased stigma of specific populations and preventing harm for data subjects resultant of data collection and processing. In the light of growing political conservatism and identity politics in the European Union, the GDPR requirement of providing a Data Privacy Impact Assessment and consequently identifying safeguards to reduce the risks of migration and ethnicity related data registration and processing, is key. This chapter provides a basis for developing such an Impact Assessment and the issues identified in the discussion should be considered in such an exercise.

In conclusion, together with other European scholars and policy makers (Farkas, 2017a; Ringelheim, 2011) we argue for the necessity to include scientifically sound migration and ethnicity related indicators that allow us to the monitor (changing) MEM (sub)populations in the substance use treatment domain and for processing this data intersectionally, in light of the specific purpose of serving their (public) interest.

Conforming with GDPR, the recommendations concerning health data collection and the outlined evidence this would mean that migration and ethnic data gathering complies with the prerequisites enumerated in table 12 below.

Explicit consent (29)	Data subject has the right to access the data and the rights to information, rectification, objection and deletion, (as defined in Recommendation, 2019).
	Data subject should be provided with his / her right prior to data collection or at the first communication (as defined in Recommendation, 2019).
Purpose specified (29 & 43)	Requested data must be proportionate to the objectives set by the monitoring system (Verwey et al. 2012, p. 76; Recommendation, 2019) (e.g. 'better combating the discrimination on the labour market').
	Data must be collected for explicit, specific and legitimate purposes (Recommendation, 2019)
	Evidence for the benefits of this data processing is provided (Varcoe et al. 2009)
	e.g. multi-level regression, propensity score matching, study of strongest net relation

Appropriate mathematical or statistical procedures devised (43)	between all variables (Agirdag, 2015), directionality social and ethnic variables (Agirdag, 2015), clear difference classification / clustering / pattern mining (Custers et al. 2014) e.g. changing characteristics, proper representation of the population, data selection process, independence of attributed characteristics (e.g. neighbourhood - ethnicity) should be analysed and reported to account for sample bias. Data collection, processing and missing data procedures should be specified, e.g. mismatched deterministic or probabilistic data linkage tested by means of reference data, post-linkage validation, sensitivity analysis, comparing characteristics should be explicit (Hjern, 2017) "Auditability" should lead to a system in which it is possible to trace any access to the information system, modifications made, and any action carried out, in order to identify its author (Recommendation, 2019).
Personal data secured (43)	Anonimisation / pseudo-anonimisation in pre-processing (Custers et al. 2014)
	Privacy preserving datamining techniques (Custers et al. 2014) e.g. risks of re-identification must be excluded throughout the entire monitoring process (Verwey et al. 2012)
	Privacy preserving data linkage methods (Hjern et al. 2017)
Data safeguard responsibilities (43)	Assessment of the potential impact of the foreseen processing of data in terms of data protection and respect for privacy, including of the measures aimed at mitigating the risk (Recommendation, 2019)
	Appropriate safeguards should be established in order to guarantee, in particular, the security of the data and respect for the rights of the individual. Any other guarantees may be provided for by law with a view to safeguarding respect for rights and fundamental freedoms (Recommentation, 2019)
Discriminatory effects anticipated (43)	Building separate models (Custers et al. 2014)
	Modifying data (labels, duplicated, synthetic samples, transforming set) (Custers et al. 2014)
	Model training constraints (Custers et al. 2014)
	Use of DCube (discrimination discovery in databases) (Custers et al. 2014)

Table 12: Prerequisites for migration and ethnicity related data gathering

Registration should be preceded by informed consent that follows from the purpose specification principle. Taking these considerations, Farkas' (2017) recommendations and the recommendations of the European Handbook for equality data collection (Makkonen, 2016) into account, migration and ethnic data gathering in the health domain should satisfy – in addition to GDPR conformity – the following prerequisites:

1. Indicator registered after **informed consent**
2. Data collection, processing and analysis **regulated** in privacy legislation
3. **Valid** data (representative for the target populations and measured by means of sound indicators)
4. **Reliable** and adequate, relevant and not excessive data (including stable categories)
5. **Comprehensive** data
6. Follow-up of dissemination and **data use** (for positive action)

Table 13: Principles for migration and ethnicity related data gathering

4. Migration and ethnicity related indicators in Belgian SUT

Charlotte De Kock

In 2011 an expert group (with the support of the former federal minister of health) made recommendations aimed at better accommodating the Belgian health system to the presence of MEM in Belgium. In their report (ETHEALTH report), experts emphasised that the lack of data on MEM in for instance the national health surveys and hospital statistics limits the possibilities to develop targeted actions to decrease health inequities (Derluyn et al., 2011). This is equally the case in substance use treatment data (see chapter 3.5). Additionally and as discussed in chapter 3.4.4, the European Guideline (2000/43/EG23) on equal treatment advises to implement such monitoring (Perrin et al., 2015).

In what follows we will discuss the current state of this debate in Belgium (4.2), Belgian population statistics (4.3), the legal framework (4.4), such registration in other domains and specifically the health domain and substance use treatment (4.5). We will conclude with possible ways forward for the Belgian TDI registration (4.6).

4.1 Methods

We used three main methods in describing the Belgian situation: semi-structured qualitative interviews, an e-mail survey and a review of literature.

First, five interviews were conducted with six purposively sampled experts in the field of ethnicity and migration related monitoring in Belgium. Each of the respondents had specific expertise in ethnicity and migration related data collection. They were sent chapter 3 (published during the research project in the *Journal for Ethnicity in Substance Use*) of this report and asked to comment on this chapter with the eye on its applicability in the Belgian context. These respondents are listed in table 14 below.

Additionally, some of the participants included in the empirical work in chapter 7, also made relevant comments concerning registration in their substance use treatment related professional context. Some of their statements have therefor been included in this chapter (see chapter 7 for sampling and data processing methods). The primary interviewees (table 14) will be referred to throughout this chapter by means of respondent numbers. Additional quotes from interviewees in chapter 7 will be identified as such.

Respondent 1&2: Two employees of **Sciensano** (responsible for TDI reporting to EMCDDA)
Respondent 3: A former researcher at **UCL** involved in researching ethnicity related monitoring
Respondent 4: A former researcher at **UCL** involved in researching ethnicity related monitoring
Respondent 5: An employee of **UNIA** involved in the writing a report on equality monitoring
Respondent 6: A former employee of the **Privacy Commission**

Table 14: Respondents (migration and ethnicity related indicators in Belgium)

Second, we conducted an e-mail consultation of all Belgian services listed by Sciensano as providing specified substance use treatment with the main question "*can you provide information about which indicators your service registers concerning migration background and nationality?*"[49] in July-August 2019.

[49] *"Beste professioneel in de drughulpverlening, Zoals u weet zijn we aan UGent met steun van het Federaal wetenschapsbeleid en in samenwerking met VAD bezig met een onderzoek naar drughulpverlening bij personen met een migratieachtergrond (zie MATREMI project onderaan deze mail). Een van de twee doelen van dit onderzoek is om in kaart te brengen hoe personen een migratieachtergrond beter geregistreerd kunnen worden om een beter zicht te krijgen op deze doelgroep in de hulpverlening. Daarom consulteer ik u graag wat*

Third, respondents to the e-mail survey and the interviews provided extra information on legislation and grey literature. The results section (4.2-4.5) consist of the triangulation of these three data sources (interviews, literature, e-mail survey).

4.2 Belgian perspectives on ethnicity and migration related indicators

*State-istical categories **may become categories that organize people's experiences** precisely because they are embedded in state-created institutions that structure that experience*

(Scott, 1998, p. 82-83 in Louckx & Vanderstraeten, p. 534-535)

In a paper on the perception of population problems through the lens of statistics or 'state-istics' Louckx and Vanderstraeten (2014) argue that the collection of population data initially aimed at counting the population but also served to exclude and even expert power over specific groups. The categorisation of persons by ethnicity or migration background in educational, labour or other categories can work to reify differences and differentiation in society. Consequently, the means of doing so – the proper categories such as nationality or other proxies – should be considered scrupulously. Indeed, in Belgium too, population censuses and registration of administrative data were first aimed at providing a comprehensive overview of the populations and they thereby sometimes reproduced social problems.

In chapter 3, we referred to the **Framework Convention for the Protection of National Minorities** as one of the most comprehensive treaties designed to protect the rights of persons belonging to national minorities. This Framework Convention also contains recommendations concerning ethnicity and migration related monitoring and registration. However, Belgium is only a signatory state and not a state party – as the majority of EU member states in this treaty. This means that Belgium does not explicitly consent to be bound by the treaty.

Jacobs & Swyngedouw (2003) note that Belgium, especially the Flemish Dutch speaking part denies the existence of national minorities due to its historical language divide and the fact that French and Dutch speaking populations are both majority populations as exemplified by the following example given by respondent 6.

> Belgian citizens living in the Brussels area contacted the Privacy Commission because they were worried that the registration of 'language used at home' in the educational system would be used in the framework of 'language counting' (French – Dutch). These citizens thought that resultant 'language counting' could influence the political situation of the municipalities, as it has been used in the past to distinguish between 'Flemish' and 'Walloon' communities. However, the purpose of the identification of home language in the educational context was in fact only to identify whether school children did or did not speak one of the national languages at home and to subsequently know whether schools would have to be granted funding for extra assistance in schools.

betreft het registratiesysteem dat uw organisatie gebruikt los van de TDI (treatment demand indicator) registratie. Graag willen we weten aan de hand van welke vragen en antwoordmogelijkheden uw organisatie migratieachtergrond registreert bij het identificeren van nieuwe cliënten bij intake. Om zo min mogelijk tijd in deze vraag te steken, kan u enkele screenshots maken van dit onderdeel van het registratiesysteem dat gebruikt wordt bij intake. Indien u ons verdere toelichting wil geven bij het registratieprotocol kan dit natuurlijk ook door bijvoorbeeld de handleiding mee te sturen. Deze gegevens zullen alleen gebruikt worden om op anonieme wijze een algemeen beeld te krijgen van de registratie."

Jacobs and colleagues (2009) and Perrin and colleagues (2015) note two mains peculiarities in Belgian designations of migration backgrounds. First, it is more likely for persons with a migration background to have the Belgian or a double nationality compared to other EU countries. Moreover, persons with a 'double nationality' are often 'enumerated' as Belgians. Second, the French speaking part of Belgium has been historically more reluctant towards ethnic 'categorization'. The Dutch speaking part of Belgium – Flanders – in turn, is more inclined to follow the Dutch model by distinguishing migration backgrounds based on (grand)mother and father's birthplace. Nationality and place of birth indeed only cover first generation migrants. For identifying second generation migration background additional registration categories such as country of birth mother / father are needed.

Nevertheless, as mentioned by Vermaut & Carlier (in Farkas, 2017a, p. 24) a third issue emerges:

> "there are problems with data comparability between different institutional levels: the Belgian state, the Flemish government, Flemish provinces and different Flemish cities use data from the National Register and the Crossroads Bank for Social Security with a different operationalisation of origin and/or migration background."

The above mentioned conflict between Flemish and Walloon traditions seems to have shifted and weakened during the past few years (Perrin et al., 2015). This is exemplified by the support of the federal government (that overarches the regions) to the dissemination of population statistics disaggregated at the levels of both nationality ánd place of birth of enumerated citizens ánd their ascendants. The statistics office has also supported large scale database coupling to monitor second generation migrants in the labour force (socio-economic monitoring, Maeter & Charlier, 2015; UNIA, 2017) (see infra 4.5.1)[50].

4.3 Belgian population statistics

Belgian population statistics are publicly available via STATBEL. The STATBEL statistics on what is called the 'foreign' population only incorporate persons with another than the Belgian nationality. STATBEL, in its definition of 'persons with a migration background' follows the definition of the Flemish Integration Decree of 7th of June 2013 that defines persons with a migration background as ***"persons who live legally and long-term in Belgium and that did not have the Belgian nationality at birth or whom at least have one parent that did not have the Belgian nationality at birth"*** (Noppe et al., 2018). Consequently, if one of the following nationalities is not the Belgian nationality, the person is considered as 'having a migration background':

- Current nationality;
- Birth nationality;
- Birth nationality of father;
- Birth nationality of mother.

[50] In 2007 the Statistical Office (DG-SIE 2007, based on recommendations formulated by the High Council for Statistics) decided to publish population data distinguishing native from foreign-born Belgians by identifying people born as foreigners and Belgian nationals at birth. This decision was based on the perceived need of tools to understand migrant populations as well as discrimination among these population (Perrin 2015, p. 200).

Contrarily to the STATBEL statistics, these numbers are not only obtained from the population registry (that only includes Belgians living in a Belgian municipality and foreigners with a permanent resident permit) but also from the following registries:

- The foreigner register (foreigners with a residence permit of more than three months);
- The register of European Union staff and privileged NATO and SHAPE foreigners;
- The waiting register (persons that have submitted an asylum application or who are awaiting a decision concerning this application).

A report on equality data collection in the EU considers this type of data collection related to ethnicity as valid, reliable and comprehensive but notes that the availability of these data is only used to a limited extent in Belgian research and policy making (Farkas, 2017c, p. 26).

4.4 Legal framework

"Though ethnic and racial origin research is prohibited, collecting data on places of birth and the nationality at birth of individuals and their ascendants is not. This interpretation has been confirmed since the Privacy Commission has authorized access to nationality at birth data several times, and it also seems as though data on parents' birthplaces could be allowed."

(Perrin, 2015, p. 200)

A European report notes that "*equality data collection is slightly more developed in Belgium than in most EU countries, with more reliable data available & used on all grounds. As in most EU countries, Belgium's equality data collection is based on limited formal guidance, the frequent use of proxies & limited community consultation*" (Farkas 2017, p. 26). **Farkas further notes that equality data gathering – including the use of ethnicity and migration related proxies – is not regulated by law.**

Vermaut & Carlier (in Farkas, 2017) specify that the most relevant legal provision for equality data collection is the **Law on the protection of privacy**[51] regarding the processing of personal data. This law prohibits the collection and processing of sensitive data in conformity with Article 8.1 of Directive 95/46/EC (see chapter 3). Racial or ethnic origin, religious or philosophical beliefs are considered sensitive data, but the same exceptions mentioned in GDPR apply (e.g. informed consent, public interest) in the Belgian Privacy Law. **As mentioned in our introductory citation of Perrin and colleagues, this law does not define racial and ethnic origin which facilitates the registration of proxies such as place of birth and place of birth of the parents.**

Additionally, **Regulation 2016/679 of the European Parliament and the Council of Europe** (**GDPR**) has been implemented in Belgium by means of the Law on protection of natural persons concerning personal data processing (30th of July 2018). Article 34 provides the same exceptions to the

[51] As the Belgian protocol was no longer in accordance with the new version of the European protocol, a new agreement protocol was signed on 30 September 2013. The registered variables and the case definitions were adjusted. When developing the data registration systems, the opinion of the Commission for the protection of privacy on the project in general within the Sectoral Committee of Social Security and of Health was requested (deliberation 10/079 of 16/11/2010) . The Committee found that the exchange of data is in accordance with the legal and regulatory requirements with regard to the protection of privacy. In addition, the use of the social security number for the identification of patients in the database was the subject of an application to the sectoral committee of the National Register (deliberation 01/2011 of 26/01/2011). The committee authorized WIV-ISP to use the identification number of the National Register.

prohibition of ethnicity related data collection as depicted in Regulation 2016/679 and Regulation 2018/1725. It states that this type of data gathering, and processing is "*only permitted when processing is strictly necessary and takes place with due observance of appropriate safeguards for the rights and freedoms of the data subject*".

It should be noted that the wording in GDPR is more restrictive ("shall be prohibited" in article 9) compared to the Belgian Law. Moreover, important to note is that the **Belgian Law on the protection of natural persons concerning personal data processing**, as opposed to GDPR explicitly allows for governmental bodies including national security to gather and process this data (article 110, 105, 142, 185). The 'explicit consent' necessity as mentioned in article 29 of the GDPR 2018/1725 is less explicit and open to interpretation in article 34 of the Belgian Law.

Art. 34. § 1. Verwerking van persoonsgegevens waaruit de raciale of etnische afkomst, de politieke opvattingen, de godsdienstige of levensbeschouwelijke overtuiging of het lidmaatschap van een vakvereniging blijken, en verwerking van genetische gegevens, biometrische gegevens met het oog op de unieke identificatie van een natuurlijke persoon, gegevens over gezondheid of gegevens over seksueel gedrag of seksuele gerichtheid van een natuurlijke persoon **zijn slechts toegelaten wanneer de verwerking strikt noodzakelijk is en geschiedt met inachtneming van passende waarborgen voor de rechten en vrijheden van de betrokkene, en enkel in een van de volgende gevallen** : 1° wanneer de verwerking door de wet, het decreet, de ordonnantie, de Europese regelgeving of de internationale overeenkomst is toegestaan; 2° wanneer de verwerking noodzakelijk is ter verdediging van de vitale belangen van de betrokkene of van een andere natuurlijke persoon; 3° wanneer de verwerking betrekking heeft op gegevens die kennelijk openbaar zijn gemaakt door de betrokkene. § 2. De passende waarborgen zoals bedoeld in paragraaf 1 voorzien ten minste in dat de bevoegde overheid of de verwerkingsverantwoordelijke een lijst van de **categorieën van personen die toegang hebben tot de persoonsgegevens opstelt, met een beschrijving van hun hoedanigheid ten opzichte van de verwerking van de beoogde gegevens**. Deze lijst wordt ter beschikking gehouden van de bevoegde toezichthoudende autoriteit.

Table 15: Law on protection of natural persons concerning personal data processing (30th of July 2018) - Article 34

Since 3d of December 2017, the Privacy Commission has been reformed to a **Data Protection Authority** (DPA) (*gegevensbeschermingsauthoriteit*), conform the new European General Data Protection Regulation (GDPR). Since these reforms – as described by a former employee of the Privacy Commission – authorisation for the collection and processing of ethnicity and migration related data should only be asked to the newly established **information security comittee** (*informatie veiligheidscomité*)[52] in case data processing requires the consultation of external databases.

Contrarily, for changing the protocol of an existent registration tool (which is the case for TDI) no authorisation is needed because there is no need for consulting external databases. A new measure since GDPR is the requirement of conducting a DPIA (**Data Privacy Impact Assessment**): an estimate of possible consequences of data processing[53]. Furthermore, institutions are required to have and consult with **data protection officers** (DPO's) that regulate and control data gathering and processing in their organisation.

Finally, in this type of data-collection in the Treatment Demand Indicator the **Law on the rights of the patient** (6th of October 2002) is important. It stipulates that the patient has the right to deny to give personal information (such as migration and ethnicity related information), should be informed

[52] This is a reformed version of the former sectoral committee on social security and health (*sectoraal comité sociale zekerheid en gezondheid*)

[53] We have listed such possible consequences and determined safeguards in chapter 4. Chapter 4 can serve as a basis for a DPIA

about the use of the given information, can withdraw previous consent and can at all times ask to see the registered information (Balthazar, 2018). A federal commission was instituted to, among other tasks, deal with complaints concerning the rights of patients.

4.5 Ethnicity and migration related registration in the health and other domains

4.5.1 European surveys, employment and educational monitoring

Although registration and monitoring of ethnicity and migration related indicators is considered sensitive in the health domain, many precedents of registration can be found in other domains as well as (European) surveys. In Flanders, discrimination based on migration background (among other grounds) is analysed by means of large-scale testing and surveys in the labour market (socioeconomic monitoring and diversity barometer), housing (diversity barometer), and in education (Farkas 2017a, p. 58).

For the **biannual Socioeconomic Monitoring programme**, administrative data from the National Register and the Labour market data warehouse of the Crossroads Database for Social Security are linked to map all persons in the National Register with a migration background (as defined above) in the labour market participation of all people of working age registered in the National Register (Vermaut & Callier in Farkas, p. 15).

Linkage of these databases opened the way for research in this domain at the level of the federal, regional and municipal governments as well as for universities (Maeter & Charlier, 2015). The second report analysed time of unemployment, type of employment regime, sectors of employment, mobility in employment and wages **per type of migration country (e.g. EU-12, EU-14, EU-28, non-European such as candidate members states, Maghreb and African countries), citizen status (e.g. recently obtained nationality), migration generation (1st and 2nd)** and gender. The third report related this data also to educational backgrounds and added additional multivariate statistical analysis (UNIA, 2017).

The **Flemish migration and integration monitor** in turn gives an overview of integration trajectories, employment, education, housing, poverty, health and social participation. It is mainly based on data in STATBEL (see supra), Eurostat, the Labour market data warehouse of the Crossroads Database for Social Security and other administrative data sources (Noppe et al., 2018) (see below for specificities in the health domain).

The Flemish study 'Living together in diversity' (Stuyck et al., 2018) (survey data) reports on employment, housing, education, religion, family, language, integration, social identity, perspectives on diversity, public spaces and health. It uses the following indicators of migration background: **birth country, current nationality, birth nationality, nationality father and mother, birth country father and mother, duration of stay in Belgium, reasons for migration**.

The global PISA questionnaire (**Program for International Student Assessment**) identifies the following categories of migration backgrounds (Danhier & Jacobs, 2017) based on the registration of

country of birth and country of birth mother / father. It additionally registers language spoken at home and language commonly used.

- Pupils without a migration background: born in the country where the survey takes place, or with at least one parent born in this country;
- Pupils with a first-generation migration background: born abroad, with both parents born abroad;
- Pupils with a second-generation migration background: born in the country where the survey takes place, but with two parents that were born abroad.

Additionally, the surveys listed in table 16 below use migration and ethnicity related indicators.

Survey	Migration and ethnicity related indicators
Labour Force Survey	- nationality - length of residency and country of birth.
EU-SILC survey	- place of birth - nationality - year of immigration
Generations and Gender Survey (GGS)	- birthplace - mother's birthplace - nationality - nationality at birth - naturalisation - religious participation and belief
European Social Survey (ESS) data	- nationality - ethnicity - religion (as well as religious practice)
Annual Report – the French Community in figures	a collection of data based on a range of administrative data (Vermaut in Farkas, 2017)
Walloon Institute for Evaluation, Prospective and Statistics (Institut wallon de l'évaluation, de la prospective et de la statistique - IWEPS)	a collection of data based on a range of administrative data (Vermaut in Farkas, 2017)
Brussels Institute for Statistics and Analysis (BISA)	nationality by municipality, based on the administrative databases of Statistics Belgium.

Table 16: Surveys using migration and ethnicity related indicators in Belgium

Across the above listed questionnaires four indicators are most commonly used: **nationality, country of birth, country of birth mother and father**. Additionally, some registers and surveys also register **language spoken at home**.

Although the interviewed respondents at Sciensano had concerns about the usefulness of a 'language' related question, one former UCL employee emphasises that such an indicator informs about real access to the health system. Two other respondents argue that registering '**home language'** is a good way to get insight in the question of integration as well as knowledge about the health system.

At first sight I do think that, the in-depth indicator on language spoken at home, that's the same as in education. At governmental level this used to be monitored for years to define the number of 'special educators' [GOK] needed. (…) But that of course had a policy function. It wasn't meant to study the migration background of

people. But along the years it has been used by education researchers as a proxy to study migration background. Respondent 7 Chapter 7

Lastly, one respondent (UCL employee) stresses the importance of registering the **date of arrival** in the country. The socio-economic monitoring (UNIA, 2017) for example discerns large differences between people that arrived in the country less than five years ago and people that arrived over five years ago. The former group has significantly less access to the labour market.

4.5.2 Health

As mentioned in the ETHEALTH report (Dauvrin et al., 2012), the Belgian health system already gathers a lot of information about health among those registered in the social security system. In what follows we mainly focus on administrative and survey data. **We do not include information about patient files and do not touch upon the debate of sharing information in light of the collaborative care platform that allow for sharing (sensitive) information and patient files among health care professionals (Balthazar, 2018) (e.g. Belrai) because they are and should be more restricted and because they are not necessary to estimate substance use prevalence or to monitor treatment demand trends among MEM populations.**

The **National Health Survey** is the first important source concerning the health of the Belgian population. It includes prevalence of alcohol use and use of other substances. Moreover, it identifies nationality, country of birth, arrival date, country of birth mother / father. The ETHEALTH report (Dauvrin et al., 2012) identifies two main difficulties concerning MEM in the National Health Survey. On the one hand, the National Institute of Statics (co-organiser of the survey) can legally not gather such ethnicity related information. On the other hand there is a need for additional sampling in the health survey. Moreover, the respondents at Sciensano stress that an additional path might be to monitor substance use prevalence among MEM populations by means of an additional purposive survey.

Second, the **Flemish migration and integration monitor 2017** included a secondary analysis of several data sources listed in table 17 to report on the health status, health behaviour, use of health care and extra reimbursements in the Flemish population (Noppe et al., 2018). Like Dauvrin and colleagues' (2012), the report notes that both EU-SILC and the national health survey only have small samples of persons with a migration background because no purposive sampling strategies were devised to reach these populations.

Topic	Database / survey	Indicators
Health status and affordability	European Union Statistics on Income and Living Conditions (EU-SILC-survey) (STATBEL)	- current nationality - Birth country
Health behaviours	Health survey (Sciensano)	- Current nationality - Birth country

Use of health care	Family survey departement Welzijn, Volksgezondheid en Gezin (WVG) (extra sample)	- Current nationality - Birth nationality - Birth nationality mother - Birth nationality father
Extra reimbursement of health related costs	Labour market data warehouse of the Crossroads Database for Social Security	- Current nationality - Birth nationality - Birth nationality mother - Birth nationality father

Table 17: Data sources used in the Flemish migration and integration monitor 2017 and their migration and ethnicity related indicators

4.5.3 Substance use treatment

Treatment Demand Indicator (TDI)

TDI, one of the five key epidemiological indicators of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), allows to get insight in the number and profile of people entering SUT (Montanari et al., 2019). It was introduced in Belgium in 2011 (Antoine et al., 2016). TDI registration of treatment episodes within Belgian substance use treatment (SUT) services with a health insurance convention are collected and processed by the REITOX national focal point (Sciensano) since 2011.

TDI is the largest reliable drug-related data set in Europe (Montanari et al., 2019). It informs about met (Ritter et al., 2019) treatment demand[54] (as opposed to unmet treatment demand) (see chapter 3). **The objective of the TDI is to collect information in a harmonised and comparable way across all Member States on the number and profile of people entering substance use treatment (clients) during each calendar year** (TDI protocol 3.0, p. 16). TDI is an epidemiological tool designed to inform EU policy making, in combination with other tools. A respondent at Sciensano stressed the importance of being able to combine several data sources and using a multi-indicator (e.g. prevalence and treatment demand) approach for policy making.

However, although coverage has improved significantly between 2011 and 2019, not all Belgian services active in or related to treatment participate in the registration (Antoine et al., 2016). In the third TDI protocol (2012), the 'nationality' variable was omitted at the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) level and consequently some countries and services do no longer register it.

The reason for excluding this variable was that there are no international standards for this type of data collection, that differing European privacy legislations limit this type of data collection and the fact that the variable had only resulted in identifying that most non-national clients have a European nationality (PV CocoTDI 23/11/2012, Sciensano)[55]. A respondent at Sciensano further exemplifies

[54] The first actor who defined a common protocol for collecting data on people entering substance use treatment was the Pompidou Group (PG), who coordinated studies at city level (in Dublin and London in 1991) and a developmental project in 11 cities and the creation of a European expert group which met several times to discuss and agree the methodological guidelines. (TDI protocol 3.0)

[55] Note that did is not the case in the Flemish 2012-2014 TDI data: European clients are underrepresented compared to their presence in the general population in Belgium and especially in Flanders (De Kock, Blomme, et al., 2020).

that the reason for having the nationality indicator was previously insufficiently argued for, meaning that the 'purpose specification' as stipulated in GDPR was absent.

> It [nationality] was of no use. There was no obvious explanation on why we'd question this or why it would be useful to just have this one question. The question is: why would you add indicators? You don't do it just to identify them? The way that we should say then: okay, you do it because then you can make an analysis comparing other substantial information that will help people treatment accessibility or whatever. Respondent 1

TDI data is supplied to Sciensano pseudo-anonymously. This means that the data is only linked to the National Identification Number (NIN) in case it was reported by the service provider. However, not all service providers identify the NIN and not all clients have a NIN. One of the resulting problems is that those units in for example the 2012-2014 database that do not have a NIN are mainly persons with another than the Belgian nationality, meaning that these populations became less visible in the data and cannot be studied on a disaggregated level. Moreover, linkage to NIN might induce legitimate concerns related to privacy. The use of a unique anonymous identifies could resolve this issue.

A multitude of registers and migration related indicators

In an e-mail request we asked all Belgian substance use treatment services subsidised by the Federal Institute for Health Insurance (INAMI / RIZIV) to identify the registration instruments, databases and respective migration related indicators used besides the mandatory TDI registration. The survey yielded a response rate of 27,8% (n=52 respondents) among the contacted Belgian specified substance use treatment services (n=187).

Most respondents were located in Flanders (n=36) and an additional 14 were located in Wallonia and 2 in Brussels. 38 respondents represented inpatient residential care (e.g. therapeutic communities, psychiatric departments of hospitals, psychiatric hospitals, crisis units etc.) and 15 represented outpatient centres (mostly methadone substitution [MSOC / MASS] and mental health care services [CGG / SSM]).

12 respondents explicitly stated that they did not use other than the nationality indicator in the TDI register. 25 respondents stated that they did not register migration background. 8 of these respondents spontaneously explained as a reason for not registering this information that their services did not have (many) clients with a migration background.

> We use a simple Excel file where we use the TDI questions. But at this moment we don't have any patients with a migration background. The little questions we do get, we cannot answer because of the language barrier. (translated from French to English) Walloon e-mail survey respondent

Four respondents state that although they do not systematically register this type of administrative data, they do have this info in case files, intake reports or anamneses. Four additional respondents reflect their scepticism towards the usefulness (e.g. type of data) or lawfulness of this type of data.

> As far as I know, this is sensitive information that you can't just process. (translated from Dutch to English) Flemish e-mail survey respondent

Only ten respondents (18%) reported that they register administrative and / or clinical data related to client migration background. Three registration systems were referred to by at least two respondents each. These registers and their migration related indicators are listed in table 18.

Datatabase	Indicators
EPD CGG (Electronic Patient File)	Personal information - Nationality (multiple choice) - Double nationality (yes/no) - Country of origin - Language used on a daily basis - (open comments) Target group (to be ticked – multiple ticking possible) - Minor / child abuse / addiction / forensic / allochthone / mental disability Target group related (allochthone) information (multiple choice) - **Birthplace mother** - **Birthplace father** - **Ethnic cultural identity** - **Generation** - **Resident status** - **Language during treatment** Possibility to add modules at local service level
CIS (VVBV Vlaamse Vereniging van Behandelingscentra Verslaafdenzorg) - dotnet	- **Birth place** - **Birth country** - **Nationality** - **Origin**
MSOC.net - Digipolis	- **Origin** - **Resident status** - **Birth country** - **Birthplace** - **Nationality**

Table 18: Registries used in substance use treatment services and the respective migration and ethnicity related indicators identified by an e-mail survey

Respondents working in the Flemish Centres for Mental Health (CGG) mention that their registration system allows to include additional modules to register these variables for internal evaluation. At least three centres reported to have included such an additional module. However, the used indicators across these centres differ considerably and are not comparable. Moreover, the existence of different modules and the multitude of registration systems causes problems for data processing and analysis, as exemplified by a respondent.

> Compatibility between systems: it's a nightmare. Everybody wants their own very specific registration system and there is no compatibility at all. The coding is different. A colleague was responsible for establishing the health file of prisoners. It was a nightmare. Because we have data, but we cannot explain it because it is so different. Respondent 3

Additionally, one interviewee mentioned that a considerable difference between the EPD and TDI data is that the former dataset is delivered to the data processor anonymously whereas this is not

entirely the case for TDI (linked to NIN) and that this constitutes a problem. This respondent also touched upon the issue of purpose specification in TDI.

> All the data from the centres for mental health [CGG] also go to Brussels. So, I tell people: "okay, all these data are sent to Brussels to see how many people are in substance use treatment, how many men, women, ages etc.". And they understand that. Then I say, "we send it to them anonymously". But for TDI it's not that evident. I do explain "it's the same data, but it's a broader research, it's broader. But for Belgium. But it is with your name and surname" I do say "with your national identification number, do you object to that?" (translated from Dutch to English) Respondent 6 Chapter 7

A survey respondent working with CIS notes that until 2015 the service monitored nationality, birthplace and analysed clients' last names. Since 2015 the new CIS registration allowed to input 'origin'. Because this indicator appeared to be insufficiently specific, the service created an internal guideline on how to register 'origin'. Nevertheless, this indicator is insufficiently discriminatory because it does not allow to distinguish between first- and second-generation migration background.

> Origin as the client defines it, with the following points of attention: respect the choice of the client but use your common sense or leave it open if you're in doubt. Some tips: in case of mixed marriage or adopted children, check what was the culture one grew up in. If the client feels Belgian / Flemish but it is known that both parents / care takers have foreign origins, are not born in Belgium or barely speak Flemish or French than the client has the origin of the parent / care givers. If the nationality or birth place of one of the parents or both grandparents are Belgian, origin can be filled out as 'Belgian' if the client does not mention another origin. Birth place of the client can be an indication but is not waterproof. (translated from Dutch to English) Flemish e-mail survey respondent

CIS and the CGG registration systems are cross-organisation systems (that incorporated TDI indicators) meaning that they allow for analysis of data across several services and a whole sector in the case of CGG. Nevertheless, many SUT services appear to use their own registration systems (De sleutel, CAD limburg, MSOC etc.) and some (usually smaller services) only use Excel sheets. A respondent for example indicated to use an Excel sheet in the framework of the project 'refugees and mental health' (FedAsil) for the registration of 'country of origin'. Additionally, many different migration related indicators are used across these registration systems (see Table 18). As noted by a respondent during the interviews, the multitude of registration systems inhibits analysing treatment demand trends.

> There're no governmental IT tools. So even across methadone substitution treatment centres: we all use a different system, another way of registering. This makes it really hard or even impossible to gather data. This is really a blind spot, and everyone deals with it differently. We use Digipolis because we're a municipal service. We can hardly use other types of systems, say the classical patient files used by general practitioners, medical files that are recognised by RIZIV [Federal Institute for Health Insurance]. It is really hard for us to implement these things because we depend on the requirement of the municipality. There's a lot of different categories that need to be filled out, but the responses are not standardised, which is why we cannot process the data. (translated from Dutch to English) Chapter 7 Respondent 4

Psychiatric hospitals, initiatives for protected living, mobile teams and centres for mental health additionally reported to work with an OBASI registration system. However, no indicators concerning migration background were reported to be used in this system and an information request by the researcher to OBASI did not clarify this issue.

Lastly a respondent working in a hospital and subsequently registering the 'minimal psychiatric information' (MPG / RPM) explains why no indicators concerning migration background are included in this tool. He also puts the absence of a national identification number (NIN) in MPG / RPM data in a historical perspective.

> In addition to TDI, Flemish hospitals are obliged to complete the MPG (federally) [minimal psychiatric data] and, until further notice, also to register forced admissions (Flemish community). Neither nationality nor ethnicity or national identification number are included. MPG started in 1996 and then this was not possible according to the privacy commission. (...) I have no 'proof' of this [as an answer to the request for clarification by the researcher]. I only remember the answer from a coordinator at the time who provided the training for implementation was that the FPS was not allowed to include this as a criterion in the MPG instrument. Before the MPG became operational, it was tested entirely by the development teams that were then connected to university hospitals with a faculty of medicine. (…) Even without having the nationality or ethnic origin, a group of doctors directed a complaint to the Council of State on the grounds that "if one sends so much data" it might not be anonymous. A few years later, the Council of State agreed with them because somewhere in the hospital law (art. 86 of the ZH law of 1986) it was stated that data transport to the government had to be anonymous. The article has then been amended by law and since then there has been no more contradiction. The Council of State judged that indeed if that much data is sent, it can sometimes not be anonymous and this should not even be proven, the hypothetical chance was sufficient. (…) In future registrations, people would like to start from the national register number, but despite all revisions and state reforms, there is still nothing new in use. (translated from Dutch to English) Flemish e-mail survey respondent

Lastly, it should be noted that a report on implementing TDI in Belgium listed some additional databases that were not mentioned by our respondents[56] (Colpaert & De Clercq, 2003). However, similar to our results, a more recent Belgian Belspo study (Hannes et al., 2013) only reports on the databases that were also mentioned by our respondents: MPG, TDI and VVBV / CIS.

4.6 Possible ways forward

> At the European level it [TDI] really is a policy support tool, epidemiologically. […] the CoCo TDI for example, their mission is mainly to make a tool for epidemiological reasons. And there is this thing of privacy and ethics behind it: it is a tool, the original purpose is epidemiological, so we can support policy making. Which means that anything that has a potential influence on something else or has an outcome on another topic, is something to avoid. Respondent 2

The 1993 Privacy Law indeed stipulates that data gathering concerning ethnicity are 'sensitive' and therefor prohibited. Nevertheless, registration in the domains of education, labour and health in Belgium have learned that gathering proxies or data related to migration background is possible without infringing privacy legislation (Ringelheim, 2010).

From a methodological perspective, the UCL based CEOOR working group proposed over a decade ago to combine information on nationality, birth nationality and countries of birth of individuals and their parents (Perrin et al., 2015, p. 207) and this appears to be largely in line with the registration methods that have been reviewed in this chapter. An example of the usefulness of registering several migration related indicators and being able to conduct cross-category analysis is given by a

[56] ASL (German-speaking community), Sentinelle (Charleroi), Addibru (Brussels), De Sleutel (RIZIV, Flanders), EUROTOX registration (French community), IWSM (SSM, Wallonia), VLASTROV (Outreach, Flanders), VVBV DARTS (RIZIV, Flanders).

respondent working at UNIA based on the socio-economic monitoring project. We added in the quotation (in bold) the related indicators to clarify their added value and purpose of registration.

> The participation in the labour market of those that have been here longest [**arrival date**] and do not have the nationality [**nationality**] is worse compared to those that have been here longer [**arrival date**] but also don't have the nationality [**nationality**]. It is worse compared to those that do have the [Belgian] nationality and those that have been here for less than five years, it is even worse, it really is a stair case… (…) We see the best labour market participation among Belgians with two Belgian parents [**birthplace mother / father**]. (…) And then you could think "should we really measure all this?". But when you see how structural…. that this is really etno-stratification of the labour market… (translated from Dutch to English) Respondent 5

Subsequently, in TDI we suggest including a standardised nationality question for minimum registration similar to what has been included in the second TDI protocol. Furthermore, we propose additional medium and in-depth indicators that would ideally also be incorporated in TDI and could additionally serve to replace non-discriminatory indicators that are currently used in for instance the CIS registry (origin) (Table 19). We omitted 'arrival date' because it can be seen an intrusive question and to limit the proposal for indicators.

Type of registration	Number of Indicators	Indicators	Analytical capacity
Minimum	2	Nationality country of birth	National / non-national specifiable per country First migration generation
Medium	3 or 4	country of birth mother (country of birth father)	Second migration generation
In-depth	5, 6 or 7	Mother Tongue Home Language A third language related question	Integration / health access Ethnicity related language use

Table 19: Proposal for minimum, medium and in-depth registration

Furthermore, **purpose specification** is needed in the Belgian TDI protocol. It can help to both engage the client in sharing sensitive information as well as to support the professional in properly registering it. For the client, equal access to treatment and equal treatment is eventually beneficial and for the professional, data can directly inform about what does and does not work to enhance treatment.

> Healthcare professionals always perceive these kinds of tools like an evaluation, assessment, control. And then you come: "hey guys, you have to send in an activity report to the bigger level, to the upper level. But you can use it for you too" and then at this point usually you see the change because they realise that the homework that they have to do – which could be a real pain in the ass – they can use it for themselves too. It needs to be a win-win situation. Healthcare professionals have to understand why for them it could be interesting to register the data. And that they can use it in the daily practice. Respondent 3

Furthermore, the requirement of 'purpose specification' should not only be considered in the light of legal requirements but should also serve to implement concrete positive action.

> The question is: to what purpose, because again, from the point of view of the people who are registering, they want to help the person, and then it doesn't matter whether they have papers or not. They act on the level of the medical advice or support that people need. Respondent 1

As mentioned in chapter 3, adjusting TDI indicators (including minimum – medium or in-depth indicators) is an important first step but will not suffice to grasp the bigger picture of service needs among MEM. Policy making and service planning should be informed by **tiered modelling** that does not only include treatment demand indicators but also at least **prevalence of (spectra from recreational to problem) substance use** (e.g. health survey) and other data sources to be able to target subpopulations. Additionally, in ideal circumstances, all registers and surveys (e.g. health survey) should make use of the same indicators. Lastly, considering GDPR requirements, the use of **a unique identifier** could offer a way forward because it implies that services will send anonymised datasets to the data processer (Sciensano). Additional GDPR related issues (see chapter 3) would ideally be studied by the data processor Data Protection Officer in a **Data Privacy Impact Assessment**.

5. EUROPEAN INSPIRING PRACTICES FOR SUBSTANCE USE TREATMENT AMONG MIGRANTS AND ETHNIC MINORITIES

Charlotte De Kock

5.1 Introduction

The literature about good, best, promising or inspiring practices aimed at substance use treatment (SUT) for migrants and ethnic minorities (MEM) is limited in the European Union (Burkhart et al., 2011; De Kock, Decorte, Schamp, et al., 2017; EMCDDA, 2013, 2019; Lemmens et al., 2017; Stöver, Mittel, et al., 2018).

In this chapter we will identify inspiring practices in and for **European SUT for MEM aimed at reach and retention of and/or access** for this population. We start out by outlining why the wording 'inspiring' is better suited compared to for instance 'good', 'best' or 'promising' practices in a realist perspective (5.2). Second, we discuss our method for identifying inspiring practices via an online survey (5.3.1). Third, we discuss the results of this survey[57] (5.3.2-5.3.5). Fourth, we describe an additional secondary analysis (5.4) and its results (5.4.2-5.4.3).

After discussing the limitations of this study (5.5), this chapter is concluded with a reflection and conclusion on the main trends in the identified inspiring practices and the identified caveats (5.6).

5.2 A realist focus on conceptual quality: inspiring practices

Evidence-based practices evaluated by means of randomised controlled trials (RCTs) are considered the 'gold standard' in evaluation science. However, Portugal and colleagues (2007) note that in the field of migration and health there are no clear-cut 'good' or 'best' practices because evidence-based practice is rare. Moreover, a sole focus on RCT's is debateable for varying reasons in this domain[58].

Additionally, two EMCDDA studies (Fountain 2013, Lemmens et al. 2017) found that practices specifically aimed at MEM are limited and that there is little to no evidence-based practice in the domain. Consequently, we did not define exclusion criteria based on evaluation standards (see 5.3.4: Inclusion and exclusion criteria) in identifying practices aimed at reach, access and retention for MEM.

A good framework for analysing the conceptual, implementation and evaluation quality of practices that have not been evaluated in randomised controlled evaluation settings are the Grüne Liste standards developed by Groeger-Roth & Hasenpusch (2011). Synthetizing conceptual and evaluation quality is in line with a 'realist synthesis' approach and mainly aims at *"[...] articulating underlying programme theories and then to interrogate the existing evidence to find out whether and where these theories are pertinent and productive"* (Pawson, 2006; Porter, 2015) (see figure 5).

[57] In April 2019 a survey was launched and distributed to over 150 purposively sampled European networks and individuals involved in migrant health, (mental) health and substance use treatment.

[58] Goris and colleagues (2007) identify serious shortcomings in relying solely on evidence-based practice. At the methodological level quantitative RCT designs often insufficiently encompass all aspects of effectiveness because implementation issues (and context) are rarely taken into account and indicators often need more refinement. Content wise, Goris and colleagues argue that the problem analysis preceding design is often not included in quantitative measures and that the side effects are often not considered in evaluation studies.

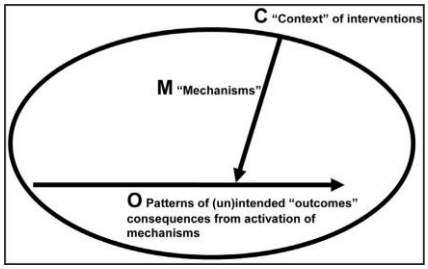


Figure 5: Realist synthesis of context-mechanism-outcome (Pawson & Tilley, 2006)

Similarly, Wikström (2012) (in the context of crime prevention) asserts that the first question should be 'how' programmes work, before 'what' works or íf programmes work. He proposes that key social, situational and developmental mechanisms should be studied before studying the outcomes of interventions that target these key mechanisms. This perspective is particularly suited for domains without a (strong) evidence base. Other realist evaluation scholars additionally stress that the context in which practices are implemented (challenges, pitfalls, prerequisites) should equally be a focus in conducting realist synthesis (Porter, 2015).

Because of the absence of an evidence base, we intended to identify inspiring practices instead of predefining strict prerequisites for identifying good, best or promising practices. **The main aim is consequently to identify the mechanisms that currently inspire practitioners and service providers in enhancing SUT for MEM in terms of reach, retention and access to SUT**. 'Practices' in turn are understood broadly, it does not only cover 'interventions' but also methods, projects and smaller scale service actions.

Conceptual quality *(refers to the mechanism behind the practice)*
1. There is a well-defined theoretical framework regarding the effectiveness of the practice, the assumed underlying mechanisms are clearly defined (based on scientifically recognized models).
2. The methods and instruments used are theoretically argued for.
3. There is a strong logical relationship between the analysis of the problem, context factors, goals, target group and the methods used.
4. The practice focuses on theoretically defined risk and protective factors.
5. The target group is clearly defined.
6. Instructions for implementation and manuals are clearly derived from the model.
7. Goals are clearly and measurably defined.
8. Adjustments to the original model are clearly described.

Implementation quality *(refers to the context of implementation)*
1. The methods and instruments used are described in terms of didactics and are understandable.
2. The materials and manuals are available and up-to-date.
3. The required training and instructions are available.
4. Costs are clearly defined.
5. Support and technical support are clearly defined.
6. Instruments for quality control (e.g. process evaluation) during implementation are clearly defined.

Evaluation quality *(refers to the outcomes of the practice)*
1. At least 1 positive evaluation is available based on theoretical effectiveness

Table 19: Conceptual, implementation and evaluation quality following Groeger-Roth & Haspenpusch (2011)

We translated Groeger-Roth & Hasenpusch's (2011) standards of conceptual, implementation and evaluation quality in a matrix that served as the basis of a survey (see 5.3.3: Survey on inspiring

practices) containing the followings topics, to the example of previous research (SOCPREV, Belspo, Pauwels et al., 2018) (www.belspo.be):

- **WHAT** (domain, setting, operational level)
- **GOA**L (conceptual quality)
- **HOW** (conceptual quality: components)
- **BACKGROUND** (conceptual quality: previous practices)
- **WHY** (conceptual quality)
- **INDICATORS / EVALUATION** (evaluation & implementation quality)
- **PREREQUISITES / CHALLENGES** (realist evaluation perspective: contextual elements)
- **TARGET GROUP**
- ***WHERE / WHO / CONTACT INFORMATION***

5.3 Survey on inspiring practices in the EU-28 member states

5.3.1 Method

Construction of the survey

An online survey aimed at identifying inspiring practices in or aimed at SUT for MEM. The survey was constructed to identify practices (interventions, methods, projects) in the EU-28 member states (excluding Belgium because an additional survey was disseminated in Dutch and French, see chapter 7 & 8) that aim specifically and explicitly at access, retention and reach of MEM (three main categories in line with Guerrero et al. 2017 & Mason et al. 1995) in SUT.

The survey structure was based on the SOCPREV survey (Pauwels et al., 2018). This research project also aimed at uncovering inspiring practices (aimed at reducing drug related crime) in a domain with a small evidence base (see 5.2 A realist focus). The survey consisted of 15 core questions: 9 multiple-choice and 6 open-ended questions. All multiple-choice questions also provided an 'other' option containing an open-ended answer field. Full multiple-choice answer options are described in the results section (see chapter 5.3.3-5.3.5 Practices in twelve member states, Portugal and Czechia) and can be obtained upon request to the first author.

0.	Gender / age / country / job function / years of experience / contact info
1.	WHAT (domain, setting, ecosocial perspective) *Name of the practice (open ended)* *In which domain would you locate this practice? (multiple choice)* *In which setting does this practice take place? (multiple choice)* *At which operational level would you locate this practice? (multiple choice)*
2.	GOAL (conceptual quality) *How would you describe the main goal(s) of the practice? (you can formulate several goals in the [other] field, but try to be as specific as possible) (multiple choice)*
3.	HOW (conceptual quality) *What does this practice consist of? Please specify in your own words what the core of this practice is e.g. what sessions consist of, what was integrated in guidelines, languages used, work methods, activities etc. dependent on the type of practice you are referring to. (open ended)*
4.	BACKGROUND *When was this practice initiated in this setting? (date)* *If the project ended, when did it end? (date)*
5.	TARGET GROUP *Which is the specific target group of this practice? (multiple choice)*
6.	WHY (conceptual quality)

	Who defined the reasons for initiating this practice? (multiple choice)
	Was this practice based on (a) previous successful project? (multiple choice)
	Why was this practice initiated, what were the main reasons? (try to be as specific as possible: refer to issues you, your organisation, research or other observed) (open ended)
7.	INDICATORS / EVALUATION (evaluation & implementation quality)
	What are the main outcomes of this practice, why was it (not) successful? (open ended)
	Is there a manual available for this practice? (multiple choice)
8.	WHERE / WHO / CONTACT
	In what country was the practice delivered? (multiple choice)
	In which city / region was / is the practice delivered? (open ended)
	Where can we find more information about the practice (e.g. website, e-mail address)?
9.	PREREQUISITES / CHALLENGES (realist evaluation perspective)
	What are the main pitfalls / challenges in this project? Please be as specific as possible (open ended)
	Can you refer us to other initiatives aimed at enhancing substance use treatment for migrants and ethnic minorities? (open ended)
	Can you refer us to research studies concerning substance use treatment for migrants and ethnic minorities? (open ended)
	How did you know about this survey? (multiple choice)
	Do you have any other questions, comments or concerns related to promising practices, the populations or this research project? (open ended)

Table 20: Survey topics and questions

Butler and colleagues (2016) in their systematic review on cultural competences subdivided practices at four levels: **the system, service, provider and individual level**. This division is in line with an ecosocial perspective on SUT service disparities that categorises areas of action at a micro, meso and macro level (M. Alegría et al., 2008; Alegría, Pescosolido, et al., 2011; De Kock, 2019a). We subsequently asked respondents at which level they located the identified practice.

The survey also intended to identify grey literature including reports on substance use treatment services, manuals as well as peer reviewed studies reviewing inspiring practices or reporting on prevalence or treatment among migrants and ethnic minorities (see last question above). The identified studies were overall limited and are included in chapter 2.

Distribution in Europe

Survey dissemination consisted of purposive and snowball sampling in two consecutive survey waves. The survey was open from 10th to 31st of April 2019. To increase adherence, the invitation letter mentioned that respondents would receive a copy of the survey results. During, the **first wave** the survey was first distributed to the EU-28 member states (excluding Belgium) (see chapter 7 & 8) via the Reitox National Focal Points and via European networks that have a core goal related to SUT or (mental) health among migrants and / or ethnic minorities (see below) (n=31).

Networks (see full list below) were identified by means of knowledge of the research team based on previous related research projects such as ZEMIV (Derluyn et al., 2008), PADUMI (De Kock, Decorte, Schamp, et al., 2017), SOCPREV (Pauwels et al., 2018). The researchers also contacted Jane Fountain, author of an EMCDDA report on European prevention practicing published in 2013 (EMCDDA, 2013), as well as an expert at EMCDDA (Principal scientific analyst in the domain of Health and social responses) for additional contacts. The survey was subsequently sent to the following networks

- AFINET Addiction and the Family International Network
- Correlation (the European network for social inclusion and health)
- DPNSEE The Drug Policy Network South East Europe
- ECRE European Council on refugees and exile
- EFUS European Forum for Urban Security
- EHRA Eurasion Harm Reduction Association
- ESSD the European Society for Social Drug Research (ESSD);
- EUPHA the European Public Health Association (EUPHA);
- EUPHA The European Public Health Association
- EURAD (A network for prevention, treatment and recovery)
- EuroHealthNet
- EURONPUD European Network of People who Use Drugs
- EUROPAD European Opiate Addiction Treatment Organisation
- European Alliance of Cities and Regions for the Inclusion of Roma and Travellers
- European network of migrant women
- European NGO platform Asylum and Migration
- European Roma Rights Centre
- Euro-TC European Treatment Centers for Drugs Addiction
- EUSPR The European Society for Prevention Research
- HWB Health Without Barriers
- Inebria International Network on Brief Interventions for Alcohol & Other Drugs
- INPUD International Network of People who Use Drugs
- IRHA - Harm reduction International
- ISSUP - The International Society of Substance Use Prevention and Treatment Professionals
- MHE - Mental Health Europe
- Migrants organise
- Pavee Point in Ireland and Addiction Prevention with Roma and Sinti Communities
- PICUM - Platform for international cooperation on undocumented migrants
- RAHRA platform (reducing alcohol related harm)
- Reitox network
- Réseau d'Échanges et de Formation

The first survey wave additionally included **four extra recruitment channels**. First, 84 purposively sampled potential respondents were contacted. These respondents were identified by means of google searches using the search terms ethn* OR migra* AND 'drug treatment' per EU-28 member state. Second, the researcher contacted all **PICUM members** (Platform for international cooperation on undocumented migrants) and **coordinators of identified European projects** related to MEM (mental) health and or SUT (see below). Third, a **blog message was posted at the ISSUP** website (The International Society of Substance Use Prevention and Treatment Professionals). Fourth and last, the survey was promoted via **social media channels** by the researcher (LinkdIn, Facebook).

- ADAPT - Adapting European health systems to diversity
- AMAC - Analysis of social Determinants of Health and Health
- CLANDESTINO - Undocumented Migration: Counting the Uncountable Data and Trends Across Europe HEALTHQUEST - Quality in and Equality of Access to Healthcare Services
- EQUI-HEALTH - Fostering Health Provision For Migrants, The Roma And Other Vulnerable Groups
- EUGATE - Best Practice in Access, Quality and Appropriateness of Health Services for Immigrants in Europe
- HOME - Health and Social Care for Migrants and Ethnic Minorities in Europe
- MIGHEALTHNET - Information network on good practice in health care for migrants and minorities

- NOWHERECARE - Improving Services for Undocumented Migrants in the EU
- RESTORE – Implementing migrant care initiatives, beyond language and cultural barriers
- SRAP – Addiction prevention within Roma and Sinti communities
- Street support project

The second survey wave took place two weeks after launching the survey. It was based on a preliminary analysis of country backgrounds of the respondents and purposively contacting those EU-28 member states we did not yet receive responses from[59]. Furthermore, all previously contacted and purposively sampled contacts were sent a reminder. One week before closing the survey, a third and last reminder was sent out to all afore mentioned contacts.

Inclusion- and exclusion criteria

We only included practices of which we had **no clear indication that the practices had ended** at the time of writing the report (June, 2019) and practices with a minimum English description. Furthermore, **Belgium was excluded here** because the country is discussed in depth in chapter 7 & 8 and in '*Wegwijzer voor een toegankelijke en interculturele drughulpverlening / Recueil sur l'accessibilité et l'interculturalité des services pour usagers de drogues'* (available online at www.belspo.be and in a book format via www.gompel-svacina.eu). The secondary analysis (5.4) did include these Belgian practices.

We included all practices that are directly or indirectly aimed at reach of, access for and / or retention of MEM in SUT services.

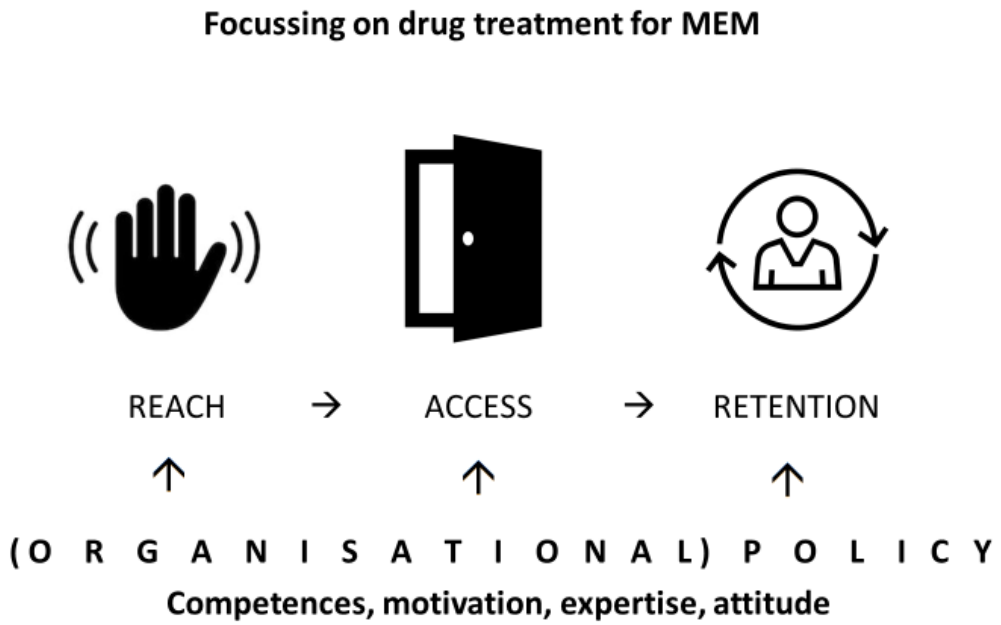


Figure 6: Focussing on substance use treatment for MEM: Reach, access & retention

Lastly, we included two additional types of practices that cannot strictly be categorised as 'SUT for MEM'. First, because of the close intertwinement of substance use and (mental) health (as reflected in the recent integration of substance use treatment in the Belgian mental health care sector) we

[59] Bulgaria, Cyprus, Estonia, Finland, France, Hungaria, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Romania

decided to secondarily **also include (mental) health practices** that can inform SUT for MEM substance users. Second, for many (especially first generation) MEM, broad health services are a first and important entry point to the health system and are an important referral point to SUT (Antoine et al., 2016). Therefore, we also included general health practices specifically aimed at **MEM, to the degree that they are relevant for SUT (e.g. referral and screening). These two types of practices are considered prerequisites for reach, access and retention in the secondary analysis (5.4).**

We decided to limit the description of the inspiring practices to a short description containing their main goals, components, member state and service or agency delivering the practice. The reason is that most of the survey respondents skipped a large amount of questions in the survey.

5.3.2 Respondent pool

A total of 107 respondents participated in the survey. 54 responses were excluded because respondents did not provide any information about an inspiring practice (n=49), practices did not meet the inclusion criteria (n=2), practices were inputted two times (n=2). Finally, one practice of a candidate member state was also excluded.

Eighteen of the excluded respondents did provide their e-mail address, indirectly indicating their interest in the research project. Six of the excluded respondents identified as researchers which could explain why they could not provide information about specific inspiring practices in or related to substance use treatment. All respondents that did not fill out the survey completely but did fill out their e-mail address were sent an e-mail with the request to let the researcher know why they were unable to respond.

Six respondents answered that they had no expertise in this specific field. One respondent explained that the survey was too specific and did not cover all types of activities that the respondent's organisation provides. This respondent additionally clarified per e-mail that providing opioid substitution treatment is illegal in his / her country, complicating the work with this population (personal communication 08-04-2019).

> We are addressing migrant populations in such different numerous ways that I can't answer such a definite question, so I decided not to proceed. (…) I also tell you that we breach the law - we provided migrants in need with Buprenorphine/Methadone which we got from friendly medical doctors. In [my country], all, or at least 75% of criminal activity by migrants is because they need sources/money to buy heroin. Our government ignores this.

The remaining **53 respondents** were mainly female (62%), aged between 45 to 54 (35%) and had over 10 years of experience in their domain of work (63%). Respondents identified predominantly as mental **health care providers** (26%), **social workers** (26%) and **health care providers** (12%). Respondents were located in 14 EU-28 member states[60], we did not receive information from another 13 EU-28 member states (excluding Belgium)[61]. Only **29 respondents completed the survey** entirely among these 53 respondents, but we included all respondent answers that provided a name of a practice that met the inclusion criteria.

[60] Germany (n=3), Greece (n=2), Ireland (n=3), Croatia (n=1), Luxembourg (n=2), The Netherlands (n=1), Austria (n=1), Poland (n=1), Portugal (n=28), Romania (n=1), Slovenia (n=1), Slovakia (n=1), Czech Republic (n=8), UK (n=1)

[61] We did not receive information from Bulgaria, Cyprus, Denmark, Estonia, Finland, France, Hungary, Italy, Latvia, Lithuania, Malta, Spain, Sweden.

20% of these respondents indicated they knew about the survey via RAHRA (a Portuguese based network for reducing alcohol related harm), which explains the overrepresentation of Portuguese respondents (n=28). Another six respondents indicated that they had received the researcher's personal e-mail to all PICUM members, which in turn explains the overrepresentation of responses from Czech Republic (n=8).

The other respondents represent a total of 12 member states with an average of two identified practices per member state. These respondents indicated that they knew about the survey via at least eight of the networks contacted for snowball sampling (see methods), indicating good coverage via snowball sampling because at least one third of the contacted networks disseminated the survey as requested. A total of 34 different inspiring practices were reported by the respondents (see Poster annex 3).

In what follows, we will first discuss the results in 12 member states, followed by the results of Czechia and Portugal. The description of practices in the tables is based on the survey responses which it why the components of practice descriptions vary.

5.3.3 Practices in twelve member states

Eighteen respondents identified practices in 12 EU-28 member states[62], excluding Belgium, Czech Republic and Portugal (see infra). The respondent characteristics are similar to those in the complete sample. They mainly identify as **mental health care providers** (28%), **social workers** (11%) and **health care providers** (11%).

Nine practices were identified in **capitals** (Athens, Luxemburg, Ljubljana, Berlin, Bucharest, Amsterdam, Vienna Dublin) whereas two practices were reported to **cover the whole country**[63] and five practices covered **specific regions / cities** (Cork, Kosice, Vukovar, Northern black forest). When asked in which additional countries these practices were provided, all EU-28 member states were ticked at least once, besides Czech Republic and Latvia. Only ten respondents (55%) completed the survey (besides identifying the practices and the locations). Table 22 below shows all mentioned practices but what follows is only based on the responses of the ten participants that completed the survey.

Country	Practice / service and what it consists of
AU	**Native Video translation during treatment** (Verein Dialog): diagnostic and counselling for drug addicted immigrants.
DE	**ADV Rehabilitation und Integration gGmbH Projekt NOKTA**/ The first 2 weeks at Nokta concentrate on the settling and reorientation of the client. Together with the reference supervisor, an individual therapy plan is carried out. During this time, there is a communications ban (no phone calls, no visits). Letters however can be written and received. At the end of the contact ban, family visits are required twice a month. After sufficient stabilization, permission to go out can be granted and also overnight stays for the client at their family home are possible. Offers at Nokta: Individual therapy Group therapy Help with immigration and social issues Mediation with relatives and family members.
GE	**Drug counselling centre Ambulant Rehabilitation**
GR	**OKANA/ Opioid Substitution Treatment**
GR	**ARSIS:** Accommodation and psychosocial support for asylum seekers
HR	**Psychological issues of those experiencing trauma** (Stichting Coalition for Work with Psychotrauma and Peace): We generally use Rogerian methods in English, Croatian/Serbian/Bosnian, and other languages. Sessions are a

[62] Germany (n=3), Greece (n=2), Ireland (n=3), Croatia (n=1), Luxembourg (n=2), The Netherlands (n=1), Austria (n=1), Poland (n=1), Romania (n=1), Slovenia (n=1), Slovakia (n=1), UK (n=1)

[63] Poland OST, LISKO Luxembourg

	combination of education, therapy, and supervision. Some are individual sessions, some are in groups. We work onsite and online.
IE	**TVG Traveller Support Project on Drugs and Alcohol**: Addiction and Recovery support work: Outreach to people's homes and community groups, rather than insisting people attend the service for support Confidentiality and the limits thereof are central to relationship building Consent around appropriate use of the service user information is clarified early in the contact with SUs. Interagency working is explained to the SU, as are care planning and key working. We focus on recovery and being trauma informed, so that SU s can become hopeful about getting well we are a flexible service, that adapts to the SU needs
IE	**Pavee Point:** Traveller Specific Drugs Initiative.
IE	**Non-residential Group Detox Program** (Cork Kerry Community Healthcare Addiction Service, Arbour House)
LU	**Red Cross dropIn – Service for sex workers:** reduce risk and transmissions of STD
LU	**LISKO (integration and social cohousing):** The aim of LISKO is to support refugees in their integration towards opening social rights and giving access to the common society services.
NL	**Social support and help desk for Eastern European migrants** (De Regenboog Groep, Amsterdam)
PO	**Opioid Substitution Treatment** (methadone) (National Bureau for Drug Prevention)
RO	**Opioid Substitution Treatment** (methadone) (ARAS - Romanian Association Against AIDSOpiod): Delivery of methadone substitution treatment, testing for HIV and Hepatitis, social and psychological counselling, general medical check-ups.
SL	**Counselling and therapy for all in need** (Centre Mokosha NGO): psychosocial support.
SL	**DMB project - outreach work with migrants that use drugs support** at our squat at Tovarna ROG, c)outreach work, d) disseminating Naloxone and I.V. paraphernalia.
UK	**The European African Treatment Advocates Network** (EATAN) promote patient involvement in the screening and treatment process, reduce stigma and discrimination, and enhance access to medical professionals(…) participation from all those who have an interest in advancing the health and social care outcomes of Africans living in Europe; (…) Collaboration (…) involve other organisations within the Pan-European community in the construction and implementation of our policies and practices.

Table 21: Inspiring practices in 12 member states (excluding Belgium, Czechia, Portugal)

Domain and operational level of the practices

Respondents located the practices mostly in the domain of **treatment** (n=8), **early intervention** (n=7) and to a **lesser extent prevention** (n=3), **harm reduction** (n=3) and **referral** (n=3). However, when taking a closer look at these practices, 8 are indeed mainly aimed at treatment but for two it is unclear how they target MEM (Drug counselling centre Ambulant Rehabilitation, Non-residential Group Detox Program). Six are mainly aimed at harm reduction. The other practices are aimed at social (re)integration.

Concerning the operational levels of the practices, respondents located it mostly at the **level of the client** (n=5), the **organisation** (n=4) and the **clinical encounter** (n=2) whereas the health system / policy and provider knowledge were only mentioned once each.

Target groups of the practices

The target groups of the practices were mainly identified as **recognised refugees** (n=7), **asylum applicants** (n=5) and to a lesser extent intra-European migrants (n=3), persons with second and third generation migration backgrounds (n=3). Three practices were aimed at sex workers, Irish travellers, first- and second-generation war victims.

Practice goals and conceptual quality

The goals of the practices were mainly described as increasing the **accessibility of services** (n=7), **increasing the reach of specific populations** (n=4) and **organisational capacity** (n=4). Four respondents also specified in the open-ended 'other' field that their practice was aimed at "*increasing the capacity of war victims*" (Coalition for Work with Psychotrauma and Peace, Mokasha), "*increasing reach of and accessibility for travellers*" (TGV Traveller support), "*work on the*

specific background of the migrant (…) in treatment of drug addiction" (ADV NOKTA). Lastly a Slovenian respondent clarified that the practice was simply aimed at providing a service, instead of access, reach or retention:

> Migrants in Slovenia are not getting OST treatment. We tried to mediate but in vain. The officials of the Ministry Of Health and doctors at the OST program told me: "Tell those migrants to go to Germany. In Germany, they will receive OST". I would like to emphasize that this is wrong from a moral point of view and it is against ethics and it is endangering public health in epidemiological terms.

In the open-ended question on why the practice was initiated most respondents identify **gaps in the capacity of existing services** (n=7) in terms of **provider competencies** (n=4) [64], specified **population reach** (n=2)[65] and their **geographical reach** (n=2)[66]. Only one practice intended to overcome the issue of retention in treatment[67].

- *The service is born from the need of specific support adapted to the refugees. (LISKO)*
- *Our service was one of the first exchange services in the train station district. (dropIn centre)*
- *The humanitarian workers did not recognize that overdose is not a diabetic syndrome of lacking sugar, so we began to intervene. As we have migrants also in our Squat it was a logical thing to join forces with other projects as "Second Home" etc. (…) Migrants on drugs (legal or illegal) do not want to talk about their substance use as they think that this will spread bad light on them - authorities in Croatia and Slovenia are ignoring this narrative in full. (DMP project)*
- *This organisation identified that addiction was a growing issue in the Traveller Community, but that travellers were poorly accessing health services (TVG traveller support)*
- *High dropout rate in conventional drug therapies. No cost transfer for specific populations of migrants in conventional therapies. (ADV Rehabilitation NOKTA)*
- *There were not enough public services providing such practice. (ARAS Romanian Association against Aids)*
- *Co-founder [of this organisation] is part of a multidisciplinary team working under AMIF project being implemented in Slovakia. (Centre Mokosha)*
- *For practical reasons to understand the clients better (Videotranslation)*
- *Lack of capacity among asylum seekers, war victims, and volunteers and staff working with them. (Coalition for Work with Psychotrauma and Peace)*
- *EATAN is driven to ensure that all Africans living in Europe affected by HIV, viral Hepatitis and TB have equitable and consistent access to health and social care, including screening, treatment, and support.*

Concerning who defined the reasons for initiating the practice most respondents (n=6) answer that **their service defined it**. Only one respondent refers to a research study. No respondents mention that the need was identified in a policy study. Five respondents indicate that their practice was not based on a previous practice whereas three answered that they do not know whether it was based on a previous practice. One respondent specified that the practice was based on his / her own expertise in the domain.

[64] DMP project, ADV Rehabilitation, Videotranslation, Coalition for Work with Psychotrauma and peace
[65] DropIn Centre, TVG traveller support
[66] DropInCentre, TVG traveller support
[67] ADV Rehabilitation NOKTA

Implementation, evaluation and challenges

Only two respondents were able to provide a **manual of their practice** in English[68] although for OST many materials are available. When asked whether respondents could refer us to studies concerning SUT for MEM in their country seven out of ten answered negatively whereas two provided the information for such studies. When asked what the outcomes of the practice are, **four respondents[69] indicate that it has not been evaluated yet. Another four respondents report positive outcomes**, as indicated below. It is unclear from these accounts though, whether and how the practices have been evaluated systemically.

- *Outcomes include an **increased take up** of addiction services and more Travellers looking for support. (TVG traveller support)*
- ***High acceptance** of drug therapy in drug related migrant population. Individual sufficient stabilization. Positive effects on drug related families and more effects similar to the outcome of conventional drug therapies. (ADV Rehabilitation NOKTA)*
- *Very positive, as people **have been in this practice for years** and have managed to reintegrate socially and professionally. (ARAS - Romanian Association Against AIDS – OST)*
- *(…) We also find that participatory therapy, especially existential therapy and humanistic therapy, work well in these groups. (Coalition for Work with Psychotrauma and peace)*

Concerning the main challenges / pitfalls of the practices most respondents refer to limited **funding** (n=4). Respondents also identify pitfalls related to **communication / language** (n=3), **vulnerabilities** in the lives of the (potential) clients including access to services (n=3), **collaboration** between services (n=2), and **cultural issues** (=2) such as disease understanding.

- ***The languages**! Refugees don't have access to the specialized drugs social services due to a lack of language knowledge. (LISKO)*
- *To get the possibility to **communicate** with every customer. (DropIn Red Cross)*
- *Lack of **money** as we are financing our work from our community donations. Sometimes we have problems as we do not have an interpreter and medical doctor available. Problem is also a lack of cooperation on the governmental level. (…) (DMB Project)*
- *We **do not yet have a peer** Traveller addiction worker, so workers are working as if 'from the outside' , culturally there are broader issues which impact significantly on our client group; especially the **accommodation problems** experienced by the community and the very poor **education attainment and employment** rates. This impacts travellers when they are considering recovery as an option. (TVG Traveller Support Project on Drugs and Alcohol)*
- *Same as other drug therapies, plus different **disease understanding** in specific migrant population. (ADV Rehabilitation NOKTA)*
- ***Funding**, location, difficulties in **accessing other services** for other health issues. It is important to mention that this project is not only for Roma minority, but for general population. (ARAS - Romanian methadone substitution)*
- ***Financia**l sustainability. (Cork Kerry Community Healthcare Addiction Service)*
- *Wi-Fi Access and **financial resources.** (Native Videotranslation during treatment)*

5.3.4 The Portuguese case

Twenty-three respondents identified 12 practices in Portugal. The respondent characteristics are similar to those in the complete sample: mainly mental health care providers (n=7) social workers (n=5), and health care providers (n=4).

[68] TVG traveller support, Coalition for Work with Psychotrauma and peace
[69] LISKO, DropIn Centre, Videotranslation, Centre Mokosha

Three respondents operated in the capital Lisbon, three in the second largest city Porto, an additional three in the Northern region and the other respondents were equally spread in municipalities across the country[70]. Only fourteen respondents (61%) completed the survey entirely besides identifying the practices and the locations. What follows is the description of results of those fourteen respondents.

Practice / service and what it consists of
ARRIMO - Harm Reduction
Centre for integrated responses (CRI) (n=6): Prevention, outreach work, mental health nursing, social work Community intervention. Harm reduction strategies like counselling, needle exchange, distribution of consumption kit, methadone treatment and referral to welfare and health care systems. Attention and care to all drug abusers and dependents.
Dissuasion Commission (CDT) (n=6): Dissuasion, psychologist counselling. Guidelines-based dissuasion, evaluation and application of appropriate intervention methods to the drug dependent, dependent or non-dependent population. Information about the effects / harmful consequences of drugs. Intervention at social competence level. Diligence for the abstinence of use. (translated from Portuguese to English). Giving tools to people who use drugs, in order for them to reduce/leave de use, initiate treatment or reduce de risks.
Dissuasion, harm reduction, community initiatives, ambulant treatment by General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD) (overarching governmental service) (n=4): Consumption of psychotropic substances has been decriminalised, but their use is not completely liberalised nor are has the market been liberalised. (translated from Portuguese to English)
Harm reduction (GAT-IN Mouraria): Avoid viral or bacterial infections and re-infections among drug users, educational sessions for safe use, education / information for educators. When we cannot communicate with the user we use google translate. Risk screening, psycho-education, counselling, brief interventions, monitoring the retention in treatment or in prevention responses (youngsters until 24 years). Help them identify risk factors for minimizing their global vulnerability as evaluated by means of multiprofessional links and with a major goal to promoting bonds with Health and Social Support Institutions. (partly translated from Portuguese to English)
Harm Reduction project: Close relationship with beneficiaries, acceptance of their life choices, comprehensive approach, pragmatic approach, psychosocial support; syringes and other aseptic material exchange, referral to treatment, comprehension of cultural factors and values.
Opiod Substitution Treatment (methadon) (Ares do Pinhal): Promoting harm reduction. Reaching drug users who are unable to engage in conventional treatment services. Promoting access to health and social public services. Improving health and social conditions. Improving quality of life. Target Population: heroin users who are usually simultaneously abusing other licit or illicit drugs, without a structured life or organization, detached from health and social institutions, frequently engaging in risky behaviour, lack of interest and/or knowledge about their own health situation, physical and psychiatric deterioration (AIDS, hepatitis, tuberculosis, syphilis, psychiatric pathologies). Services: medication methadone, tuberculostatics, antiretrovirals, antibiotics, etc.). Direct observational treatment, syringe exchange, condom distribution, surveillance of personal health for the promotion of public health, blood tests, microradiography, and periodic sputum smears for diagnosis of tuberculosis.
Projeto Vivências Saudáveis (Grupo Instrução e Sport): This project was developed in the area of prevention of dependent behaviours and substance dependence. It is aimed at different influences such as social and personal competences and parental behaviours in the sense that it strengthens protective factors and reduces risk behaviour as well as reducing and postponing the age of first contact with licit and illicit substances. Several programmes with varying active and participate methods (e.g. role-play) were developed to strengthen personal, social and parental competences. The working language is Portuguese. (translated from Portuguese to English)
Rehabilitation unit Algarve - “Desabituação”
Specialised technical treatment team (ETET) Sotavento: Psychological consults. Access to consultation concerning dependencies (with and without substances) to everyone who needs it. (own translation Portuguese to English)
Therapeutic Community Horta Nova: Treatment of dependent drug and alcohol use
Therapeutic Community Lugar da Manhã: Tintonic therapy, psychology

Table 22: Inspiring practices in Portugal

[70] Olhão / Algarve, Bragança, Setúbal, Beja, Figueira da Foz, Espinho, Setubal Peninsula, Évora, Castelo Branco, Setúbal, Leiria

Domain and operational level of the practices

Respondents located the practices mostly in the domain of **harm reduction** (n=9), **prevention** (n=5) and to a **lesser extent treatment** (n=4), referral (n=2) and early intervention (n=2). Concerning the operational levels of the practices, respondents located it mostly at the **level of health system / policy** (n=8), the **provider** (n=6) and the **clinical encounter** (n=5) whereas the client was not ticked as an answer.

Target groups of the practices

The respondents almost only identified target groups in the open ended 'other' field (n=6) and to a much lesser extent ticked the predefined categories. **Only one respondent specifically mentioned MEM populations** whereas all other respondents identified broader vulnerable user groups.

- *Heroin users, severe drug users (translated from Portuguese to English)*
- *Children, youth and families (translated from Portuguese to English)*
- *Drug users that do not access the health care system*
- *Drug-using population*
- *People who are identified by the authorities*
- *Coming from PALOP countries (Portuguese speaking countries), Romania and neighbouring countries, Pakistan and neighbouring countries, Brazil and neighbouring countries, some African countries, Spain, Italy, France (translated from Portuguese to English)*

The Portuguese respondents ticked to a much lesser extent 'recognised refugees' (n=2) and 'intra-European migrants' (n=2) in the predefined category field (compared to the other 12 member states, see 5.3.3). Asylum applicants, third country nationals and professionals in substance use treatment were each ticked once. SUT services in turn were identified as a target group by four respondents.

Goals and conceptual quality

The fourteen respondents indicated that the goals of their practice were equally **increasing accessibility** (n=6), **retention in treatment** (n=6) and **reaching specific populations** (n=7). **Increasing provider** knowledge (n=5) and **organisational capacity** (n=4) were mentioned to a lesser extent. Four respondents also specified in the 'other' field that their practice was aimed at:

- *Increasing public and personal health, reduce criminal acts, reduce risks related to drug use.*
- *Reinforcing community dialogue with social and health partners of their territory residence about their specific vulnerabilities.*
- *Referral to prevention, treatment and reintegration programs.*

Interestingly, the only **NGO that took part in the survey identified some more specific goals**.

> Access to health care in undocumented migrants, increased linkage and retention to health care, HIV screening, Hep B and C, and syphilis, safer drug education with a special focus on injected intakes, social support and referral, and connection to other social responses, support by peers, we provide other services such as: telephone, internet computer, dispensing of materials for consumption (syringes, needles of various sizes, containers, bi-distilled water, alcohol wipes, citric acid , pipes for consumption of crack, silver sheets, distribution of internal and external condoms, lubricating gel).

Concerning **who** defined the reasons for initiating the practice most respondents (n=6) answer that **their service defined the goals whereas four respondents refer to a policy or research study**. In the 'other' field three respondents indicated that the government defined the reasons for initiating the practice. One of these respondents specified that *"there are guidelines for interventions and criteria*

to conduct the procedures but without a section specifying these target groups". The ONG respondent specifies that it was the service that felt the need for this specific intervention.

Seven respondents indicate that their practice was **not based on previous practices** whereas five answered that they did not know whether it was based on a previous practice. One respondents specified that the practice was based on "outreach work with vulnerable groups".

Fourteen respondents answered the open-ended question on **why** the practice was initiated. One respondent answered, "I don't know". Most respondents (n=8) identified that **Portugal's integrated policy of decriminalising the use of illicit substances and referring users to varying types of treatment or support by means of the dissuasion commissions** was the reason for initiating the practise (see below). Only three respondents refer to the specific needs of migrant populations as identified in their service: two harm reduction services and one representative of a Dissuasion Commission (CDT).

- *It was the necessity of our migrant clients that called for this intervention. In Portugal the referral of undocumented people to services is very difficult. (own translation from Portuguese to English). (GAT-IN Mouraria)*
- *Identification of that need with the target group we were working with. (harm reduction project)*
- *In late 80's and early 90's we had in Portugal an epidemic of heroin and other drugs use. ±6000 drug users moved every day to Casal Ventoso to buy all kind of illicit drugs (mostly heroin at that time) ±400 severe drug users lived in the vacant plots of the shanty town in improvised shelters Sharing of drug consumption paraphernalia was common. (opioid substitution treatment)*
- *Because there are more and more immigrants in the country and because there are more individuals coming from ethnic minorities. (CDT)*
- *Because of the varying diagnoses and the varying problems among varying target groups that we identified, that we are trying to eliminate or reduce in our project. (own translation from Portuguese to English) (Projeto Vivências Saudáveis)*
- *Case studies evaluation. (CRI - Setúbal)*
- *The outreach work resulted from the Portuguese Law of Decriminalizing substance use and, therefore, to reach drug users who otherwise wouldn't be treated. (CRI – Porto)*
- *Consumption has been decriminalized, but not decriminalized. Consumption of illicit psychoactive substances remains an act punishable by law, but it ceased to be a criminal offense (and treated as such in the courts) and became a social misconduct. (SICAD – Lisbon)*
- *Government policy. (CRI – Alentejo)*
- *Decriminalising consumption of illicit substance with the goal of reducing the use. (own translation from Portuguese to English). (CDT – Castelo Branco)*
- *Dramatic situation about drug-use in Portugal during the 80's and 90's and also health problems associated. (CDT – Setúbal)*
- *Because drug addiction is a disease not a crime. (CDT Leiria)*
- *The general practice for drug addiction dissuasion began with the law nº30/2000 to maximize synergies between Justice, Public and Mental Health with the Organization that leads Intervention on Addictive Behaviours and Dependencies to promote accessibility and early responses according to their particular needs. (SICAD – Porto)*

*Im*plementation, evaluation and challenges

Eight respondents indicated that there was no manual available for their practice whereas six respondents answered that a manual was available referring to SICAD reports as well as manuals concerning outreach work. When asked whether respondents could refer us to studies concerning

substance use treatment for MEM in their country nine out of fourteen answered negatively whereas five answered positively without referring to specific studies. When asked what the outcome of the practice is, three respondents indicated that it had not been evaluated yet whereas three indicated that they do not know the outcome **and eight that it had positive effects**, indicating three main effects (see below): **better referral, decrease in new users and infectious diseases**. The respondents do however not refer to evaluation studies.

- *The outcomes are positive, mainly, the referral to the welfare and health care system of people who wouldn't go without this support; health results like diminishing the rates of HIV among drug users.* (CRI)
- *Decrease of recent users among general population. Increase of treatment demand, also among cannabis users. Decrease of problematic users. Reduction of drug related deaths and infectious diseases. Decrease of social stigma over drug users.* (Dissuasion Commission)
- *Restrain HIV spread, tuberculosis, robberies, social exclusion is much less visible, and people are being treated and fill better whit themselves and in their families and community.* (CRI)

Fourteen respondents answered the question concerning the main challenges / pitfalls. Respondents mainly refer to **involvement in and access to treatment** (n=5). They refer to the difficulty of **involving parents** in treatment, **participatory diagnosis** as well as the difficulties related to the **geographical location of treatment** and to the aging of both treatment providers and client populations. Furthermore **communication / language** (n=3) and **cultural issues** (=3) are mentioned as pitfalls in treatment. Lastly, some respondents refer to general pitfalls in the treatment of harmful substance use such as creating consciousness about harmful substance use in the general population.

- *Linguistic barriers. (translated from Portuguese to English* (GAT-IN Mouraria)
- *Cultural differences.* (harm reduction project)
- *Deal with migrant population (**communication, cultural differences**). Deal with users **aging** (less autonomy, more specific needs). (harm reduction project)*
- *Cultural and social identities and differences. (translated from Portuguese to English)* (CDT)
- *Involving families in the preventive process. (translated from Portuguese to English)*
- *Participatory diagnosis.* (CRI)
- *Financial support and dealing with phenomenon fluctuations.* (CRI)
- *The need to bring consumers closer to illicit substances from **health services**.* (SICAD)
- *Accessibility in interior **regions** and **the age** of professionals - everybody is older and there are no new people coming in for the past 15 years.* (CRI)
- *Make people **conscious** of the fact that psychoactive substances can have detrimental effect in the long run. (translated from Portuguese to English)* (SICAD)
- *The **new patterns of consumption** and the banalization of the consumption of certain drugs. Creating appropriate responses.* (Dissuasion commission)
- *Establishing the **initial relation** with de people identified by de authorities, in order for them not to feel judged.* (Dissuasion commission)
- *Case variability. different and subjective histories. Different level of emotional disturbance, many **residence and employment** concerns, **access for primary health care**, **language**, several information, their descendants and education concerns many from families fragmented. Risks behaviours. commitment to institutions, working in a different paradigm, including and integrating them, defending them and empowering to deal with social stigma.* (SICAD)

5.3.5 The Czech case

Eight respondents identified as working in Czech Republic. Five respondents filled out the survey entirely. Worth mentioning is that a recipient of the survey e-mailed the researcher notifying that he / she had special interest in the research project because the topic is "*neglected within the policy making or national legislation and (…) practices are scarce and uncoordinated*" (personal communication, 25-04-2019).

The respondents identified seven practices initiated in five organisations. One respondent (mental health care provider) filled out the survey to indicate that there were no practices, indicated 'nothing' in all answer fields. Six respondents identified as social workers and one as a mental health care provider, which is similar to the entire survey sample.

Three practices were located in the capital Prague, two in the Pilsen region (Western Bohemia), and one each in the south Bohemia capital České Budějovice, the smaller border municipality of Domažlice and one in the whole Central Bohemian region.

Practice / service and what it consists of
Contact and counselling centre for drug users (Prostor plus - charitable society): harm reduction services
Contact Center & street work(Point 14, z.ú.): volunteering - The user of the service decides for the provided services voluntarily low-threshold - means availability, free entry, without member card, without application, without surname equal access - services are provided regardless of gender, race, education, political or other opinion, religion, legal or social status, nationality or ethnic minority, mental or physical condition secrecy and confidentiality - the protection of personal and sensitive users' data is maintained, workers protect the user's right of privacy and the confidentiality of his / her communication Individual approach - workers take into account the current life situation of the service user and his / her individual needs expertise - services are provided by workers with appropriate education and experience.
Drop-in Centre Prevent (Kontaktní centrum Prevent/): social work.
Harm reduction services (Sananim, z.ú.): basic medical help, psychotherapeutic help, support for family members Harm reduction in town and in the contact center (changing syringes, counselling, medical help, psychotherapeutic support), one of workers speaks russian, other workers have basic English and Czech They don't have special programs only for migrants, but they're open for everybody without asking about residency.
Streetwork (Centrum Jana)

Table 23: Inspiring practices in Czechia

Domain and operational level of the practices

Respondents located all identified practices in the domain of **harm reduction**. They also indicated that they were related to **treatment** (n=4) and **prevention** (n=4). Early intervention and referral was only indicated by two of the respondents. Concerning the operational levels of the practices, respondents located it mostly at the level of the **clinical encounter** (n=4) and to a lesser extent the organisation (n=2) and the health system / policy (n=2).

Target groups of the practices

The target groups of the practices were mainly identified as **substance use treatment services (n=6), professionals in substance use treatment (n=4), intra-European migrants (n=2) and third country nationals (n=2).** One respondent specified that the practice was aimed at sex workers. Looking at the main aims of the practices, these answers might indicate that respondents did not understand the question fully because it appears that the practices were not aimed at substance use treatment services but rather at (potential) clients in harm reduction services.

Goals and conceptual quality

The goals of the practices were mainly described as increasing the **accessibility of services** (n=4), **increasing provider knowledge (n=4)** and to a **lesser extent client retention in treatment**. Two respondents also specified in the 'other' option that their practice was aimed at minimising social and health risk related to harmful substance use.

Concerning **who** defined the reasons for initiating the practice three respondents indicate that they do not know whereas two other respondents indicated it was inspired by an unspecified policy study. Four respondents indicate that they do not know whether the practice was based on a previous practice whereas one respondent indicated it was **not based on previous practices**. Three respondents skipped this question.

In the open-ended question on **why** the practice was initiated two respondents indicated that such a **service did not yet exist** in the Pilsen region (streetwork and contact center) and another respondent mentioned that the organisation *"helps everyone without asking about residency or passport. If the client can understand the rules of service, they're welcome there, doesn't matter where they're from"*. Five respondents skipped the question.

Implementation, evaluation and challenges

Two respondents indicated that a **manual for the practice was available, but not in English.** Three other respondents indicated that no manual was available. None of the practices are properly 'manualised' in English although of course for OST many materials are available. When asked whether respondents could refer us to studies concerning substance use treatment for MEM in their country five responded 'no' and three skipped the question. When asked what the **outcomes** of the practice is, all respondents answered, **"I don't know".** Only one respondent answered the question concerning the main pitfalls of the practice by stating the following.

Society doesn't really understand that this practise is necessary, and they don't have special service for migrants.

5.3.6 Discussion of the survey results

The **online survey identified a total of 34 practices in the EU-28 member states** (excluding Belgium, see chapter 7 & 8)

It is hard to discern trends in the survey responses[71] because of the diversity of responses and identified types of practices and because of sample bias (see limitations). We will limit the identification of trends to those that are discernible across ánd within the three cases (12 countries, Portugal, Czechia).

The majority of the participants were (mental) health providers and social workers. At least 20 practices were located in the **harm reduction domain**. Practices in early intervention, prevention and treatment were mentioned to a much lesser extent. The main identified goals of practices were **access** to treatment (n=17) and **reach of MEM populations** (n=11). Retention of clients in treatment was reported to a lesser extent (n=6). This could be a consequence of the fact that when services do not reach populations, their priority is not to retain a population in treatment. Additionally, harm

[71] For example concerning the operational level of the practices in the survey, respondents located practices at the level of the client (n=5), provider knowledge (n=7) and the clinical encounter (n=11), the health system / policy (n=11) and the organisation (n=4).

reduction services may apply a different concept of successful outcomes (that are less retention oriented).

Moreover, the reasons for starting the practices were **mainly defined by the services themselves**, as opposed to policy incentives or research studies. Only in Portugal, most respondents indicated that the practice had started because of the **integrated decriminalisation policy** that contains an explicit harm reduction pillar. Concerning the pitfalls and challenges for the practices respondents mainly pointed out **language and communication** difficulties.

Most notably, only one Portuguese respondent identified MEM populations. The other Portuguese respondents denoted vulnerable drug user groups, referring to a universal rather than targeted strategy. Respondents of the other 12 member states and Czechia rather focussed on **third country nationals, including recognised refugees and to a much lesser extent on intra-European and undocumented** migrants.

The MEM populations targeted by the practices where quite different in the three cases. This is corroborated in the 2016 EMCDDA prevention profiles when looking at the differences between efforts for 'immigrants' versus 'ethnic groups' (see above) (see also variable histories of migration and national minorities in 3.4.2).

The fact that Portugal and for instance France do not specifically target MEM in substance use treatment has to do with the fact that these countries do not categorise targeted services by ethnicity, but rather by vulnerability to substance use and problem use. As noted by Fountain (EMCDDA, 2015, p. 9), one reason for this is because they do not wish to stigmatise MEM populations. Indeed, European health systems often adhere to a generalist or universal rather than a targeted intervention perspective: in theory the majority of EU-28 members states provide care to 'all' presupposing that this will also cover MEM while when looking at the numbers in treatment services, this is often not the case. Nevertheless, an exploratory comparison between non-nationals in treatment in Belgium and Portugal did demonstrate that although proportionately there were differences between non-nationals and nationals in Portugal, they were less pronounced compared to Belgium (De Kock et al., 2018).

Concerning conceptual quality, over 80% of the respondents stated that the practice was not based on a previous practise or that they don't know whether it was based on a previous practice. Relatedly, 70% of the respondents answered negatively to the question to identify national studies on substance use treatment for MEM. **These results could imply that services are not supported or backed by policy funds or research studies concerning the national situation of substance users with a MEM background. It could also imply that there is insufficient collaboration between services to enable knowledge transfer about existing practices.** On the other hand, services are well placed to identify and respond to gaps in service provision and could inform bottom-up policy making.

Concerning evaluation quality, about half of the respondents state that the practice has not (yet) been evaluated or that they do not know. The other half reports positive outcomes, specifying that outcomes are the reach of specific populations, increased treatment uptake or behavioural change. Concerning opioid substitution therapy and needle exchange programmes this appears to be in line

with Wiessing's findings, outlining that 'coverage' is the main evaluation standard in this field (Wiessing et al., 2017). More research is warranted concerning retention in residential treatment.

None of the respondents refer to reports or evaluation studies when reporting these outcomes. This is in line with a 2018 UNHR funded review (Kane & Greene, 2018) on interventions targeting substance use disorders among refugees. This review did not find any evaluated intervention in the European continent. **They concluded that there is a clear caveat in academic and unpublished literature concerning refugee substance use prevention and treatment approaches.**

5.4 Secondary analysis of inspiring practices in (grey) literature[72]

5.4.1 Method

Because the survey resulted in a very dispersed picture of the inspiring practices, we decided to use additional methods to **identify inspiring practices**. We used three additional methods.

First, we screened both the 2014 and 2017 Reitox national drug reports submitted by the EU-28 member states to the EMCDDA by means of the following queries: **ethn*, minorit*, migra*, nationali*, foreign, roma, asylum, refugee**. The publicly available versions of the 2017 reports contained little to no information on inspiring practices aimed at MEM whereas not all 2015 and 2016 reports were online available. We subsequently focused on the 2014 reports for in depth analysis. Full paragraphs including the search terms were listed and read per country. Lastly, inspiring practices related to SUT for MEM were listed.

Second, review studies and reports were identified by means of opportunistic sampling based on references in previous studies in this domain. Inspiring practices in and for SUT and related mental health services for MEM were derived from the following review studies and reports.

- *Drug prevention interventions targeting minority ethnic populations: issues raised by 33 case studies* (EMCDDA, 2013)
- *Addressing Alcohol and substance use disorders among refugees: a desk review of intervention approaches* (Kane & Greene, 2018)
- *Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum applicants and irregular migrants* (Priebe et al., 2016)
- *Health of refugees and migrants: Regional situation analysis, practices, experiences, lessons learned and ways forward* (WHO, 2018)
- *Geflüchtete Menschen und Drogen-/Abhängigkeitsproblematik Expertise im Auftrag des Bundesministeriums für Gesundheit* (Stoever et al., 2018)
- *Substance use services for refugees* (Greene et al., 2019)

We also consulted the EMCDDA EDDRA (Exchange on Drug Demand Reduction Action) database (15-05-2019). However, MEM are not included as a target group in the database but 'ethnic' is included as a 'type of approach' and 13 practices are identified in this category. All these practices are targeted or indicated prevention practices. Two of the interventions were included in the 2014 drug

[72] Parts of these results were included in a background paper on drug-related social responses for migrants, refugees and ethnic minorities, published by EMCDDA. The main differences between this chapter and this background paper are the following: in the latter paper, some practices were moved to other categories or excluded and additional practices were added based on a screening of the 2019 Reitox workbooks.

reports (Belgian drug prevention for ethnic minorities, Irish Traveller Specific Drug Initiative). At least seven projects / interventions ended over a decade ago whereas three other practices do not specify how they targeted MEM. Subsequently, only one project / intervention was included based on its inclusion in Fountain's review (EMCDDA, 2013) (Austrian ANABABA - Mam & Dad - Let's empower our children).

Third, we included the inspiring practices that we identified in Belgium by means of two online surveys and purposive searches (see chapter 7 & 8 for methods and results) (De Kock, Toyinbo, et al., 2020) as well as the European practices discussed in 5.3 (via the European survey).

5.4.2 Results in treatment, prevention, harm reduction and early intervention

We identified a total of 58 practices in the domains of treatment (n=8), prevention (n=27), harm reduction (n=20) and early intervention, screening and brief intervention (n=2) and self-help (n=1) (not discussed in the results[73]). The full list is available upon request to the author and discussed below.

Treatment (n=9)

We identified 9 practices in the treatment domain. Six out of nine of these practices are services that specialise in serving specific MEM populations such as migrants and refugees (Kethea), men with varying cultural backgrounds (ADV Nokta), foreign language speakers (Transit, ADIC, Verein Dialog) and Irish travellers (Pavee Point, TVG Traveller Support, Voice of New Communities Drugs and Alcohol Network). Two programs (Transit, ADIC) focussed on vulnerable drug users with limited access to services, including undocumented migrants.

Four main characteristics of programmes can be discerned: adaptation to the **language knowledge** (Transit, ADIC, Verein Dialog), **cultural or migration of the client** (ADV Nokta, Kethea Mosaic), adding a **social component to treatment** and fulfilling an **active liaison function to increase access to services** (Pavee Point, TVG Traveller Support, Voice of New Communities Drugs and Alcohol Network, Lama).

[73] adapted AA- (Alcoholics Anonymous) en NA- (Narcotics Anonymous) groups

Country	Short Description	Population	Source
AU	**Native Video translation during treatment** (Verein Dialog): diagnostic and counselling for drug addicted immigrants	Foreign language speakers	MATREMI European Survey 2019
BE	**Transit:** Low threshold unconditional substance use treatment during 13 days	Drugs users with low access to services	MATREMI Belgian survey and review 2019
BE	**ADIC:** crisis treatment during 7 days	Foreign language speakers	MATREMI Belgian survey and review 2019
BE	**Project Lama:** mobile guidance of drug users to treatment	Persons with a migration background	MATREMI Belgian survey and review 2019
DE	**ADV Rehabilitation und Integration gGmbH Projekt NOKTA:** The first 2 weeks at Nokta concentrate on the settling and reorientation of the client. Together with the reference supervisor, an individual therapy plan is carried out. During this time, there is a communications ban (no phone calls, no visits). Letters however can be written and received. At the end of the contact ban, family visits are required twice a month. After sufficient stabilization, permission to go out can be granted and also overnight stays for the client at their family home are possible. Offers at Nokta: Individual therapy Group therapy Help with immigration and social issues Mediation with relatives and family members	Men with varying cultural backgrounds	MATREMI European Survey 2019
GR	**KETHEA MOSAIC** is an intercultural transitional non-residential programme that seeks to facilitate the social integration of migrants and refugees. In doing so, it introduces therapeutic principles (such as self-help, mutual help and self-management) into the psycho-social support services it provides. Its services prioritize prevention and counselling on health care, work, family relationships, legal procedures, racism, delinquency, drug abuse, violence and marginalisation. Its mean length of stay is approximately 2.5 months, while it offers its clients the option of staying in the programme longer than initially scheduled. (Reitox national drug report, 2014, p. 49, personal communication 08.11.2019)	Migrants & refugees	Drug Report 2014
IE	**Pavee Point:** Traveller Specific Drugs Initiative	Irish Travellers (trauma-informed)	MATREMI European Survey 2019
IE	**TVG Traveller Support Project on Drugs and Alcoho**l - Addiction and Recovery support work: Outreach to people's homes and community groups , rather than insisting people attend the service for support confidentiality and the limits thereof are central to relationship building consent around appropriate use of the service user information is clarified early in the contact with SU. Interagency working is explained to the SU, as are care planning and key working. We focus on recovery and being trauma informed, so that SU s can become hopeful about getting well we are a flexible service, that adapts to the SU needs	Irish Travellers	MATREMI European Survey 2019
IE	**Acts of Compassion Project** (now known as Voice of New Communities Drugs and Alcohol Network): A range of information and support to members of minority ethnic populations and to those engaged in drug use, especially those who are addicted and those who have recently arrived in Ireland and are socially excluded. Actions comprise: Leaflets in several languages, Art therapy, Advocacy, Assessments and referrals to treatment,	Minority ethnic populations	Fountain / EMCDDA 2013

	One-to-one counselling, Drop-in, Seminars on substance use (including in asylum hostels). (Fountain, 2015)		

Table 24: Inspiring practices in treatment

Prevention (n=26)

We identified 26 prevention practices. These practices are aimed at foreign language speakers, parents and youth with a migration background and especially vulnerable MEM populations including Roma, asylum applicants and migrant girls.

These practices have three main characteristics. First, we identified **translated information materials** such as leaflets and online videos (in grey in the table 26 below). Second, at least seven practices consist of **intensive peer work for the development of targeted prevention** (*Tuppercare homeparties, PaSuMi, RAR Drug prevention, Herkunft-Ankunft-Zukunft, Cannabis Intelligence Amsterdam, PeAS*). The last category consists **of universal prevention programmes that were adapted to reach 'hard to reach'** MEM populations.

Country	Short Description	Population	Source
AU	**ANABABA – cocuklarimizi güclendirelelim (empower our children)** (Supro – Werkstatt für Suchtprophylaxe): The Turkish community's cultural taboo on talking about substance use because of stigma and shame was addressed by a workgroup of Turkish parents and adolescents to discuss possible actions and projects. Actions resulting from their discussions were: Production by the workgroup of a short film and a leaflet (both in Turkish) as a basis for discussion. Training of several people from the Turkish community to moderate different 4-hour workshops. (Fountain, 2015)	Turkish families	Fountain / EMCDDA 2013
BE	**Prevention methods for asylum applicants** (Flemish expertise centre on Alcohol and other drugs, Belgium)	Asylum applicants	MATREMI Belgian survey and review 2019
BE	**Information leaflet:** tobacco, alcohol and other drugs ((Flemish expertise centre on Alcohol and other drugs, Belgium)) & Drugs ABC in your language (Druglijn) (Dutch, French, English, Arabic, Turkish, Romenian, Russian, Pashtu, Polish, Albanian, Somalian, Dari / Farsi)	Foreign language speakers	MATREMI Belgian survey and review 2019
BE	**Tuppercare homeparties** (Flemish expertise centre on Alcohol and other drugs, Belgium): Mothers visit peers at their home and organise information evenings to inform about substance use in a known environment and in the own language	Parents with a migration background	MATREMI Belgian survey and review 2019
BE	**Parental skills and support** (Flemish expertise centre on Alcohol and other drugs, Belgium)	Parents with a migration background	MATREMI Belgian survey and review 2019
BE	**Mind Spring**	Refugees and asylum seekers	MATREMI Belgian survey and review 2019
BE	**RAR Drug prevention among youth with a migration background** (Flemish expertise centre on Alcohol and other drugs, Belgium): Guide to identify the needs and set up targeted prevention by means of a Rapid Assessment Method.	Youth with a migration background	MATREMI Belgian survey and review 2019
DE	**Prevention for persons with a migration background:** establishing contact with a public addiction facility, activating and supporting self-help initiatives to strengthen the personality and reduce the risk of developing addictions.	Persons with a migration background	Drug Report 2014

	These activities are generally embedded in comprehensive measures to promote the social and societal integration of immigrants. (Reitox Drug Report, 2014, p. 71)		
DE	**Warum kann Alkohol für mich gefährlich werden?** (Hessische Landesstelle für Suchtfragen e.V.) The explanatory videos on alcohol, cannabis and medicines draw attention to the dangers of the respective psychoactive substances by means of easily understandable stories. They are available in four languages both on the HLS homepage and on YouTube. With a length of 90 or 120 seconds, the barrier for watching videos is kept very low.	Foreign language speakers	Stoever et al. 2018
DE	**Shisha information leaflet** - *Shisha – was Du dazu wissen solltest …*: information leaflet (Fachstelle für Suchtprävention Berlin e.V.) (Arabic, German, English, Farsi, French, Kurdish, Pashto, Russian, Turkish, Urdu)	Foreign language speakers	Stoever et al. 2018
DE	**Medication information leaflet Medikamente** – *Die Dosis macht das Gift* (Fachstelle für Suchtprävention Berlin gGmbH) (Arabic, German, English, Farsi, French, Kurdish, Pashto, Russian, Turkish, Urdu)	Foreign language speakers	Stoever et al. 2018
DE	**Cannabis prevention leaflets** (Fachstelle für Suchtprävention Berlin e.V., Deutsche Hauptstelle für Suchtfragen e.V., Stadt Nürnberg Jugendamt) (Arabic, German, English, Farsi, French, Kurdish Pashto, Russian, Turkish, Urdu)	Foreign language speakers	Stoever et al. 2018
DE	**Alcohol prevention leaflets** (Fachstelle für Suchtprävention Berlin e.V., Deutsche Hauptstelle für Suchtfragen e.V.) (Arabic, German, English, Farsi, French, Curdic, Pashto, Russian, Turkish, Urdu)	Foreign language speakers	Stoever et al. 2018
DE	**PaSuMi** (Deutsche Aids-Hilfe e.V.): The project targets participatory development, conception and implementation of addiction prevention measures. For this purpose, community members are involved as peers in the project and trained in search-relevant content and methods. At the same time they support the identification of needs in the community and contribute to the development, implementation and evaluation of the implemented measures.This project is not only about the use of peers, as in similar projects, but also that they can contribute to the design of the project measures.	Refugees and migrants	Stoever et al. 2018
DE	**Gambling & Gaming prevention leaflets** (Sucht.Hamburg gGbmH, Landesstelle Sucht NRW, Bundeszentrale für gesundheitliche Aufklärung, Deutsche Hauptstelle für Suchtfragen e.V., Bundeszentrale für gesundheitliche Aufklärung, Ethno-Medizinisches Zentrum e.V.), Leaflet on *Wenn Spiel zur Sucht wird – Information zur Glückspielsucht)*: The booklet provides information on the origin, course and consequences of gambling addiction in six languages. It makes it clear that gambling addiction is a recognized dependence disease without demonizing. Furthermore, the booklet contains a small self-test, which is intended to suggests to reflect critically on one's own gambling habits and, if necessary, get help. The booklet convinces through multilingualism, through the normalization of addiction, that it is not an individual failure, and the integrated self-test.	Foreign language speakers	Stoever et al. 2018
EE	**Information leaflets in Russian** (National Institute for Health Development): A a drug-related brochure for parents (Reitox national drug report, 2014, p. 23).	Foreign language speakers (Russian)	Drug Report 2014
GE	**PEaS – Peer parents at school:** an evaluated programme for alcohol and addiction prevention parents' education in school (Fachstelle für Suchtprävention im Land Berlin, pad e.V): PEaS supports parents, particularly so-called 'hard to reach' parents and migrants, by integrating existing structures and key persons in the upbringing of their children in terms of health promotion and addiction prevention, and motivates them to be more involved in their children's schools. The peer concept is used,	Persons with a migration background	Fountain / EMCDDA 2013

	because for parents, one of the most important information sources on matters of health or children's health education is conversations with other parents. The central themes of the PEaS concept are that parents can do a lot to protect their children against risks of addiction and that school is a place they can help to shape. (Fountain, 2015)		
GE	**Herkunft-Ankunft-Zukunft project** (Hamburgische Landesstelle für Suchtfragen e.V.Büro für Suchtprävention): The project comprises 40 training hours during which members of migrant groups – key persons or 'multipliers' (e.g. adult peer educators) – receive tailored training on the causes of the onset of addiction and on the addiction services system in Hamburg. These key persons, who work on a voluntary basis, pass on their knowledge into their own social environment. After the completion of the training, they are capable of organising and running information events in their mother-tongue on the addiction help system and other substance-specific topic areas. (Fountain, 2015)	Persons with a migration background	Fountain / EMCDDA 2013, Stoever et al. 2018
GE	**Gleich oder Anders oder Wie?** (Wutha-Farnroda, Thuringia): targeting children with a migration background, those who are social disadvantaged, and children of at-risk families. The project works intensively with 12 children per year on the following issues: Integration, coping strategies, alternative leisure possibilities in the neighbourhood, Knowledge of the addiction services system in the neighbourhood. (Fountain, 2015)	Children with a migration background	Fountain / EMCDDA 2013
GR	**'Fairytale without borders': a** prevention tool for primary education (Prevention centre of addiction and promotion of psychosocial health 'Athena Ygeia'): an original prevention tool, which is delivered to children in pre-school and of school age by prevention specialists or teachers. Its primary goal is to enhance the development of personal and social skills. The children are given the opportunity to exercise their creativity and imagination in a playful way. At the same time, through symbolism and the mechanisms of identification and projection, they develop a better understanding of themselves and others, and are enabled to talk about matters that concern them in their everyday life, through the story of the heroes of the fairytale. (Fountain, 2015)	Minority ethnic children	Fountain / EMCDDA 2013
LT	**Drug addiction prevention** in Kirtimai Roma Settlement in Vilnius (Reitox Drug Report, 2014).	Roma	Drug Report 2014
NL	**Cannabis Intelligence Amsterdam (CIA) (Jellinek Prevention, Arkin):** Peer education among young minority ethnic people consists of them discussing their experiences with cannabis or alcohol, the social norms surrounding this behaviour, and strengthening self-efficacy. The aim of the groups is to prevent risky alcohol and cannabis use and to reduce harmful effects among those who already use these substances, by setting standards of responsible usage. (Fountain, 2015)	Young minority ethnic people	Fountain / EMCDDA 2013
NL	**"If you have stress, think a lot and sleep badly…"** (Pharos): Leaflet in many different language aimed at self-care for refugees with mental health complaints.	Foreign language speakers	purposive
SE	**Honour-related violence and addiction** (Tänk Om!): The project targets all immigrant girls and women who are victims of honour-related violence and may be addicted to drugs and have a criminal background, and workers in governmental or nongovernmental organisations who may come into contact with the target group. The aims are to improve knowledge about honour-related violence and its potential relation with addiction, so that those who work with the affected girls and women better understand the problem and are better able to offer support, and to empower the girls/women by giving them the self-confidence to manage on their own and to deal with their problems. (Fountain, 2015)	Immigrant girls and women who are victims of honour-related violence	Fountain / EMCDDA 2013

SI	**SRAP - Addiction prevention within Roma & Sinti communities.** In June 2013, the staff of the Novo Mesto Centre for Development and Education finished working on the international SRAP project (www.srap-project.eu), which began in July 2010 and was dedicated to preventing addiction in Roma communities (a more detailed description of the project can be found in the 2012 National Report). The activities carried out in 2011 and 2012 showed that young Roma stress their own lack of awareness about the consequences of addiction and poor knowledge about the available forms of help and support in the community, should they develop an addiction. (Reitox National Drug Report, Slovenia, 2014)	Roma	Drug Report 2014
SK	**Prevention for Roma**: prevention and strengthening the ability to defend oneself against socio-pathologic phenomena. The lectures and discussions were tailored to the specific needs of the participants, providing all kinds of promotional materials and educational activities. The individual activities were organised with active participation of field staff and social workers of the Žiar nad Hronom municipality, and the municipal police. (Reitox Drug Report, Slovakia, 2014, p. 132)	Roma	Drug Report 2014

Table 25: Inspiring practices in prevention

Harm reduction (n=24)

Of the 24 identified harm reduction programmes over half aim at reaching specifically vulnerable substance users such as those who do not have access to other services. The other ten programmes additionally aim at specifically vulnerable MEM populations such as Roma, asylum seekers & refugees, irregular migrants, female drug users and sex workers. These are mainly **opioid substitution treatment** programmes with a variable offer of **health and social services**.

Country	Short Description	Population	Source
CZ	**Harm reduction services** (Sananim, z.ú.): basic medical help, psychotherapeutic help, support for family members	Indicated	MATREMI European Survey 2019
CZ	**Harm reduction in town and in the contact centre** (changing syringes, counselling, medical help, psychotherapeutic support), one of workers speaks Russian, other workers have basic English and Czech. They don't have special programs only for migrants, but they're open for everybody without asking about residency.	Indicated	MATREMI European Survey 2019
CZ	**Contact and counselling centre for drug users** (Prostor plus - charitable society): harm reduction services.	Indicated	MATREMI European Survey 2019
CZ	**Contact Center & street work (Point 14, z.ú.):** free entry, without member card, without application, without surname equal access - services are provided regardless of gender, race, education, political or other opinion, religion, legal or social status, nationality or ethnic minority, mental or physical condition secrecy and confidentiality - the protection of personal and sensitive users' data is maintained, workers protect the user's right of privacy and the confidentiality of his / her communication, individual approach - workers take into account the current life situation of the service user and his / her individual needs expertise - services are provided by workers with appropriate education and experience.	Indicated	MATREMI European Survey 2019
CZ	**Terenni programy SANANIM (**Romský terénní programme): outreach work, individual casework, counselling, including motivation to change, crisis intervention, needle and syringe exchange, distribution of medical supplies, assistance with access to substance use treatment. (Fountain, 2015)	Roma	Fountain / EMCDDA 2013
DE	**Frauentreff Olga:** Work with female (including transgender) drug users and	Female and	Fountain /

	prostitutes to create opportunities to leave (or survive) prostitution and stop using drugs. The practice includes, needle and syringe exchange, general medical assistance and hospital referrals for a wide range of physical and mental illnesses, diseases and injuries, including emergencies, realistic advice and assistance on employment and continuing education opportunities for women wishing to leave prostitution (Fountain, 2015)	transgender drug users and sexworkers	EMCDDA 2013
FR	**National Hepatitis program:** Targeting the most vulnerable and precarious individuals in society, and migrant populations in particular. (Reitox National Drug Report, France, 2014, p. 73)	Indicated	Drug Report 2014
GR	**OKANA**: Opioid Substitution Treatment	Indicated	MATREMI European Survey 2019
HR	**Udugra Terra:** Harm reduction among (…) those who came from foreign countries due to deportation, termination of asylum, etc., or recently released from prison.	Irregular migrants	Drug Report 2014
IE	**Ruhama** works on a nationwide basis with women affected by prostitution. It provides support and assistance to women who are active in prostitution, have a history of prostitution, or are victims of sex trafficking. (Reitox Drug Report, 2014)	sex workers	Drug Report 2014
LI	**Outreach in Roma Settlements** in Vilnius: general practitioners outreach to HIV positive substances in a Vilnius based (Lithuania) Roma settlement (Subata & Tsukanov, 1999).	Roma	Drug Report 2014
LU	**DIMPS** (Croix-Rouge in collaboration with the Ministry of Health and the CHL**) Mobile intervention for the promotion of sexual health**: inform on risk behaviour and provide free and rapid infectious disease testing in difficult-to-access populations. Among other interventions, rapid tests for HIV and HCV and HBV are proposed. Currently the DIMPS van visits low threshold drug agencies, gay meeting places, red light spots and asylum seekers facilities. DIMPS may be described as an outreach offer for specific target populations and vulnerable groups aiming to access difficult-to-reach populations and provide prevention counselling and infectious disease testing on site. (…) In 2013, 88 counselling episodes have been reported by involving a total of 265 clients. 252 HIV, 134 HCV and 16 syphilis rapid tests have been performed during 2013. (Reitox national drug report, 2014, p. 107)	Indicated	Drug Report 2014
LU	**Red Cross dropIn:** Service for sex workers to reduce risk and transmissions of STD	sex workers	MATREMI European Survey 2019
PO	**Opiod Substitution Treatment** (methadon) (National Bureau for Drug Prevention)	Indicated	MATREMI European Survey 2019
PT	**Harm Reduction project:** Close relationship with beneficiaries; Acceptance of their life choices; Comprehensive approach; Pragmatic approach; Psychosocial support; Syringes and other aseptic material exchange; Referral to treatment; Comprehension of cultural factors and values;	Indicated	MATREMI European Survey 2019
PT	**Harm reduction (GAT-IN Mouraria):** Avoid viral or bacterial infections and re-infections among drug users, educational sessions for safe use, education / information for educators. When we cannot communicate with the user we use google translate. Risk screening, psycho-education, counselling, brief interventions, monitoring the retention in treatment or in prevention responses (youngsters until 24 years). Help them identify risk factors for minimizing their global vulnerability as evaluated by means of multiprofessional links and with a major goal to promoting bonds with Health and Social Support Institutions. (partly translated from Portuguese	Indicated	MATREMI European Survey 2019

	to English)		
PT	**ARRIMO - Harm Reduction**	Indicated	MATREMI European Survey 2019
PT	**Opiod Substitution Treatment (methadon) (Ares do Pinhal):** Promoting harm reduction. Reaching drug users who are unable to engage in conventional treatment services. Promoting access to health and social public services. Improving health and social conditions. Improving quality of life. Target Population: heroin users who are usually simultaneously abusing other licit or illicit drugs, without a structured life or organization, detached from health and social institutions, frequently engage in risky behaviour, lack of interest and/or knowledge about their own health situation, physical and psychiatric deterioration (AIDS, hepatitis, tuberculosis, syphilis, psychiatric pathologies). Services: medication methadone, tuberculostatics, antiretrovirals, antibiotics, etc.). direct observational treatment, syringe Exchange, condom distribution, surveillance of personal health for the promotion of public health, blood tests, microradiography, and periodic sputum smears for diagnosis of tuberculosis.	Indicated	MATREMI European Survey 2019
PT	**Community intervention**: Harm reduction strategies like counselling, needle exchange, distribution of consumption kit, methadone treatment and referral to welfare and health care systems. Attention and care to all drug abusers and dependents.	Indicated	MATREMI European Survey 2019
RO	**HORIZON –** Mobile Integrated Services for Vulnerable and Marginalized Groups (CARUSEL): Harm reduction targeted at Roma. HORIZON initiated several actions aiming to improve national and international visibility of this issue aiming to assess attitudes, behaviour and knowledge of Roma drug-injecting women, beneficiaries of Integrated Care Services for Addictions (Reitox national drug report, 2014, p. 26, p. 64)	Roma	Drug Report 2014
RO	**Opiod Substitution Treatment** (methadon) (ARAS - Romanian Association Against AIDSOpiod): Delivery of methadone substitution treatment, testing for HIV and Hepatitis, social and psychological counseling, general medical check-ups.	Roma	MATREMI European Survey 2019
SL	**DMB project** - outreach work with migrants that use drugs support at our squat at Tovarna ROG, outreach work, disseminating Naloxone and paraphernalia	Indicated	MATREMI European Survey 2019
UK	**Victoria Hall drop-in** is a weekly session: multi-agency event for asylum seekers and refugees (CRI Arundel Street Project, Sheffield). CRI attends the weekly multi-agency drop-in, in order to enhance discussions of substance use amongst all ethnic groups there, especially normalising frank and open discussion about drugs and the implications within different communities. CRI provides culturally appropriate support to ethnic groups to overcome barriers to drug-related interventions. (Fountain, 2015)	Asylum seekers & refugees	Fountain / EMCDDA 2013
UK	**Bro-Sis Project** (Freshwinds): Black Caribbean people are underrepresented in substance use treatment services in Birmingham because of, for example, the cultural elements of substance use, the stigma that surrounds class A drug use, and because mainstream services often do not meet their cultural needs. The project provides a range of harm reduction interventions to promote the physical, psychological and social wellbeing of Black Caribbean drug users and helps them access treatment services. (Fountain, 2015)	Black Carribbean drug users	Fountain / EMCDDA 2013

Table 26: Inspiring practices in harm reduction

Screening, Early and brief intervention (n=2)

We identified one evidence-based practice aimed at screening the nature of substance use with the possibility of a brief intervention guided by a (mental) health or other professional (ASSIST). The Shurkan project in turn is aimed at early intervention among drug using refugees.[74]

Country	Short Description	Population	Source
DE	**Shurkan (Fixpunkt e.V.).** The project activities are primarily aimed at and adapted for refugees who already had contact with drugs in the country of origin and / or are particularly at risk in Berlin, to get in contact with drugs. Special risk characteristics can be in the person (traumatization, low level of education) or strengthened by the current life situation (lack of prospects, insecurity and inactivity before or during the asylum procedure, inadequate housing, city or even nationwide distribution of families and friends to different accommodations, proximity of the accommodation or of the migration route to places of drug trafficking).	Drug using refugees, professionals working in Asylum Centres	Stoever et al. 2018
NA	**ASSIST Screening and brief intervention** in Dutch, Arabic, Chinese, French, German, Hindi, Perzian, Portuguese, Spanish and Vietnamese.	Foreign language speakers	MATREMI Belgian survey 2019

Table 27: Inspiring practices in screening and brief intervention

5.4.3 Prerequisites of substance use treatment for MEM

We identified 47 practices located in domains that are affiliated to substance use treatment and that indirectly contribute to access for, reach and / or retention of persons with a migration background in SUT. They are considered prerequisites of substance us treatment for MEM.

Access to (mental) health services (n=13)

Among those practices that are mainly aimed at increasing the access to (mental) health services or offering health services we can discern three types of practices:

- **Increasing knowledge** by informing about the available services (*Smartphone application, paper guide, video*);
- **Outreach medical support** for 'hard to reach' MEM populations (*doctors of the words, outreach in Roma settlements, Association Salud y Familia, Health Promotion Programme for Disadvantaged Communities*);
- **(mental) health screening and follow-up** of refugees upon arrival.

The identified practices aimed at refugees including applicants for international protection and irregular migrants, foreign language speakers and to a lesser extent Roma.

Country	Short Description	Population	Source
BE	**Smartphone application** with an overview of welfare, (mental) health and other services (www.refaid.com)	Foreign language speakers	MATREMI Belgian survey and review 2019
BE	**Medical support** by 'doctors of the world'	People with	MATREMI

[74] We categorised a third practice (initiating a drug policy in an asylum centre) under the header 'organisation competence' (below) because it does not consist of an intervention but is rather to be considered as a practise at the organisational level.

		low access to services	Belgian survey and review 2019
BE	**Leaflet on accessible health care for Roma** (Ghent Municipality)	Professionals	MATREMI Belgian survey and review 2019
BE	**Guide and support for accessible mental health for refugees** in Brussels (Ulysse)	Refugees	MATREMI Belgian survey and review 2019
DE	**Guide for refugees in Berlin** Mut machende Infos für Ihre Gesundheit – Kleiner Wegweiser für Geflüchtete in Berlin (Fachstelle für Suchtprävention Berlin gGmbH): The search guide's available in more than nine languages, including Arabic and Dari / Farsi, and provides general information for addicts on addiction and (mental) health, as well as contact information for counselling centres and help centres in Berlin. Due to the multilingualism and the clear presentation of the information, it represents a good first contact to the addiction help system.	Foreign language speakers	Stoever et al. 2018
DE	**Translated video on substance use treatment** "Ein Angebot für Sie" (Deutsche Hauptstelle für Suchtfragen e.V.): The film was produced by the DHS a few years ago to inform Russian-speaking late repatriates to provide access to the German addiction support system (Russian).	Foreign language speakers	Stoever et al. 2018
ES	**Association Salud y Familia** (Health and Family): programmes to improve access to health services for irregular migrants in the Barcelona region (WHO, 2018, p. 21).	Irregular migrants	WHO 2018
FI	**TERTTU 5** (the National Institute for Health and Welfare) Developing the Health Examination Protocol for Asylum Seekers in Finland: a National Development Project 2017–2019 (WHO, 2018, p. 23)	Asylum seekers	WHO 2018
GR	**Outreach in Roma Settlements:** primary health programmes that will be carried out in Roma settlements (Matrix, 2014, p. 146).	Roma	Drug Report 2014
GR	**PHILOS - Hellenic Centre for Disease Control and Prevention** (supported by Greek Ministry of Health): Meetings the sanitary and psychosocial needs of people living in open camps (WHO 2018, p. 17).	People living in open camps	WHO 2018
SE	**Health screening** must be offered to all applicants for international protection by the county councils/regions in which they reside, including mental health (WHO, 2018, p. 19).	Applicants for international protection	WHO 2018
SK	**Health Promotion Programme for Disadvantaged Communities** (Ministry of Heath 2007-2015). Continued as the "Healthy Communities" project (Ministry of Interior) Involvement of health promotion assistants in activities in Roma settlement (Reitox national drug report, 2014, p. 63. Matrix, p. 146).	Roma	Drug Report 2014
UK	**The European African Treatment Advocates Network (EATAN)** promote patient involvement in the screening and treatment process, reduce stigma and discrimination, and enhance access to medical professionals(…) participation from all those who have an interest in advancing the health and social care outcomes of Africans living in Europe; (…) Collaboration (…) involve other organisations within the Pan-European community in the construction and implementation of our policies and practices.	(advocacy)	MATREMI European Survey 2019

Table 28: Inspiring practices in access to (mental) health services

Social (re)integration (n=11)

We identified 12 practices that are mainly aimed at social (re)integration. The majority of these practices aim **at integration in the labour market,** but some also focus on **housing** (*Housing Café, ARSIS, LISKO*) and broader **social integration** (*Pauke – Life*).

Country	Short Description	Population	Source
BE	**Mentor 2 Work** (Minderhedenforum)	Persons with a migration background	MATREMI Belgian survey and review 2019
BE	**Housing Cafés for refugees** (Caritas) to support refugees in finding housing	Refugees	MATREMI Belgian survey and review 2019
CZ	**Roma Integration Policy Document:** Government Council for Roma Minority Affairs (2014) has issued its 2013 annual report, in which it describes the preparation of the Roma Integration Policy Document, during which a working group met to discuss, among other matters, the strategies for social inclusion, health-related topics, including the issue of drug use, and the nature of programmes regarding substance use among Roma. (Reitox National Drug Report, Czechia, 2014, p. 151)	Roma	Drug Report 2014
DE	**Pauke - Life (Pauke Bonn gGmbH)** The project is committed to the stabilization and social participation of people with addictions. It provides the participants with basic work skills, makes them fit for the job market and develops a realistic career perspective with them. The climate in dealing with addiction is described as open. Although Pauke-Life is only a small project and has only a partial focus on refugees, it convinces in particular by its direct integration into education and the labor market, which represents one of the biggest barriers to integration in the life context.	Refugees	Stoever et al. 2018
DE	**Prospects for (female) refugees** (Federal Employment Agency): To improve support for refugees, asylum seekers and those designated as tolerated individuals (where deportation has been temporarily suspended) in accessing the labour market by gaining occupational orientation combined with practical work experience in companies (WHO, 2018, p. 25).	Refugees and asylum seekers	WHO 2018
GR	**ARSIS: Accommodation and assistance to asylum seekers and relocation candidates** (1/1/2017 until 1/12/2017)	Asylum seekers & Relocation candidates	MATREMI European Survey 2019
LU	**LISKO (integration and social cohousing):** The aim of LISKO is to support refugees in their integration towards opening social rights and giving access to the common society services.	Refugees	MATREMI European Survey 2019
MA	**St. Jeanne Antide Foundation** (volunteer NGO): The objectives of the Foundation are mainly to create support and self-empowerment of socially excluded persons, families and minority groups. (Reitox National Drug Report, Malta, 2014, p. 38)	Socially excluded (including minority groups)	Drug Report 2014
NL	**Social support and help desk for Eastern European migrants in Amsterdam** (De Regenboog Groep)	Eastern European migrants	MATREMI European Survey 2019
NL	**24 x 24 programme (Leiden municipality):** tailored approach aimed at helping migrants to integrate into Dutch society and the labour market (WHO, 2018, p. 25).	Migrants	WHO 2018

UK	**BARKA project:** aimed at improving access to occupational skills training, rehabilitation and housing for migrants suffering from homelessness and substance misuse. The project connects the migrant with both home and host country services depending on needs and helps to overcome cultural and language barriers in accessing health care in the host country. In 2014, 145 people were given occupational skills training, rehabilitation or help in finding homes in London (WHO, 2018, p. 15).	Migrants suffering from homelessness and substance misuse	WHO 2018

Table 29: Inspiring practices in social (re)integration

Organisational competency, training and support (=10)

We identified 6 practices that were mainly aimed at increasing the organisational capacity of substance use treatment and other services and 5 practices aimed at **training staff**. The former practices are mainly aimed at diversifying services and subsequently making them more 'diverse-sensitive'.

The identified training modules (in grey below) have the same goal at the level of the individual service provider. One practice stands out - *The Migrant and Refugee Communities Forum* – because it is aimed at coaching refugees with a medical degree to strengthen the diversification of the health work force.

Country	Short Description	Population	Source
AU	**10-month intercultural prevention training**: 110 teaching units and 20 hours of job shadowing, training programmes for staff of integration offices and for immigration and refugee workers. (2014 Reitox national drug report, p. 7)	Professionals	Drug Report 2014
BE	**Competence profile** to attract a diverse sensitive colleague (Hrwijs, DeTouter	Services (in substance use treatment)	MATREMI Belgian survey and review 2019
BE	**Measuring barriers** in your own service (Drempelmeter, Municipality Hasselt)	Services (in substance use treatment)	MATREMI Belgian survey and review 2019
BE	**Case support and expertise sharing** concerning recognised refugees in mental health in centres for mental health (funded by AMIF).	Professionals	MATREMI Belgian survey and review 2019
BE	**Reflection tool for interculturalising a health / welfare service** (VIVO, with the support of the Flemish government)	Services (in substance use treatment)	MATREMI Belgian survey and review 2019
DE	**TransVer Guidebook:** The guidebook supports the development of what is called 'transcultural competence' in SUT and aims at implementing standards for evaluating such practices. The guidebook comes with a comprehensive checklist for analysing the service context and identifies 18 good practices that emphasise outreach to migrant specific organisations, service development, staff support, team processes, a welcoming culture, communication and considering life philosophies in treatment. (Schu, Martin, & Czycholl, 2013)	Services (in substance use treatment)	purposive
FI	**The National Institute for Health and Welfare** (WHO, 2018, p. 22) **PALOMA**: is a free, web-based and comprehensive training package, which gives you basic information about encountering people with refugee background and fostering their wellbeing. Sixteen training videos have been subtitled in	Professionals, services	WHO 2018

	Finnish, Swedish and English. The training is based on a comprehensive handbook (PALOMA-käsikirja) for professional advancement of refugees' mental health and well-being, written in the National Development Project for Improving Mental Health Services for Refugees (PALOMA). Episode 6 focusses on Recognizing Mental Health Problems and Using Cultural Interview. (WHO, 2018)		
PT	**Training for health care professionals** (Ministry of Health) on the rights and duties of refugees in accessing the national health system. (WHO, 2018, p. 16)	Professionals	WHO 2018
SI	**A training programme** for professionals who deal with Roma youth in a professional capacity carried out as part of an addiction prevention project aimed at the Roma community. The programme puts great emphasis on learning about Roma history, culture and intercultural communication. In 2013, the pilot modules 'Special Features of the Roma Community in Slovenia', 'Intercultural Communication', 'Prevention Workshops for Roma representatives', and 'Provision of Information and Raising Awareness among Roma about Forms of Health Care and Social Work Help' was developed. (Reitox national drug report, 2014, p. 8)	Professionals working with Roma	Drug Report 2014
UK	**Migrant and Refugee Communities Forum:** a bilingual mentoring support scheme developed in 2007 in order to take advantage of the skills of unemployed refugee doctors who wanted to support non-English-speaking refugees and migrants experiencing mental illness (WHO, 2018, p. 26).	Unemployed refugee doctors	WHO 2018

Table 30: Inspiring practices in organisational competency, training and support

Translation and mediation methods & services (n=6)

We identified seven practices that mainly aimed at overcoming language barriers by means of communication cards, native speaking professionals, translators, (inter)cultural mediators and tele psychiatry.

Country	Short Description	Population	Source
BE	**Intercultural mediation in hospitals** (funded by the federal government only in hospitals) & by Centre Bruxellois d'Action Interculturelle. (Verrept, 2019)	Foreign language speakers	MATREMI Belgian survey and review 2019
BE	**Websites with the available psychologists who speak different languages**	Foreign language speakers	MATREMI Belgian survey and review 2019
BE	**Social translators** (funded by the regional governments only in centres for mental health)	Foreign language speakers	MATREMI Belgian survey 2019
CZ	**Communication cards** (Ministry of health) for foreigner patients and health professionals in various languages (WHO, 2018, p. 18).	Foreign language speakers	WHO 2018
MA	**Cultural mediators** (Migrant Health Liaison Office) attend specifically to the health needs of migrants and assist health professionals working with them and to facilitate communication between migrants and health care providers and overcome some of the cultural and linguistic barriers experienced on both sides during the health care encounter (WHO, 2018, p. 24).	Foreign language speakers	WHO 2018
SE	**National and international tele psychiatry service:** enhance access to refugee groups to more appropriate mental health care in terms of the bilingual proficiency and cultural competence of the health professionals (WHO,	Refugees	WHO 2018

	2018, p. 20).		

Table 31: Inspiring practices in translation and mediation methods & services

Specific mental health services (n=6)

We identified six practices that were mainly aimed at enhancing the mental health of persons with a migration background by making use of specific expertise on for instance **trauma** (POZAH, ELEA), **healthy relations** (PACCT©) and **cultural specificities** (Cultural Formulation Interview). One practice specifically aims at serving as a **liaison between asylum centres and mental health care facilities**.

Country	Short Description	Population	Source
BE	**Psychiatric support for Asylum seekers (POZAH)**	Asylum seekers	MATREMI Belgian survey and review 2019
BE	**Guidance and liaison for refugees (ELEA):** a link between asylum centres an mental health care facilities	Refugees	MATREMI Belgian survey and review 2019
BE	**PACCT®:** Psychiatry Assisting the Cultural diverse Community in creating healing Ties	Culturally diverse clients	MATREMI Belgian survey and review 2019
HR	**Psychological issues of those experiencing trauma** (Stichting Coalition for Work with Psychotrauma and Peace): We generally use Rogerian methods in English, Croatian/Serbian/Bosnian, and other languages. Sessions are a combination of education, therapy, and supervision. Some are individual sessions, some are in groups. We work onsite and online.	Trauma victims	MATREMI European Survey 2019
NA	**Cultural Formulation Interview** (CFI) (Rohlof et al., 2017)	Clients with a migration background	MATREMI Belgian survey 2019
SL	**Counselling and therapy for all in need (Centre Mokosha NGO):** Centre Mokosha is a non-profit organisation based in the Eastern part of Slovakia, established in 2014 by two psychologists dedicated to providing individual, couple or family counselling and therapy for all in need, regardless of age, gender, religion, or ethnic background. Some of our clients come from a refugee background with severe emotional problems due to trauma. Centre Mokosha is treating both English and Slovak speaking clients, and works closely with interpreters Slovak – Dari – Russian, when needed. Centre Mokosha specializes in mood and anxiety disorders, cultural adaptation,	All in need, regardless of age, gender, religion, or ethnic background	MATREMI European Survey 2019

Table 32: Inspiring practices in specific mental health services

5.5 Limitations

The information we got about the practices via the online survey varies greatly. It is for instance not in all cases clear whether the practices are still being used, whether they are still implemented and whether the practices are project based or structurally embedded in services. Moreover, there appeared to be clear overlap between the answer categories in the survey meaning that the answer options were not sufficiently discriminatory. This is however an inevitable error because independent of the formulation of survey questions and answers one can for instance interpret harm reduction activities as 'prevention activities' for injecting drug users.

Differential response rates to our online survey, as noted by Fountain in a similar study (EMCDDA, 2013, p. 11) may have to do with heavy workload and other requests for information to be provided voluntarily. As was the case in Fountain's study, the questionnaire was in English and this may not have may have been a problem to service providers who do not understand English.

Because of the variability of the identified practices and because of the low full response rate of the survey we decided to convey an additional search intended to identify additional practices. We narrowed our goals to the simple identification of practices (as opposed to also pinpointing their target groups, exact goals, evaluation and conceptual quality etc.). This allowed us 'recategorise' the practices to identify what their main focus was and to overcome the problem that the answer options in the survey were insufficiently discriminatory.

It is not always clear what the exact nature of the practices is. The review of Stoever and colleagues' (2018) for instance denominates many of the examples as 'projects' whereas we choose to use the overarching term 'practice', which also includes 'projects'. Additionally, the delineation and exact number of 'practices' is unclear which results in the fact that it is hard to pinpoint the exact number of identified practices. One practice may for instance be the development of a diversity policy in treatment that includes many different methods while one of these methods could well be considered as one single 'practice'.

An additional apparent limitation is that we identified a large number of practices that are strictly speaking not aimed at substance use treatment for MEM. We turned this apparent limitation into an advantage. The fact that respondents in both the Belgian and the European survey chose to identify these practices in a survey that was clearly aimed at identifying practices in substance use treatment (see introduction), sparked our choice not to exclude these practices. Several respondents noted that the survey aim was too specific. Moreover, and in line with a realist focus, we intended to understand 'how' programmes work and what their main goals are, instead of 'what' works or íf programmes work. As noted by Porter (2015), the context in which these practices are implemented should equally be a focus in conducting realist synthesis (Porter, 2015). Part of this context consists of prerequisites (e.g. access to [mental] health, organisational competency etc.) for practices and practices that are indirectly aimed at or contribute to access, reach or retention for MEM in SUT.

Lastly, the total number and nature of the identified practices is not representative. This study is also confronted with a recruitment bias that resulted in an overrepresentation of Belgian, Portuguese and German practices. However, because of the extensive methods (survey waves, purposive searches, survey follow-up and reminder, follow-up of previous research etc.), the overview does give a reliable picture of the nature of the existing practices as well as the main aims of these practices. This time depend picture allows us to analytically identify the main aims of substance use treatment for MEM as well as some caveats in current practices which will be discussed below.

Additional contact with all the professionals that are responsible for the practices was not possible within the scope of the current research but would be advisable in future research although the risk for bias of socially desirable answers (wanting to present a 'good practice') will persist.

5.6 Discussion and conclusion

Excluding the practices that we secondarily considered to be universal (as opposed to targeted or indicated practices, see 5.3), we identified a total of 107 inspiring practices that were directly or indirectly aimed at increasing access and retention for or the reach of MEM in SUT (prerequisites).

The **online survey identified a total of 34 practices in the EU-28 member states** (excluding Belgium, see chapter 7 & 8) of which we included only 23 in the secondary analysis because ten were broad practices framed in a universal drug strategy (mainly in Portugal). The Belgian survey and review in turn identified 29 practices. Additionally, we identified 38 practices in review studies (EMCDDA, 2013; Kane & Greene, 2018; Priebe et al., 2016; Stöver, Grundmann, et al., 2018; WHO, 2018). Lastly, 19 practices were identified in the 2014 Reitox drug reports.

Five or more practices were identified in Belgium, Czechia, Germany[75], Greece, Portugal and UK. Austria, Luxemburg, Ireland, The Netherlands, Sweden and Slovenia in turn each represented three to four practices. We only identified two practices in Finland, Hungary, Malta and Romania and only one each in Estonia, Spain, France, Latvia, Lithuania, Poland and Slovakia. We were unable to identify practices in Cyprus, Bulgaria and Denmark. Lastly, Belgium, Czechia, Germany and Portugal each represented over 7 practices because of a sampling bias (see limitations above).

The comparison between our results and the latest update of the EMCDDA prevention profiles (2016) for migrants and ethnic minorities[76] is not straightforward (see figure 7). One should consider that these profiles only represent prevention and not treatment or harm reduction whereas our results included the whole spectrum from prevention to harm reduction.

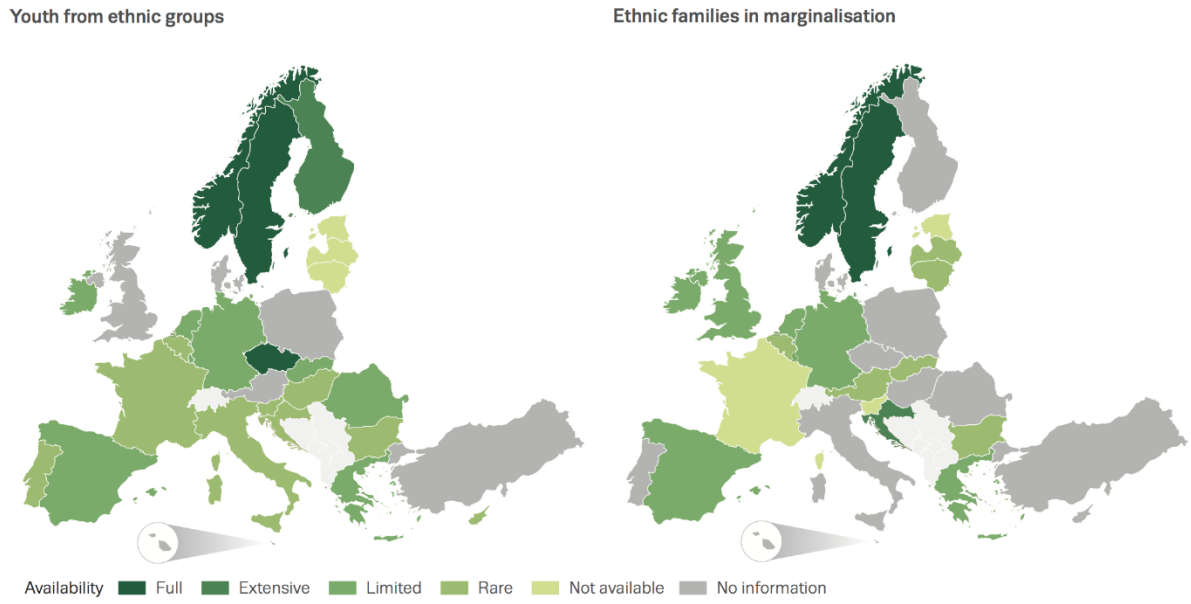


Figure 7: Availability of selective prevention interventions for ethnic minority groups in the European Union, 2015/16

[75] Note that Belgium, Czechia, Germany and Portugal were overrepresented in the sample (see methods & limitations).

[76] Ethnic groups here are understood as "Groups that have lived for more than one generation (or much longer) in a country while preserving their own identity, norms, values and language". Immigrants in turn are defined as "Groups that have recently arrived in a country and may be striving to adapt culturally and economically". The full prevention profiles can be consulted at http://www.emcdda.europa.eu/countries/prevention-profiles .

The EU-28 national drug reports of 2014 reported a total of 17 practices located in alcohol and drug related settings and aimed at MEM. About one third (n=10)[77] of these reports did not identify specific practices aimed at MEM populations[78]. Only in the case of Bulgaria, Cyprus, Denmark and Hungary this seems to be in line with the 2016 prevention profiles (see figure 7 above) that report that these countries have limited to no prevention initiatives targeting MEM. The identified practices in the Reitox drug reports are mainly located in respectively the **harm reduction and prevention domain**. But for the prevention domain, the Reitox national drug reports (2014) remain rather vague.

We conclude that the identified practices that are directly related to SUT for MEM are mainly located in the prevention (n=26) and in the harm reduction (n=24) domain and to a much lesser extent in treatment (n=9), early intervention, screening and brief intervention domains (n=2).

Outreach and harm reduction practices make up the bulk of the identified practices. Practices for MEM in substance use treatment are mainly aimed at access and reach, and less at retention. Although it should be considered that the harm reduction domain is focussed mainly on coverage (Wiessing et al., 2017) and not on retention, this is an important finding concerning the state of substance use treatment for the broad group of MEM populations.

There seems to be a caveat in higher threshold residential treatment. We discerned little practices in the latter treatment setting, possibly implying that it is insufficiently adapted to these populations. A recent systematic review on treatment effectiveness of depression for instance concluded that there is only weak evidence for the effectiveness of psychological treatment among Turkish populations with depression (Sempértegui, Knipscheer, Baliatsas, & Bekker, 2018)[79]. It follows that, in line with Butler and colleagues' recommendation, there is a need to adapt established protocols to better meet the needs of MEM in health care settings (Butler et al., 2016). **Health service planners and drug policy makers should reflect on how to serve the needs of those non-nationals that require other than opioid substitution treatment (e.g. crisis, detox, residential treatment services) and how to adapt evidence-based methods.**

There also appears to be a caveat concerning screening, early and brief intervention. This is in line with a 2018 UNHR funded review (Kane & Greene, 2018) on interventions targeting substance use disorders among refugees. It posits in its conclusions that early intervention, screening and brief intervention among asylum applicants and other refugees are cost-efficient measures for these respective target groups (Greene et al., 2019; Kane & Greene, 2018) because they reduce the cost of

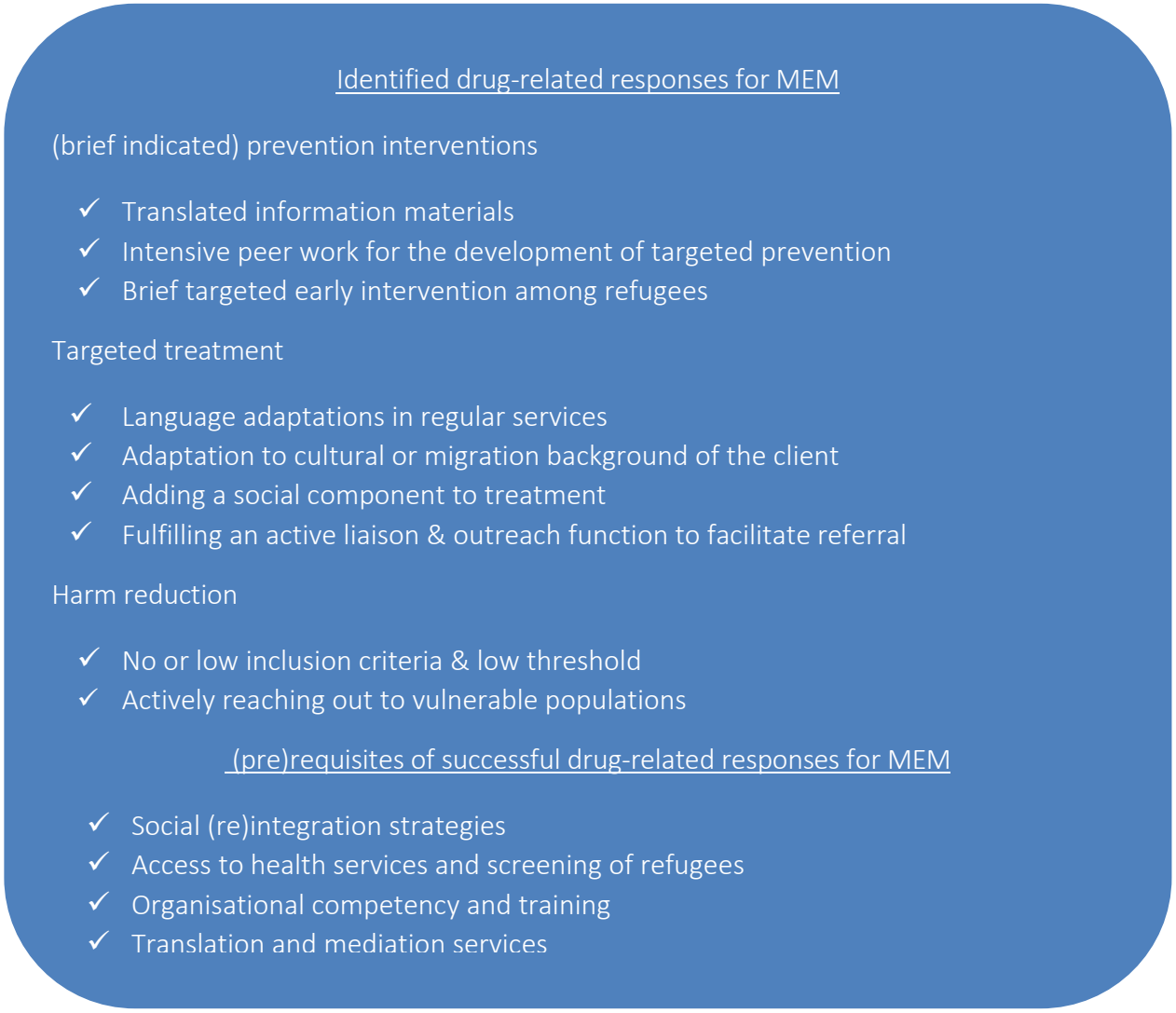
[77] The Bulgarian, Cyprus, Danish, Hungarian, Italian, Latvian, Dutch, Polish, Portuguese and UK reports

[78] The Dutch report for instance reports that "the proportion of non-Western migrants among the homeless people was 40%" (p. 83) whereas the Swedish report notes that among homeless none-nationals "one fourth had no other known problem besides their lack of housing, compared to 14% of the Swedish-born. The most usual reason for being homeless in the foreign-born group is not being approved on the regular housing market" (p. 71) and "the income gap has increased. Poverty is increasingly more common among immigrants" (p. 67).

[79] Salient obstacles to therapeutic success were identified as socioeconomic problems, higher levels of psychological symptoms at baseline, and negative attitudes towards psychotherapy. Facilitators were in turn identified as interventions attuned to social, cultural and individual needs. These results were most representative of first generation, low SES Turkish immigrant patients and Moroccan-Dutch members of the general populations.

treatment in the health system. **Nevertheless, this review did not find any evaluated interventions in the European continent.**

Besides the practices that directly aim at access, reach or retention, half of the identified **practices are prerequisites for successful treatment for MEM: access to (mental) health services (n=13), social (re)integration (n=11), organisational competency and training (n=10), translation and mediation (n=6) and targeted mental health services (n=6).** Although these practises are strictly not



aimed at

Figure 8: Identified practices and prerequisites aimed at access for, reach and retention of migrants and ethnic minorities (MEM) in substance use treatment (SUT)

access, reach or retention, they indirectly contribute to attaining these goals, which is why we did not exclude these practices. Access to (mental) health services as well as organisational competency and training can be considered **prerequisites** of SUT for MEM: if they are absent there will be no (successful) SUT for MEM. Additionally, a focus on translation and mediation as well as social (re)integration are **prerequisites that were identified to be of special importance** in SUT for MEM.

Lastly, the identified practices are mainly located at the provider and to a lesser extent the organisational and policy level. We identified little structural measures at the policy level besides in Finland, Spain and Sweden (overarching refugee mental health policies and access to health services). Nevertheless, we stress that in the past decade the World Health Organisation has been at the forefront to sensitise governments concerning migrant and ethnic minority health and the need for health system aptness. The KNOMAD-indicators for instance can be used to evaluate health system aptness to these population.

At the European level, several projects have been funded to monitor and enhance migrant health (services) (e.g. CARE, AMAC, CLANDESTINO, EQUI-HEALTH, HEALTHQUEST, EUGATE, HOME, MIGHEALTHNET, NOWHERECARE, PALOMA, RESTOR, SRAP), subsidised by among other European funds the Asylum, Migration and Integration Fund (AMIF). Unfortunately, the results of many of these projects are not fully publicly available and it remains unclear whether recommendations have been implemented. Moreover, these project rather focus on broader health goals and – besides SRAP – not on substance use treatment for MEM.

In conclusion, Fountain in an EMCDDA report on drug prevention interventions targeting minority ethnic populations (2013) stresses **that it is crucial not to identify membership of a minority ethnic population *a priori* as an indicator of vulnerability to substance use or problem use.** Indeed, identifying ethnicity related characteristics (e.g. religion) as 'risk factors' can be harmful to these populations and individuals because it can add to social stigma (De Kock, 2020). Nevertheless, many authors have stressed that MEM are often overrepresented in *de facto* socially excluded groups and that this can contribute to the onset of or continuing problem substance use (Burkhart et al., 2011; WHO, 2010b). The most recent EMCDDA programming document additionally stresses that *"some [MEM] may be more vulnerable to substance misuse for reasons such as trauma, unemployment and poverty, loss of family and social support, and the move to a normatively lenient setting"* (EMCDDA, 2019, p. 9).

6. Substance use and treatment among MEM in Belgium

Charlotte De Kock

6.1 INTRODUCTION

For effective treatment planning and service provision, it is essential to have estimates of the extent of treatment need and treatment demand. Ideally, these need and demand estimates are matched to considerations about the available treatment types and explored in terms of geography and subpopulations. The combination of this data allows for tiered and targeted substance use treatment planning at local and sub local levels. (Ritter et al., 2019)

On the 'need side' of the equation one must distinguish between prevalence of various types of (from recreational to harmful or problem) substance use and the reasons and root causes of problem substance use. The 'demand side' too consists of more than the number of people in treatment because this only answers the question of 'met' treatment demand and not the question on unmet treatment demand among for example hidden populations. Therefore, it is important to understand both presence in treatment (met treatment demand) and pathways to treatment.

Analytically, these topics should be studied both quantitatively (e.g. numbers of users, numbers in treatment) ánd qualitatively (e.g. underlying reasons for use and treatment across [sub]populations) to be able to act upon the complex underlying mechanisms and to devise targeted policies.

In what follows, we provide a narrative review of the knowledge that has been produced during the last decade on the Belgian level: what we know about substance use prevalence rates among MEM (6.2), reasons and risk factor for problem use (6.3) and treatment among MEM at the national level (6.4). We conclude by pointing out the most important caveats in the current knowledge in Belgium (6.5). In the chapter on Flanders (chapter 7) and the chapter on Brussels and Wallonia (chapter 8), we elaborate on region specific studies published in the past decade.

6.2 Prevalence of substance use

Research on the prevalence of mental health issues and (problem) substance use among migrants and ethnic minorities (MEM) is scarce in Belgium (Dauvrin et al., 2012). There are four main sources to measure prevalence of (varying types of) substance use at the population level: the secondary school survey (*VAD Leerlingenbevraging*), the National Health Survey (*Gezondheidsenquête*), the student survey (*VAD Studentenbevraging*) and the Global Drug Survey (GDS2019).

The National Health Survey identifies nationality, country of birth, arrival date, country of birth mother and country of birth father. However, in the 2013 results, less than 6% of the total sample (about 6000 respondents) had a migration background (Noppe et al., 2018) meaning that the sample cannot be considered representative and that it is insufficiently powered to establish significance. Similarly, in the GDPS2019 Belgian sample only 8% had another than the Belgian nationality or administered an other 'ethnicity' (personal communication Tina Van Havere 3.10.2019).[80] The

[80] By using choice categories: "Autochtoon, Niet-westers allochtoon- Afrikaans / Caraïbisch, Niet-westers allochtoon - Afrikaans-Amerikaans, Niet-westers allochtoon Zuidoost-Aziatisch (incl. Chinees, Vietnamees, Japans, Thais), Niet-westers allochtoon Aziatisch (Pakistaans, Indisch, Bengalees), Westers allochtoon Spaans / Latino, Niet-westers allochtoon Aboriginal / Maori, Westers allochtoon - Native Amerikaans, Gemengd, Andere? Licht toe"

Student Survey in turn does not use migration or ethnicity related indicators. The secondary school survey recently (2018-2019) introduced three migration related indicators: birthplace and birthplace mother and father (personal communication Johan Rogiers 29.08.2019). However, the results of this survey were not available at the time of writing (they are expected to be made available in 2020).

Moreover, these surveys use quite general indicators of drug use. Some argue that they distinguish insufficiently between recreational and problem substance use. The surveys distinguish broadly between lifetime, past year and regular use. We do note that the National Health Survey also contains questions about starting age and intensity of use (Gisle, 2014) and that the 2021 Survey will contain additional indicators on cannabis use (Personal Communication Lies Gremeaux, 13.06.2019). Nevertheless, the reports of these respective surveys do not contain information about prevalence among MEM populations at the time of writing.

One study did venture in analysing alcohol use among those respondents in the Health Survey that identified as having a migration background (first- or second-generation and a western or non-western migration background) (Van Roy et al., 2018). Respondents with a first-generation non-western migration background were significantly less likely to report excessive alcohol use (2,6%)[81] compared to the 'Belgian' sample (7%) whereas second generation migrants were more likely to report excessive alcohol use (9,3%). When controlling for socio-demographic factors in the first-generation sample, no differences were found, indicating a significant difference between excessive use and migration background (p<0,001). The relation between time and excessive alcohol use is only significant for those migrants born in Belgium (second-generation) (p<0,001). (see figure 9)

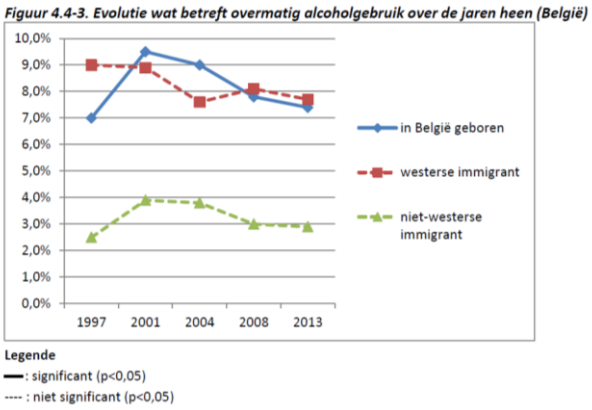


Figure 9: Evolution of excessive alcohol use over the years (Belgium) (Van Royen et al., p. 90)

Respondents with a non-Western background (both first- and second- generation) indicate more often that they have ever thought to decrease their drinking patterns (25,8% en 26,7% versus 19,7% in the Belgian sample), indicating a significant relation between this statement on the one hand and migration background on the other hand (p=0,008). However, multi-variate analysis demonstrates that this difference is explained by socio-demographic variables. There is a significant relation between time and this thought: Respondents born in Belgium and Western migrants have had this thought more over the years. (see figure 10)

[81] Interpreted as >21 units per week for men and >14 units per women. This threshold has more recently been lowered to >10 units for men and women.

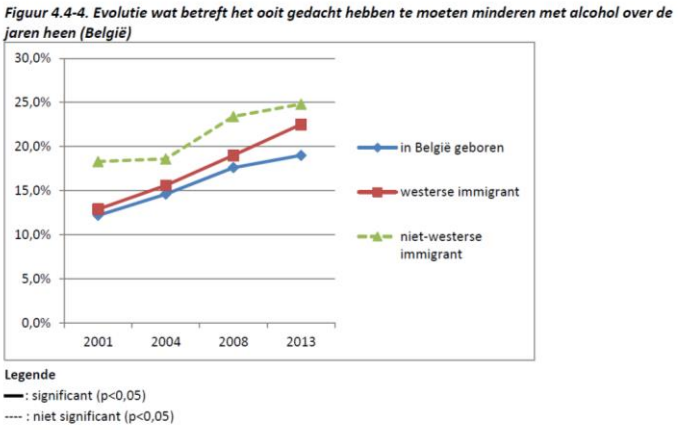


Figure 10: Evolution of ever having thought to diminish alcohol, over the years (Belgium) (Van Royen et al., p. 90)

After controlling for socio-demographic factors, Van Royen and colleagues (2018) also found significant differences between binge drinking and migration background. Respondents with a western first- and second-generation as well as those with a non-western migration background less often got involved in binge drinking compared to 'Belgian' respondents. There only appeared to be an interaction between first-generation non-western background on the one hand and average or high education on the other hand. The latter group was more involved in binge drinking (average: OR=3,039; p=0,004 and high: OR=2,727; p=0,012).

We did not find other surveys or studies published during the past decade (2009-2019) that inform about substance use prevalence among persons with a migration background.

6.3 Reasons and risk factors for problem substance use

Although we could expect substance use prevalence to be similar among MEM compared to non-MEM (Priebe et al., 2016; Vanderplasschen et al., 2003), prevalence could well be lower or higher among some MEM subpopulations due to for instance intersecting risk factors and among those individuals endorsing substance use related coping (Alamilla et al., 2019; Gibbons et al., 2016). So even if substance use prevalence is believed to be lower among some MEM subpopulations, understanding risk mechanisms, is key to targeted treatment planning for MEM populations. Additionally, research stresses that substance use among MEM will become increasingly similar to use in the general population over time.

Risk factors for mental health such as disadvantages in general health (Lorant et al., 2008; Nielsen & Krasnik, 2010), in education (Agirdag et al., 2011; Boone and Vanhoutte, 2014; Danhier and Jacobs, 2017)[82], in housing (Verhaeghe, 2013, Van den Broucke et al. 2015), in the labour market (F. Verhaeghe et al., 2016; P.-P. Verhaeghe, 2013) and in the justice system (Mutsaers, 2013;

[82] In terms of education, the 2015 PISA results demonstrate that pupils with a migration background consistently score lowest on scientific literacy compared to pupils without a migration background and that this difference is very large compare to other European countries besides Finland. Adjusted for socio-economic background, this difference compared to Belgian pupils remains significant (Danhier & Jacobs, 2017b), implying that other issues such as ethnic bias in education, might play a role. This these is corroborated by the fact that pupils with a migration background are more often referred to professional and special education, the fact that they more often leave education without a diploma and that they are less present in higher education (Boone & Vanhoutte, 2014; Noppe et al., 2018).

Petintseva, 2017) are well documented and often culminate among specific MEM subpopulations in Belgium and Flanders. Additionally, use in the home country could influence use, especially during the first years of residence in the receiving country.

Levecque and colleagues (2007) demonstrated that depression and generalised anxiety were more prevalent among persons with a Turkish and Moroccan migration background in Belgium compared to the general population. In addition, there was a tendency for higher risks for psychological distress, depression and generalised anxiety among foreign-born as compared to Belgian-born Turkish and Moroccan migrants (Leveque et al., 2008). A study of Van Ooyen and colleagues (2011) later specified that when socio-economic factors and living conditions are considered, Belgians with a Turkish and Moroccan migration background ran a lower risk for subjective bad health compared to non-MEM counterparts.

Similarly, Van Roy and colleagues (2018) found in an analysis of the Belgian Health Survey that first-generation non-western migrants were more prone to depressive symptoms, anxiety and sleeping disorders but that this difference disappears for the two former mental health issues when controlling for socio-demographic variables, indicating the importance of a social gradient (income, education). First-generation migrants with a western background appeared to have lower odds of reporting depressive symptoms, anxiety and sleeping disorders compared to all other groups (Van Roy et al., 2018)

In a study across 23 European countries, Missine and colleagues (2012) additionally found that MEM experience more depressive symptoms compared to non-MEM counterparts. Moreover, socio-economic conditions and the experience of ethnic discrimination were found to be important risk factors whereas migrant status appeared to be unrelated. Additionally, the prevalence of PTSD among refugees – estimated at 9% among refugees (Giacco et al., 2018) – can be a risk factor for substance use (Horyniak et al., 2016).

Various Belgian and Dutch studies demonstrate a higher prevalence of depression and anxiety among persons with a first- and second-generation Turkish and Moroccan backgrounds compared to the general population. Older age and low socio-economic status raise the chances for depression. (Beutel et al., 2016; Levecque et al., 2007).

The different dynamics between reasons for substance use between adolescents and adults require some attention. International studies concerning substance use among adolescents with a migration background are inconclusive. Some studies suggest that these adolescents are more likely to adopt risky behaviour, whereas others argue that they exhibit lower risk of substance use (Lorant et al., 2016).

A large-scale European study including Belgian adolescents (located in Namur) (Lorant et al., 2016) with a migration background (first and second generation) aimed at uncovering how social networks are associated with substance use. Lorant and colleagues found that **a higher proportion of social ties with non-migrants was associated with increased use of cannabis and alcohol among adolescents** with a migration background, corroborating the hypothesis that prevalence will become

similar to general population prevalence over time[83]. Additionally, adolescents with a migration background that had broad and diverse social networks were at less risk of alcohol and cannabis use compared to 'popular' non-migrant adolescents.

A study of the 2011 Brussel Youth Monitor (Berten et al., 2012) hypothesised that educational track as a proxy for social status would affect substance use[84]. A similar monitoring exercise was conducted in the cities of Ghent and Antwerp but did not report results concerning substance use among adolescents with a migration background. The Brussels study concluded that **students without a migration background in lower educational tracks use alcohol and cannabis more often than students in upper educational tracks. Such a relationship was not found for students with another 'ethnic background'**.

The study additionally found that regardless of student migration backgrounds, growing up in a **'highly educated family' increased the risk of frequent alcohol use**. In their discussion, Berten and colleagues hypothesise that religion (Islam) would act as a buffer among students with a migration background. However, Berten and colleagues have no data to support this hypothesis.

The **PADUMI study (patterns of substance use among migrants and ethnic minorities, Belspo, DR/69)** intended to qualitatively understand patterns of substance use among four sub-groups: persons with a Turkish and Congolese migration background, the broad group of undocumented migrants, refugees and asylum applicants as well as persons with an Eastern-European migration background. The research study used a community based participatory research (CBPR) design and reached over 200 self-defined recreational and problem substance users (De Kock, 2017; De Kock et al., 2016).

Similar to the Belgian population prevalence, these respondents mainly reported the use of cannabis, alcohol and cocaine. Nevertheless, this qualitative study does not enable us to establish prevalence rates. The main reasons for problem substance use were **marital and other family related problems** among the Eastern-European and Turkish respondents. Eastern-European respondents additionally reported **financial problems**. Among undocumented migrants, refugees and asylum applicants **uncertainty concerning residence status and migration histories** were mainly mentioned as reasons for problem substance use (De Kock, Decorte, Schamp, et al., 2017).

Moreover, all Eastern-European and Turkish participants were confronted with (inter)ethnic **discrimination** (De Kock & Decorte, 2017). Lastly, the study documented that Turkish problem users had more difficulties in coping with the **identity issues related to stigma and ethnicity,** compared to recreational users with a migration background (De Kock, 2020).

[83] Similarily, research among young immigrants (15-24 years) of Surinamese, Turkish, Moroccan, Antillean, or Asian descent in the four major cities shows that the ever use of cannabis is higher among adolescent immigrants who speak Dutch at home, compared to those who speak Dutch at home speak mother tongue (Delforterie et al., 2014). This is partly explained because they often have friends who use cannabis.

[84] The Flemish secondary school system is highly tracked and mainly consists of three different types of education that can be ranked in difficulty level from vocational, technical, to general secondary education. (Berten et al., 2012)

6.4 Substance use treatment for MEM in Belgium

6.4.1 Presence and profiles in treatment

Blomme, Colman & De Kock (2018) analysed all Belgian treatment episodes in 2012-2013. They found that European non-Belgians are a lot less **present in residential treatment (mainly therapeutic communities)** compared to their share in the population and compared to the number of non-European clients in treatment. They also documented an overrepresentation of non-nationals in ambulant methadone substitution treatment. An additional analysis (De Kock, Blomme, et al., 2020) in this same data (with the addition of 2014 data) found a significant association between nationality on the one hand and type of solicited service, gender and housing situation, on the other hand. Treatment episodes involving non-national clients were more often located in outpatient OST services compared to those involving Belgian clients that more often solicited and were referred to higher threshold inpatient services. The identified regional differences are reported in chapter 7 (Flanders) and 8 (Brussels and Wallonia).

The documented European gender gap (one in four to one in five of SUT clients is female) (Montanari et al., 2011) was larger among third-country nationals compared to Belgians (De Kock, Blomme, et al., 2020). A comparison between European and third-country non-national clients consistently suggested lower socio-economic parameters among third-country clients (housing, education, labour) in this study. Third-country clients more often never went to school and were more often unemployed.

The analysis of housing situation demonstrated that in episodes involving third-country clients, clients significantly more often had an unstable housing situation. As regards primary substance in treatment, the main difference – but albeit not significant – was that episodes with non-national clients more often concerned opioids and less often cannabis and alcohol compared to Belgians. It appears that these populations are most often treated for the most harmful drugs, namely heroin.

These results concerning **client characteristics** are similar to Derluyn and colleagues' findings (2008): persons with a (first generation) migration background in treatment were less often female and often older, and they were more often unemployed or precariously employed, compared to Belgian clients. Clients with a migration background more often identified heroin, cocaine and methadone as their main substance whereas Belgians more often reported alcohol. This could be the result of a treatment gap: not consulting services in the case of problem use of these substances. Moreover, subgroups such as women, youngsters and persons with an Eastern-European migration background appear to be underrepresented compared to other subgroups and their representation in the general population (De Kock, Blomme, et al., 2020).

We found no Belgian studies concerning MEM client satisfaction in treatment or retention in treatment.

6.4.2 Treatment trajectories

Derluyn and colleagues (2008) conducted the ZEMIV study (ethnic and cultural minorities in substance use treatment, DR/28, Belgian Science Policy Office). The authors alerted over a decade ago that persons with a migration background often had higher susceptibility for harmful substance use (because of socio-economic reasons), that they were confronted with barriers in (mostly residential) substance use treatment and that at the individual level, they often had mistrust

towards treatment. Derluyn and colleagues also reported that there was little Belgian research concerning this topic. Based on three hypothesises (double stigma, alternative treatment services, cultural blindness in treatment) they studied whether **treatment trajectories** of persons with a migration background were different compared to Belgians.

Apart from the proper access to treatment, Derluyn and colleagues studied the trajectories of clients in treatment departing from studies that had demonstrated earlier drop-out in treatment and the fact that treatment may be insufficiently adapted to MEM needs (Verdurmen et al., 2004). The ZEMIV study concluded that treatment trajectories differed significantly across types of migration backgrounds but that individual factors, rather than migration background, were most decisive. Additional findings will be reported below.

6.4.3 Referral and types of treatment

Regarding **referral**, treatment episodes involving non-national clients in 2012-2014 were less often upon referral of general practitioners and hospitals compared to episodes involving Belgian clients (De Kock, Blomme, et al., 2020). This could point at referral bias by general practitioners but needs further research. Furthermore, non-nationals were more often referred by 'other' actors and self-referred to treatment and these results did not differ across European and non-European nationals. In this context, it should be noted that first-generation third country migration background less often have a steady general practitioner and, that all first-generation migrants in the 2013 health survey data were less likely to have had visited a GP during the past 12 months (Van Roy et al., 2018). Additionally, the relation between having used emergency services and migration background was found to be significant: respondents with a first-generation non-western background more often made use of these services compared to Belgians, but this difference disappears after controlling for socio-demographic variables. (Van Roy, 2018)

Whereas the ZEMIV study (Derluyn et al., 2008) hypothesised that referral by informal networks and judicial referral might play an important role among MEM, this was not the case for non-nationals in the 2012-2014 treatment demand data (De Kock, Blomme, et al. 2020). Derluyn and colleagues did identify some alternative strategies used instead of or in addition to regular treatment such as leaving to the home country for rehabilitation, religion and marriage.

Concerning **types of treatment used,** the PADUMI study (see above, De Kock, Decorte, Schamp, et al., 2017) found that one third in the sample of undocumented migrants, refugees and asylum applicants as well as the Turkish respondents had consulted a wide array of treatment services. In the Eastern-European sample, this number was much lower approximating one in seven respondents. The types of consulted services differed substantially across the groups. The Turkish respondents had knowledge of and consulted all specific substance use treatment services whereas the group of undocumented migrants, asylum applicants and refugees mainly consulted ambulant OST services. Eastern-European respondents in the PADUMI study mainly asked for help to general practitioners, hospital emergency services, public social welfare offices but also trade unions and mutual health insurance services.

These results indicate low knowledge of services among Eastern-European respondents as well as among refugees, asylum applicants and undocumented migrants. The identified use of alternative treatment methods was limited and we framed it in a 'health bricolage perspective' (Phillimore et al., 2017) similar to health seeking behaviour in the general population (De Kock, 2020).

6.4.4 Barriers to treatment and equitable health

At the macro policy level (Dauvrin et al., 2012; Derluyn et al., 2011), an expert group identified a number **of issues regarding access to mental health care** for MEM. Especially outside the big cities there appears to be an acute lack of professional care providers who can provide mental health care tailored to MEM. The experts also found that there are insufficient intercultural mediators and / or interpreters who speak varying MEM languages and that there is a shortage of financial resources for interpreters and intercultural mediation in specialized centres.

The 2019 Belgian Health Report (OECD et al., 2019, p. 9) alerts that

> *"Irregular migrants (people without a residence permit authorising them to stay in Belgium) cannot be affiliated to a Belgian illness fund. They are entitled to receive Urgent Medical Aid, but few reach out to these medical services. It is estimated that only 10-20 % of irregular migrants had at least one contact with a medical service in 2013, compared with approximately 90 % for people affiliated to a Belgian illness fund. Applicants for international protection (or asylum seekers) are entitled to medical care to preserve human dignity. They live either in reception centres or outside, but each reception centre to which they are affiliated is responsible for organising and paying for any needed medical services. Little is known about their actual use of health services, however."*

Moreover, the continuity of care for this population is alerted to be problematic. The experts alert that this is exemplified by the fact that compulsory hospital admissions are twice as high for MEM compared to the general population. This can partly be explained by negative perception of mental health care and the fear of stigma.

The barriers to treatment and equitable health as outlined in chapter 2.1 in the European context, also exist in Belgium. A study based on the QUALICOPT research project identified that in Belgian migrants consistently had worse experiences during the healthcare process compared to the other studied European countries. Being a first- or second-generation migrant was reported to have a significant effect on all studied access, treatment and outcome indicators. The respondents reported less access, had more negative experiences with treatment procedures, indicated to be less satisfied and postponed treatment more often compared to non-migrant counterparts (Hanssens et al., 2016, p. 446). Additionally, both first- and second-generation migrants experienced significantly lower continuity of care.

In addition, the access to 'project 107 actions' (Vandeurzen, 2018) in Flanders remains problematic for MEM because they inadequately address the training of health professionals and due to the shortage of intercultural mediators / interpreters for removing cultural and language barriers. A more recent **KCE report lists a lack of coordination, regional differences regarding health care, lack of monitoring, lack of transparency about expenses as well as administrative support and qualified personnel as the main macro barriers to equitable access to health for asylum seekers. (Dauvrin et al., 2012; Dauvrin et al., 2019)**

In the ZEMIV as well as the PADUMI study micro individual barriers to treatment were identified among specific MEM subpopulations such as the taboo on substance use and double or even 'triple stigma' (De Kock, 2020; Derluyn et al., 2008), a lack of information and linguistic problems, identification issues, stress, discrimination (De Kock & Decorte, 2017) and a lack of social networks

(De Kock, Decorte, Derluyn, et al., 2017). At a **meso organisational level** PADUMI respondents critiqued the predominant focus on medication in psychiatric units of hospitals (PAAZ) and the habit of 'black listing' difficult clients, disabling to seek further treatment in a residential setting.

6.5 Intermediate conclusion

For effective treatment planning and service provision, it is essential to have estimates of the extent of a least treatment need on the one hand and treatment demand on the other hand (Ritter, 2019). However, research on the prevalence of (problem) substance use (treatment need) among migrants and ethnic minorities (MEM) is scarce in Belgium. The main problem is the fact that the national health survey does not contain a representative sample of persons with a migration background (Noppe et al. 2018). Only one study (Van Royen et al., 2018) ventured in studying alcohol use by means of the 2013 health survey data and found significant differences among non-western first-generation migrants compared to persons without a migration background.

Concerning treatment demand – measured by means of the numbers of treatment episodes – Blomme and colleagues (2017) established that there is an overrepresentation of non-nationals in outpatient OST services and an underrepresentation in higher threshold therapeutic communities compared to general population presence. We additionally established lower socio-economic statuses among third country (or 'non-western') non-nationals compared to European clients and observed a very low number of non-western females in treatment (De Kock, Blomme, et al., 2020). These findings confirm earlier preliminary findings of Derluyn and colleagues (2008). Additionally, Derluyn and colleagues emphasised the importance of distinguishing between types of migration background in SUT trajectories.

Lastly, qualitative research indicates that problem substance users with a Turkish migration background more often suffer from stigma in the perceived religious community as well as the consequences of perceived discrimination (De Kock, 2020). Additionally, this qualitative study found that intra-European migrants, refugees, asylum applicants and undocumented migrants were less knowledgeable about the existent SUT services compared to those with a Turkish migration background. This too, will need attention in future service planning.

Concerning risk factors, several Belgian studies have established higher odds for persons with first-generation and second generation (mainly Turkish and Moroccan) migration backgrounds for depression and anxiety (Missine et al. 2012; Levecque et al. 2007). Much less work has been done concerning its relation to substance use in Belgium, especially among refugees. Lorant and colleagues (2016) found that a higher proportion of social ties with non-migrants was associated with increased use of cannabis and alcohol among adolescents but it remains unclear if this also applies to adults.

Several studies pointed out barriers to SUT and other (mental) health services at the policy (macro) and service (meso) organisational levels. These barriers will be elaborated in chapter 7 and 8 as SUT has become a regional responsibility in Belgium. We will come back to the issues of service fragmentation as a result of the state structure in the conclusions and recommendations of this study.

The findings of Lorant (2016) and Van Royen (2018) appear to corroborate the hypothesis that prevalence will, over time, become increasingly similar to general population prevalence among

those with a migration background (Priebe et al. 2016) but further research is needed. Additionally, the fact that persons with a 'non-western' or 'third country' first-generation background appear to have higher odds for depressive symptoms and anxiety (Van Royen et al. 2018) and have lower socio-economic statuses in treatment in treatment (De Kock et al., 2020) warrants further inquiry and attention in treatment settings.

7. Substance use and treatment among MEM in Flanders

Charlotte De Kock

7.1 Health (care use) and social integration among MEM in Flanders

In 2016 20,5% of the Flemish population had a migration background meaning that these citizens (used to) have a foreign nationality or had at least one parent with a foreign birth nationality. This percentage rose with 5% since 2009. Looking at the migration background of these citizens, they mainly had respectively Dutch (17%), Moroccan (14%), Turkish (10%), Italian (5%), Polish, French and Russian (4% each) backgrounds (Noppe et al., 2018).

The subgroup of persons with a migration background (one parent with foreign nationality) is about 2,5 times higher than the group of citizens with only a foreign nationality which made up 8,4% of the population in 2016. In this subgroup, the following nationalities are most prevalent: Dutch (25%), Polish (7%), Romanian (5%), Moroccan (5%), Italian, French, Bulgarian (4% each) (Noppe et al., 2018, pp. 297-298). Antwerp, Gent and Leuven are the cities that harbour most persons with a migration background (Noppe et al., 2018, p. 46).

The health status of persons with a migration background is less documented compared to the domains of education, employment and housing. In Flanders – as is the case for Belgium – there are no reliable data available concerning the prevalence of recreational, harmful or other types of substance use among persons with a migration background (e.g. limited sample in the National Health Survey 2013, 2018). The Flemish government recently commissioned a large scale survey among persons with a migration background (*Samenleven in Diversiteit* [Living together in Diversity]) (Stuyck et al., 2018). However, this study contained little items concerning (mental) health and health seeking and the methods did not include significance analysis.

Nevertheless, Noppe and colleagues point out that the number of persons with self-rated very bad health is larger among non-EU nationals compared to EU-nationals and Belgians in Flanders. Van Roy and colleagues (2018, p. 49) affirm this finding in their analysis of the 2013 health survey data, by reporting that respondents with **first-generation non-western migration backgrounds had significantly worse self-rated health**, after controlling for other variables. It should be noted that scholars hypothesise that worse self-rated health is linked to accessibility to health services and vice versa (Jarcuska et al., 2013).

Van Roy and colleagues (2018) found in the 2013 National Health Survey data that in Flanders **first-generation non-western migrants suffer least from one or more chronic diseases** (compared to non-migrant and western migrant counterparts) but at the same time report significantly lower self-rated mental health and significantly lower social support compared to Belgians. There was no significant relation between self-rated health, depression, anxiety, sleeping disorder and migration background.

The amount of people **postponing health care consultations because of financial reasons** is significantly larger in the group of non-EU nationals compared to Belgians in Flanders. Studies indicate that lower socio-economic status (education, employment and housing) can significantly influence health (Marmot, 2016) and mental health (Julia et al., 2017).

Consistent **lower statuses in the domains of labour, education and housing** are documented in the Flemish Integration Monitor 2018 (Noppe et al., 2018) which bring together data from PISA, EU-SILC, the Flemish 'Living together in Diversity' Survey and other surveys. Persons with origins outside the EU appear to have an especially precarious position. Unemployment among non-EU nationalities is among the highest in all the Belgian regions compared to the EU-15 countries.

Nevertheless, the causality between the above mentioned facts, the internal directionality and their relation to substance use and access to substance use treatment at the individual level, remain understudied.

7.2 Non-Nationals in Flemish treatment

Blomme, Colman and De Kock (2017) used Treatment Demand Indicator registers to descriptively explore treatment episodes in 2012 and 2013 in all official Flemish substance use treatment services that are subsidised by the Federal Institute for Health Insurance (INAMI / RIZIV). The study departs from the hypothesis that presence of MEM in substance use treatment should be equal to or approximate their presence in general society (Vanderplasschen et al., 2003, p. 19). Our analysis of the presence of non-Belgians in Flemish treatment revealed major differences between treatment types.

There was an overrepresentation of non-Belgians in the medical-social reception centres (MSOC). More than 15% non-Belgians found their way to the different Flemish MSOC, compared to a representation of 7.2% (in 2012) and 7.4% (in 2013) in the Flemish population. The authors note that the considerable representation of non-Belgians in Flemish MSOC contrasts with their scarce presence in crisis and residential services. Moreover, this difference was especially prevalent in Flanders but persisted in the other Belgian regions (Brussels, Wallonia).

The percentage of non-Belgians in crisis services varied between 3.5% and 5.8% over the studied years. The clientele of therapeutic communities only had a representation of 1.8% (in 2012) and 2.2% in 2013 of people with another than the Belgian nationality. Outpatient services (day centres excluding methadone substitution services) had a less pronounced underrepresentation of this population with 6.10% in 2012 and 5.3% in 2013.The large presence in treatment of people from outside the European Union was striking within the "non-Belgian" group. **Except for the therapeutic communities, there were twice as many individuals with a non-EU nationality compared to EU-nationals in all treatment types. Contrarily, the vast majority of non-Belgians in the 2012-2013 populations statistics had a EU nationality, possibly pointing out an underrepresentation of Europeans in Belgian treatment. Additional studies are needed to understand this gap.**

Although the study is not framed as such, it indirectly also hypothesised that Belgian nationals' presence in varying treatment services should be similar to non-nationals in treatment to account of equitable treatment possibilities. Considering the availability of this data, future studies should keep monitoring these subgroup differences. Comparing populations with and without a migration background is well accepted in MEM health studies, together with the study of populations with similar backgrounds across national contexts (to study policy effects) and subgroup analysis of similar populations that have and have not migrated (to study the role of migration) (Agyemang & van den Born, 2019).

7.3 Policy framework

In 2016, the Department of Public Health, Wellbeing and Family (*Departement Volksgezondheid, Welzijn en Familie*) published a policy analysis concerning ethnic diversity in this Flemish policy domain (Demeyer & Vandezande, 2016). The analysis mainly included policy notes and briefs, action plans and discussion notes in a broad array of domains including poverty reduction, equal opportunities and integration policy. The analysis included the 'Policy plan mental health care' (2010), 'Action plan Roma' (2012), 'integrated action plan for integration policy' (2012-2015), 'a strong first line wellbeing work' (CAW) (2011) as well as the Flemish government agreements of 2009 and 2014.

The analysis identified an 'ethnic cleavage' because the social position of persons with a migration background is often worse compared to counterparts without a migration background. The study points out specific vulnerabilities among second and third generation individuals with a non-European, mostly Turkish and Moroccan background and notes that other migration backgrounds remain unstudied. (Demeyer & Vandezande, 2016, p. 68)

The answer to the main question – "*what is the policy framework concerning ethnic diversity in healthcare and wellbeing?*" – is that policy documents demonstrate a willingness to focus on diversity but that the concrete goals remain vague. The overarching policy note of the policy domain did mention the importance of accessibility of services, the need for increasing MEM client population reach, adapted treatment methods and increasing the number of persons with a migration background in health professions.

The specific analysis of the mental health domain identified that the topic is mainly approached on a project basis and that this impedes long term and continuous policy making (Demeyer & Vandezande, 2016, p. 70). The authors also mention that dialogue with self-organisations[85] remains undiscussed in the policy documents. Lastly, the analysis points out that no means for policy evaluation are in place in Flanders.

This study did not include the 'concept note on substance use treatment' (*concept nota verslavingszorg*). The reason is most probably that this 'concept note' had not been translated into a proper 'policy note' at the time of writing the report or that it was published after the publication of the study. Subsequently, we screened this document with the same keywords Demeyers & Vandezande used[86] and conclude that the note does not specifically focus at migrants and ethnic minorities in substance use treatment because none of the key words are present in this text.

[85] In Flanders, persons with a migration background were long inhibited to establish a non-governmental organisation. In the eighties, these restrictions were cancelled. Ever since ONG's set up by persons with a migration background aimed at these populations, have been denominated 'self-organisations' in policy documents. It remains unclear why these organisations are called 'self-organisations' and other types of NGO's are not.

[86] diversiteit' – 'etni*' – 'cultu*' – 'allocht*' – 'minderhe*' – 'buitenland' – 'vreemdeling' – 'migr*' – 'herkomst'-'afkomst' – 'kleur'.

7.4 Understanding substance use and treatment among MEM in Flanders: a decade of research

There is very little research available on MEM and drug use in Belgian treatment, let alone studies that specifically focus on Flanders. In the early 2000's some research focussed on this topic such as for example:

- The Antwerp based SODA research project on treatment needs conducted among ONG's (SODA, 2001 in El Osri et al., 2012);
- A master thesis on MEM client perspectives on treatment (Aga, 2001);
- The EU funded SEARCH project on prevention among asylum applicants, refugees and undocumented migrants (Van Der Kreeft & Van den Bossche, 2002);
- A study on SUT professional perspectives on cultural responsiveness (Vandevelde et al., 2003)

In what follows, we will briefly discuss academic work and grey literature in this domain in Flanders that has been published during the past decade (2009-2019). The premature nature of the research domain is exemplified by the fact that the gathered literature is topical and that our search of citations of each of the mentioned publications, did not yield any results for Belgium. Consequently, in what follows, we structured the results chronologically and per topic. These are mainly qualitative studies.

7.4.1 Khat use among Iranian in Belgium (Muys, 2010)

This PhD thesis explored to what extent pre-migration cultural frameworks influenced substance use among a sample of 129 Iranian refugees in Belgium. Muys found that pre-migration frameworks are not predominantly important to patterns of use in Belgium. She posits that pre-migration standards, values and traditions could persist, but do not necessarily do so. She also reports that culturally sustained forms of use of opium compose an important consumption pattern among first- and second-generation Iranian war migrants. She further stresses that substance use was often a social ritual that allowed social interaction among the respondents.

Respondents also reported that substance use functioned as self-medication to deal with migration related stress and host country hostility. Muys concludes that migrants are more likely to self-medicate if this is a part of pre-migration patterns of use. She further stresses that socio-economic differences rather than cultural traits influence patterns of substance use. She consequently recommends focussing on the root causes of substance use and subsequent targeted prevention.

7.4.2 Reaching, supporting and guiding family members of substance users with a migration background (Noens et al., 2010)

This article describes the efforts of a treatment service (*De Kiem*) to involve MEM family members in treatment, based on interviews with 24 family members and experts.. The municipal client coordination platform had alerted that less than 5% of the parents reached by this platform, had a migration background and this was corroborated by other services. These efforts were funded from 2007 to 2010 by the Flemish government and mainly aimed at persons with a Turkish and Moroccan migration background.

To overcome the knowledge gap about substance use treatment, *Tuppercare* sessions were organised to reach women. Furthermore, 14 professionals that were in contact with the target groups got training in substance use treatment to serve as a liaise between the service and 'ethnic communities'. Although many mothers were reached by means of the *Tuppercare* sessions, the main goal of attracting more clients with a migration background was reached only to a limited extent. The liaises pointed out that imams should have been included in the trajectories.

Third, a 'family house' was created where parents could come with all their questions concerning substance use and treatment. Building relationships of trust, cultural responsiveness and the availability of translators was key in the success of this initiative. Fourth, an information folder that explained substance use and treatment related issues was developed. Fifth, peer-to-peer contact and group sessions were organised.

An analysis of all these efforts demonstrated that face-to-face contact and outreach work were most successful for reaching these populations and that for example the use of translated folders only worked to a limited extent.

It should be noted that during the PADUMI project (De Kock, Decorte, Schamp, et al., 2017) staff members of the service that initiated this project noted that the project overall led to more referral to the service. Nevertheless, referral dropped again after the project ended because the outreach work stopped. Similarly, in the PADUMI project, several substance users in recovery as well as professionals in treatment mentioned the usefulness of one specific outreach liaise organisation (*vzw De Eenmaking*).

7.4.3 Antwerp substance use treatment for ethnic and cultural minorities (El Osri et al., 2012)

This report is the result of 37 semi-structured interviews with MEM substance users, professionals and experts in Antwerp. This research project aimed at identifying whether the Antwerp services were sufficiently accessible for diverse MEM populations, which individual barriers exist and how accessibility could be enhanced. The main study result, in line with Derluyn and colleagues (2008) was that needs, barriers and care trajectories are very individual and that client-centred care is important for the MEM client.

The study made specific recommendations to reduce barriers at the level of MEM individuals and communities (sensitising, targeted prevention, outreach work with key figures, knowledgeable information about treatment, support of key figures by means of peer-to-peer training) and at the level of treatment services (reducing waiting lists, more low threshold treatment, use of unsophisticated language and translators, professional awareness and open attitude and having staff with a migration background).

7.4.4 The coordination between treatment demand and offer (D. Mortier, 2012)

This master thesis aimed at better accommodating the treatment offer to the real treatment needs in East-Flanders and is based on 20 interviews with professionals and five clients in treatment. **Professionals in non-specific substance use treatment alerted that there was a large group of foreign, mostly Eastern-European problem substance users that was not reached by treatment**

services. It is noted that this target group is visible in low threshold initiatives such as night shelters but that they are insufficiently referred to treatment when needed.

Other types of substance use (e.g. glue sniffing) were reported and subsequently the need for sensitising and prevention actions was stressed by the respondents. **This trend and the urgent need for outreach sensitising and preventive work in this target group** was equally argued for by a municipal prevention worker (personal communication Peter Colle, 10.07.2019). Lastly, professionals in this study coined that incarcerated individuals with a migration background often did not reach substance use treatment after their incarceration.

7.4.5 Substance use treatment after detention among ethnic minorities (M. Mortier, 2017)

The author – a former employee of the centralised registration service for substance use treatment in prisons (CAP, *Centraal Aanmeldingspunt*) – aimed at quantitatively understanding differential treatment trajectories between detained individuals with a Turkish (n=88) and Moroccan migration background (n=396) and those without a migration background (n=1990) (based on the indicator '[double] nationality'). 753 unique trajectories between 2011 and 2014 were analysed in a longitudinal perspective. **The analysis of treatment referral, start-up and outcome among 2474 clients identified selection-effects of client characteristics and more negative treatment outcomes for (ex-)detainees with a migration background, especially among Moroccan detainees.**

The ages of clients involved in this referral system did not differ significantly across migration backgrounds. Belgian clients appeared to have a longer phase of orientation and guidance to treatment and Moroccan clients dropped out significantly more often compared to Belgians during this phase of orientation. **Clients with a migration background were significantly less often referred to residential treatment compared to Belgians: 30% Belgians, 17% Moroccan and 11% Turkish**. Seven in ten of these referrals were to ambulant centres and centres of mental health (CGG) and to a much lesser extent to ambulant methadone substitution centres (MSOC).

Moreover, referrals to MSOC appeared to have much more drop-out among all client types. During the phase of start-up of treatment, Moroccan clients dropped out twice as many times, and Turkish three times more often compared to Belgian clients. **Lastly, Moroccan clients significantly more often ended treatment with a 'negative advice' whereas there was no significant difference between Turkish clients and Belgians. (M. Mortier, 2017, pp. 59-57)**

The author stresses that these numbers do not inform about the way in which treatment providers deal with requests for treatment of detainees with MEM nor do they inform about the attitudes and motivations for referral of judicial partners. The two latter issues require further research because bias among providers could play an important role in the referral process.

7.4.6 Social network, discrimination and religion among Turkish and Eastern-European drug users (De Kock, 2020; De Kock & Decorte, 2017)

Based on the results the PADUMI research project De Kock & Decorte focussed on a sub-study examining respondents with a Turkish (n=55) and Eastern European (n=62) migration background in Flanders. They explored whether and how these individuals perceived discrimination, ethnic identity and (ethnic) social networks. **They concluded that almost all the respondents reported perceived**

(inter-)ethnic discrimination. They further established that problem users in the study had a complex but albeit weak sense of ethnic identity and that they did not have a strong ethnic or social network. The authors concluded that discrimination, ethnic identity issues and a lack of social network conjointly composed additional risk factors for continued problem substance use that may hamper recovery from problem use.

An additional analysis of 47 interviews with Turkish substance users intended to understand the influence of ethnicity and religion on participant substance use and treatment (De Kock, 2019a). The study found that all participants agreed that a Turkish community exists in Ghent and all but three identified as Muslims. However, problem users and users in recovery tended to link being 'Belgian', 'Turkish' and 'Muslim' to negative feelings of exclusion whereas recreational and, to a lesser extent, recovered users more often linked this part of their identity to positive feelings of belonging.

These two studies point out that religion in this specific case is not a 'protective factor' for continued problem use because of the related shame and stigma the participants experience. Respondents often accounted that substance use is considered 'forbidden' or 'haram' and related this to social isolation induced by ethnic conformity pressure (Van Kerckem et al., 2014). The study concludes by stating that the continuous construction and embodiment of what is perceived of as Turkish, Muslim and Belgian is far more significant in the lives of the participants than what Barth called 'the cultural stuff' (Barth, 1969/1998) that is enclosed within the perceived boundaries of these concepts and should subsequently be taken into consideration during substance use treatment.

Indeed, whereas some studies on substance use and mental health (a risk factor for problem use) in persons with a migration background, point out that having a primarily ethnic network buffers for substance use initiation (Lorant et al., 2016), increased substance use (Gibbons et al., 2016), depressive symptoms (Ikram et al., 2016), and psychological distress (Heim et al., 2011; Phinney et al., 1997), these studies qualitatively demonstrate that ethnic identity and being religious is not protective in relation to continued problem use among the studied participants. **This is in line with well-established recovery capital research that conceives of diversified social networks (Bathish et al., 2017) (as opposed to isolated and primarily ethnic networks) as an essential component of sustainable recovery from substance dependence.**

7.4.7 The influence of religion on female Muslim substance users (Bekkers, 2019)

Bekkers – who is a professional in substance use treatment – researched the influence of Islam on the experience of substance use and treatment among women who self-defined as Muslim. This was a small qualitative study among female substance users (n=5), experts and professionals in treatment (n=5). She notes that religion has a very individual meaning for the interviewed women and that some find strength and peace in religion during treatment.

The women emphasised that their religion – as other life domains – became less important during treatment. The shame, taboo and stigma related to the fact that substance use is perceived as forbidden in Islam, had a negative impact on their recovery process. Barriers to treatment were mainly a lack of family support, lack of knowledge about the treatment offer and stigma. The women also alerted that substance use treatment is quite male-dominated (both in terms of clientele as in terms of 'treatment culture') and that this may impede them to feel safe in treatment services.

7.4.8 Interculturalising a residential SUT service (Meylaers, 2019)

This bachelor thesis describes the process of 'interculturalisating' a residential SUT service (*Katarsis*) by means of in-depth interviews and a focus group. The process was analysed among both staff and clients involved in the detox programme, the therapeutic community and in the aftercare department. The author studied the domains of organisational identity, staff policy, methods and the reached populations. The research concludes that the process is not yet fully integrated in the organisational structures.

7.5 Empirical findings: the perspective of professionals and policy makers

7.5.1 The data

Twelve Qualitative semi-structured interviews

Semi-structured interviews with substance use treatment program coordinators and other professionals in Flanders, Brussels and Wallonia were conducted to **map needs, challenges and subsequent inspiring practices to increase SUT reach of, access for and retention of MEM**. The rationale for focussing at professionals was the policy-oriented focus of this research project and the fact that in previous research, we had focussed on user voices (De Kock, 2020; De Kock & Decorte, 2017; De Kock, Decorte, Schamp, et al., 2017).

During the first part of the interview (see annex 2: interview guide), the researcher elicited variations across migration backgrounds, types of substances used, types of residence permits, types of treatment services, regions in the country and gender. The second part of the interview aimed at **making a SWOT (strengths, weaknesses, opportunities, treats) analysis of substance use treatment in the respective regions where respondents worked or were responsible for**. This qualitative method allowed the researcher to explore the (contextual) processes (e.g. SUT organisational context and policy strategies) that influence reach and retention of and accessibility for (potential) MEM service users.

The researcher purposively sampled Flemish respondents via professional partner VAD and based on contacts obtained via previous research (PADUMI). We aimed at representativeness in terms of Flemish provinces, types of treatment (outpatient-inpatient, low- and high threshold), gender and professions in a sample of at least ten respondents. As a result, we interviewed 14 respondents during 12 interviews (see table 34: Flemish respondents). Respondent 1 and 2, and respondent 8 and 9 were duo-interviewed. The interviews lasted between 56 and 96 minutes.

At least two respondents were located in each of the following provinces: Limburg (n=2), East-Flanders (n=3), West-Flanders (n=3). One respondent was responsible for the integration of culturally sensitive care in the newly established Antenna for mental health care (*Steunpunt Geestelijke Gezondheidszorg*). Two respondents were not affiliated to a region or province because they were respectively a researcher and a Health Ministry staff member. In terms of professions, respondents were mainly psychologists (n=5), general practitioners (n=3) or involved in policy making at the organisational level (n=3), involved in federal and Flemish targeted treatment initiatives for MEM (n=2) and one was a researcher.

Respondent quotes are referred to anonymously in the results section (respondent numbers 1 to 14) but quotes are preceded by relevant respondent characteristics (e.g. profession). These characteristics are also listed below.

IDENTIFIER	PROFESSION	ORGANISATION	Region
Respondent 1	Policy coordinator	Inpatient substance use treatment	Limburg
Respondent 2	Director	Inpatient substance use treatment	Limburg
Respondent 3	Psychologist	independent / policlinic	Antwerp
Respondent 4	General Practitioner	Methadone Substitution Treatment	East-Flanders
Respondent 5	Psychologist	independent / Integration centre	Antwerp
Respondent 6	Pychologist	Centre for mental health	East-Flanders
Respondent 7	Team leader	Ministry of Health	NA
Respondent 8	Policy coordinator	Centre for mental health	Antwerp
Respondent 9	Psychologist	Centre for mental health / referral point	Antwerp
Respondent 10	General Practitioner	Inpatient substance use treatment / outpatient methadone substitution treatment	West-Flanders
Respondent 11	Researcher	University	NA
Respondent 12	Policy coordinator	*Steunpunt cultursensitieve zorg*	NA
Respondent 13	Psychologist	Centre for mental health	West-Flanders
Respondent 14	General Practitioner	Community health centre	East-Flanders

Table 33: Flemish Respondents

Additional empirical work

During data collection and analysis (June-October 2019) the researcher received two reports: one of the East-Flemish 'alcohol and medication cluster' (11 professionals working in 9 different East-Flemish specific SUT services) and one of a meeting of the Antwerp 'addiction forum'. An affiliated researcher (Aline Pouille) asked attendees during the latter meeting to respond to two questions: **what are your needs concerning MEM and what would be your policy recommendations?** The six participants that answered these questions work in at least four different Antwerp SUT services. Additionally, the researcher was invited to a municipal meeting and coaching session on MEM in SUT in Gent. The information acquired during these three meetings will not be included in the interview results section (7.5.3) but will be discussed in the conclusion of this chapter.

7.5.2 Coding strategy

All interviews were transcribed ad verbatim by the researcher. NVIVO 11 was used for data management, coding and analysis. The researcher used a combined deductive and inductive coding

strategy. The strategy consisted of three phases. First, all information in the interviews was coded in vivo following the content of the interview guide (see annex 2) and inductive themes were added throughout the data analysis process. Second, and in line with the ecosocial framework (see chapter 2), all codes were assigned to a micro (potential) client or professional level, a meso ethnic group or SUT service level and the macro level of health system and perspectives on treatment. Third and last, all codes within these categories were assigned axial codes. The overarching codes are used to structure the results section. This approach was based on a recent UK based study with similar aims (Staniforth & Such, 2019).

During our analysis we aimed at linking pitfalls and challenges to opportunities and practices. This implies that in some cases information initially coded at micro level will be linked to for example the meso organisational (see micro-meso crossroads) or the macro policy level.

7.6 Results[87]

7.6.1 Populations and characteristics

The interviewer asked respondents to describe the characteristics of MEM populations that they could identify in their service in term of nationalities, migration backgrounds and other specificities such as vulnerabilities. We talked about how these issues could – in their opinion – contribute to problem substance use. We also asked respondents whether they could identify caveats in the substance use treatment service provision for specific populations.

A respondent noted that all MEM populations need special attention but that **undocumented migrants are especially vulnerable,** and this was corroborated by other respondents.

> For me, all migrants should be cared for. We need to have attention for all migrants, for the mental health but depending and I think especially on the legal situation the problem would be different. For undocumented migrants and asylum seekers: they both share the fact that they are in a perpetual uncertainty, so it creates lots of anxiety with a lot of psychosomatic consequences: sleep deprivation, sometimes depression. Respondent 11

A psychologist in a centre for mental health care explains that when persons are still awaiting their asylum decision, they are not ready for therapy yet because they still live in a 'survival modus' and cannot start grieving and processing their feelings yet. Therapy, in this perspective, is indirectly identified as the main goal of these second line mental health care services. This respondent consequently advises to have these people helped in first line services.

> It might be better not to let refugees without a residence status enter in second line services because they are often still in a survival mode. They are taking care of their asylum procedure and that kind of stuff. They are not really ready to start thinking about school, work, their social network and so on. It would be better to focus on these issues in a first line service. Respondent 13

A general practitioner indeed reports that he sees these asylum applicants in his consultation room.

> We see people with depression, but we also have some people with psychosis, some used to have symptoms before starting their journey, but of course the journey worsened these symptoms. Respondent 14

[87] All quotes have been translated from Dutch to English, beside those from respondent 11 (interview in English).

A general practitioner in a methadone substitution service in turn identified **political refugees** such as Iranians in his service but notes that what first line workers have to offer often does not suffice considering their needs. He also asserts that there is insufficient support in asylum centres. He identifies that refugees **could have already been problem substance users in the home country** in addition to new mental health issues related to the asylum procedure.

> I'm talking about people from for instance Iran. It's quite striking that people from this region often already were substance dependent. These are often highly educated people, they are not necessarily socially vulnerable. They often flee their country because of political reasons (...). Respondent 4

Lastly, three respondents mention the groups of **unaccompanied minors**. The respondents active in centres for mental health care mention that they can be referred to their service within the framework of the 'trauma and refugee' project.

> They often come in because of their refugee history and the associated problems but then also appear to have trouble with substances. They use a lot, they're often youngsters. They start a trajectory in early intervention. Respondent 6

Five respondents also talked about their contact with clients with a **Turkish and Moroccan migration** background. A participant notes that in a mental health care centre the presence of colleagues who speak their languages, results in the fact that these clients more easily attend these services.

> In [that service] we have a Moroccan and a Turkish colleague and we do see that it works. I wouldn't say that this is 'categorical' [targeted] work. It's just using the languages that you have available in your service. This way the service builds its reputation among certain communities… For the Flemish people it's the same, they tell each other "you should go there for your back: that's a good one". Respondent 12

When asked whether in their service participants would also see **European** client populations the respondents in residential treatment and mental health care centres answered negatively. Only three participants answered positively: one in methadone substitution and one working in a referral service. One of these respondents emphasises that among these populations, clients were often already in problem substance use before migrating. He notes that staff has little knowledge about the migration background of this population.

> We are certainly seeing a change: opioid dependence is becoming sort of an 'import disease': almost all of our new intakes involved persons with a migration background. I would say that they are mostly Slovaks, Czeque, people with a Roma background… it strikes me that we don't have a lot of feeling with these people: we don't really know what it means to be Slovak or Czeque for instance. And the concept of 'Roma' is also very broad… I do think that we tend to see them as one big group, as if they would all be the same… which of course probably is not the case. Respondent 4

> Many people from Eastern-European countries. Many Polish. It's difficult to get them in treatment. They often come with alcohol related problems. There's a Polish AA group in Antwerp, so we do have the ability to refer them a little bit. Respondent 8

A psychologist notes that she does not see clients with a European background but that colleagues in integration services do alert mainly alcohol related problems in the mandatory integration courses. However, **these signals in integration centres often do not get picked up because 'integration' is the main aim** in these services.

I used to coach teachers in integration classes. They told me stories about people coming to class drunk. People from uh… Bulgaria, and these teachers had trouble communicating with them and to help them (…). But that moment [during the integration classes] is usually not the best moment to think about referring these people to get help. While on the other hand, this should also be one of the tasks of integration teachers: seeing into whether people need help. But I haven't heard about such cases in these populations. Respondent 5

Two respondents note that in methadone substitution they also see a considerable **Russian speaking population** such as clients from Georgia and Chechnya but also Russia. These populations are not seen in residential treatment and mental health care centres, in the opinion of the other participants.

Sometimes we have a whole group of Czeque people, because of what I call 'mouth to mouth' promotion. They often live together and then say, "you can go there for help". Than they come for opioid substitution. But the people that we don't really see are for instance Moroccan people. Respondent 10

MICRO

7.6.2 Comparable reasons for use but also trauma and feeling excluded

A tendency in most of the interviews was that professionals emphasised that the reasons for use are **not that different among MEM compared to persons without a migration background**. The two medically schooled respondents most explicitly emphasised these similarities.

It is often caused by emotional and psychological neglect during childhood… having wrong coping styles… they didn't get the right tools from home or from school. It's the same among the Flemish, for instance persons with problems at school. Respondent 10

The pressure people experience. Drugs are an escape. They have always been an escape. I mean, it can be… [acceptable] but when it no longer helps you to escape or when the pressure gets too high, it might derail. Often, it's the pressure that becomes too much for people. Respondent 14

Eight respondents with different professional backgrounds did emphasise the relation between **trauma and post-traumatic stress** on the one hand and substance use on the other hand, especially among refugees. Two respondents also noted that in the field of specific substance use treatment, the expertise concerning these issues, is often limited.

Why do you use? To forget your misery. In that case I understand that you use. (…) What can we really give those people? Not a lot you know, (…) these people live in very insecure and difficult situations. So, what can I say: you should stop? (…) But when we start looking at the psychosocial situation and we start a joint trajectory we can start wondering about the root causes. How was your childhood? And what you see is that people have heavy PTSD related problems. Our staff is often insufficiently trained to deal with that. War crime, war related problems, we don't really know how to deal with that. Honestly, we don't know a lot about that in our sector. Respondent 10

One respondent pointed out the relation between **perceived discrimination, racism and feeling excluded** on the one hand and trauma on the other hand.

People go through many things. They deal with racism, they are excluded, they don't feel part of society. These are all issues that can lead to risky behaviour. So, if you [as a professional] can't really be there for these people as a human being, if this feeling of being different is not correctly channelled, than the trauma will only be confirmed so it's necessary to help strengthen these people. Respondent 3

One respondent pondered about how clients in treatment explain and understand substance use themselves. He refers to and questions the literature on 'alternative explanations' that posits that problem users with a migration background would refer to culture or religion related reasons for their use.

> On the one hand I'd say it still exists, but on the other hand young people they say okay in the past we would have said: 'it's a spell' or something like that, but that's just an easy way out, a spell. If your husband cheats, it is easy to say it's a spell. And they do admit nowadays that a psychologist might be able to help. Respondent 7

Among these identified populations, the respondents alert that subgroups of **youth and female drug users** might be exposed to additional risk factors. A psychologist in a mental health care centre notes that youngsters are more often confronted with identity conflicts which contributes to substance use. Two participants added that identity related issues are especially prevalent among unaccompanied minors and that this issue needs special attention.

> In our 'children and youth team', we often see identity related problems. But these are often not the primary problems at intake. But we identify them later [in the care trajectory]. (thinks) In the child and youth team we had several cases of behavioural problems in schools, externalising behavioural problems… the symptoms often only get identified by means of another problem. Respondent 13

Participants active in methadone substitution and residential treatment note that they see little to **no women with a migration background**. They alert that SUT populations are predominantly male but that some women with a migration background such as Turkish and Moroccan women are especially absent. A participant in a methadone substitution programme accounts that this is less the case among for example Czech clients.

> About 75% of our patients are male and 25 percent are female… but the difference is larger. Maybe because the prevalence is lower? (…) But I should say that the number of Turkish or Moroccan women in treatment is very low (…). We do see for instance Czeque women… They do seem to find their way to treatment. Would it be because addiction is more prevalent among women in a certain country or a culture? Maybe that's not the case among Turkish or Moroccan women? Actually, I wouldn't know. Respondent 4

Two female psychologists do account that a large part of their clientele are females with a migration background. One of them alerts that alcohol abuse is prevalent among women with a Turkish migration background.

> Whether alcohol is maybe more accepted among Turkish people? Certainly not among women, because there is quite a lot… I do see some Turkish women that drink secretly. And they won't easily say that out loud. Respondent 5

A respondent in a mental health care centre also notes that females with a migration background were well reached by their service. In conclusion, female substance users may rather seek help in mental health services as opposed to specified substance use treatment, compared to male counterparts.

> In our regular services we see large groups of Moroccan women between thirty and sixty years old. We do see that in this group migration plays it role in their depressive feelings, it's a quite recognisable group and we're thinking about organising group sessions for these people. Respondent 8

7.6.3 The question for help often comes via a detour

Many respondents, by means of cases in their own practice exemplify that questions for help are often identified via detours. These detours consist of **questions in other services or to other professionals, questions via family or questions concerning other life domains**. A respondent in a centre for mental health exemplified how she identified problem substance use via a detour during therapy and how she acted upon this knowledge.

> At a certain moment this man had finally admitted that he was homosexual and that he was HIV positive and needed a lot of medication. So, he was also experimenting a bit to deal with his pain. I felt that there was a large risk for prescribed substance dependency in addition to the fact that he appeared to lose his sense of reality once in a while. It was quite difficult for me. I was allowed to talk to his general practitioners. But I had the feeling that he totally wasn't aware of the full picture. Respondent 13

Three psychologists in turn report that clients sometimes come in with other questions such as stress or physical issues and that it is necessary to dig a little deeper to identify substance use related problems.

> [a client of mine] was referred by her general practitioner. The primary question was dealing with medication related problems. This client was taking a lot of pain killers, really a lot. But when she started coming here, it appeared that she was also drinking a lot. So, she basically did not come here first for an alcohol related problem. She... came here first because of the medication related problems. So, the general practitioner also got informed about these alcohol related issues. She was admitted to a hospital. Respondent 5

At least three respondents mention that concerns are often formulated by a family member in therapy sessions or via centralised services such as the referral service *Adviespunt Antwerpen*.

> I'm thinking of a couple of people, there was one that was quite dependent on his joints, the other one was mainly cocaine focussed. These were both young fathers, about thirty years old. So first we get some alarm signals from the family, sometimes to various of our in-house general practitioners. So, when we have a team meeting, we talk about that. We share info such as not having seen a client for a while. Respondent 14

> [A client of mine] had mentioned briefly that her husband was drinking, as if he was drinking too much. So, I asked her: "how much?". So, it became clear slowly. So, it is important that a professional sometimes pushes to get to the bottom of things (…). So, we did a test together and it appeared that her husband was a daily drinker and that he drank about six to seven units a day. Respondent 3

Sometimes there is of course **not at all a question for help**. A general practitioner told a story about a couple in methadone substitution treatment that never asked for any additional help. This GP had the feeling they had a 'utilitarian' perspective on substitution treatment and explains that many colleagues also had this feeling.

> I think we doctors but also the nurses and psychologists sometimes are a bit blocked by a utilitarian attitude on the part of the patient. (…) But I think it might also have to do with the organisation of the health system in people's home countries. They might be used to the fact that it is mainly unidirectional, so: we just do something for them. Or well, they ask something, and we do it and that's where it stops. Respondent 4

When the GP asked why this couple did not ask for help they told him that they had the feeling that he was too busy doing other things during the consultation, pointing out the necessity of asking these questions directly instead of presupposing the reasons for certain behaviour, such as not asking help.

At a certain moment I asked them: "it might be a weird question, but why do you never talk?". They answered, "But you're working, so we won't…, you know, you're working, you're obviously doing something, so we won't say something because you're doing your job and we're just waiting". Respondent 4

A respondent noted that persons coming in via compulsory referral, especially youth, often do not have an explicit question for help but that the mere fact of having them in their service sometimes elicits a concrete question for help.

At first, clients, like youngsters, they may not have a direct request for help. They often come here because of external pressure. That's why we also started with early intervention under 25 years old, from 18 to 25 years old. This way we can refer many youths with a migration background to early intervention. So, they don't really need to have a direct request for help. If they come here because of external pressure that's just okay for use. Respondent 6

Lastly, several respondents note that questions for help are formulated differently according to individual backgrounds. A GP for instance felt that differing educational backgrounds would influence the type of question clients formulate.

Syrians for instance they sometimes ask, "can I go to a psychiatrist?". Yes, they come from a urban context. Others come from villages. But people from urban contexts, they're used to these kinds of services. They know for instance which kind of medication they used before. Respondent 14

A psychologist with a migration background accounted that her clients would sometimes not tell her about substance use related problems because clients might see her as a community-peer and therefor feel the normative pressure and taboo concerning substance use. The psychologist subsequently suspected that some clients are afraid to talk about their substance use.

Actually, I'm rarely confronted with substance use related problems. They are often ashamed towards people from their own community, yes, ashamed. This results in the fact that they won't easily ask for help to someone who belongs to the community. (…) Certainly not when the problems are alcohol related, and not when their drug related. But alcohol is worse. Among Moroccans, problem alcohol is a bigger taboo, while among the Turkish drugs is a bigger taboo. Even partners of drug users, only get to say these things after a couple of sessions. Respondent 3

7.6.4 Important characteristics of the professional and the relation with the client

Trust

All respondents emphasised the importance of creating a relationship of **trust**. A psychologist in a mental health care centre coined the necessity of what he calls 'epistemic trust' (trust in the social world as a learning environment) related to the knowledge one has about the content and goals of treatment and the health system.

I kind of agree with Patrick Luyten: he talks about 'epistemic trust'. It takes a while to check whether one trusts in, or whether one believes in what is happening [in the therapeutic context]. Some do give it a chance. I'm convinced that they need knowledge about what happens when you go to a psychologist. For white, middleclass Flemish people… we see this daily, we grew up with that concept. Respondent 12

Trust is really important. It's related to accessibility: if you choose to go to a service you already need sufficient trust in this service, and you need to be sure that they will treat you well there. Respondent 5

The biggest challenge in services is creating trust. I am convinced of that. Respondent 7

Relatedly a psychologist exemplified that when she refers a client to SUT and the client cannot be admitted, this is detrimental to her relation of trust with the client and the client's trust in the health system, or what had been called epistemic trust by the above quoted respondent.

> Convincing these people takes a lot of time. The client trusts me. I kind of represent the service in the eyes of the client. Based on his trust in me, he might agree with my proposal [to be admitted]. When a crisis unit or another service does not really respond to this request or they won't have an intake or they say, "it won't work because of the language" (…) than you really think about quitting. It really demotivates both the client and the professional. Respondent 3

She additionally noted that it is sometimes harder to create trust among these clients because of their **anticipation to latent racism** in the mental health care setting.

> Racism is a bit taboo in treatment settings. I think that's also true for substance use treatment settings, that it can hamper the trust of clients because they do not feel safe. I saw that among my client, when they would be in my waiting room, they did not feel safe there. Respondent 3

A psychologist noted that trust can also be **increased by means of little things**, such as a warm welcome in the service by offering coffee.

> We deploy many of these strategies, like offering coffee and water, we really find that important for our relationship of trust. Respondent 6

Being open, authentic, reflexive, confrontational and client-centred

A psychologist with a migration background emphasised that she believes that it is important to be 'real' towards the client, not to hide emotions per se and to communicate confrontationally when necessary. She accounts that this, as a professional, is important to fight the own presuppositions during treatment.

> Sometimes professionals see what they want to see. (…) To reach a position of authenticity you sometimes need to go in search of confrontation… in your own way. (…) I think this authenticity can be really helpful. As professionals, we learn to hide our own emotions while it can be really helpful to be open about your opinion, to give something back to your client. (…) When people pass my personal boundaries, I can get really confrontational. I've even already ended the session. (…) But I am very clear towards clients about my own boundaries. It's no because I want to try to understand that I have to take anything. Respondent 3

A GP in a methadone substitution service corroborated this feeling and his struggle with this type of openness.

> You have to make sure not to rely on prejudice or bias towards a specific population… You try to be… to be open, but that's… we see that it's…. It's not always as easy to deal with… others. Even when you have a very open and empathic attitude, it's so difficult! Respondent 4

A participant noted that this **open and authentic** attitude should be based on a reflection of the professional about his or her own presuppositions.

> In my opinion, the most important thing is to think about your own attitude. "which are my feelings and images about the other? Which are my prejudices? Who do I like and who do I not like?". [A GP] once told me, and he is a general practitioner, he told me: "I really have difficulties dealing with substance users". It is important to know for yourself who triggers what in you. You see that a lot when professionals deal with foreigners. Respondent 7

A participant exemplified that during a training session, **female professionals** noted that male clients would not take them seriously. Once these female professionals reflected about this situation during the training session, they learned to see it differently and dealt with the situation from another perspective.

A recurrent question from female staff members was: "I have the feeling that clients, mainly male clients, do not take me seriously because I am a woman". And we started working with that. With role-plays they identified: "could it be that this person just wants 'his stuff' and that they actually just go in search of your weaknesses, and that they would do anything to manipulate you? When they see, it works if I use this gender issue, they will keep using that just to get you out of balance." I noticed that once they approached the issue from that perspective, they really started to deal with it differently. Respondent 5

Additionally, many respondents noted that **client-centeredness is** important: working with what the client has to offer. A psychotherapist accounts that she chooses which method (e.g. behavioural, contextual, gestalt approaches) to use dependent on the client needs from an interactionist therapeutic perspective.

I studied interactionist therapy. We work with various client-centres perspectives. So, you really go in search of the 'entrance' with your client. It can be contextual or behavioural therapy. It can by psycho analysis of psycho synthesis or gestalt. You just look at what works for your client. I also studied EMDR. I notice it's useful to many people, of course some see it as an easy way out, but it also really works for some. Respondent 5

Two psychologists describe the influence of **religion** on feeling ashamed and the role of this feeling in treatment. They both note that religion can well be used as a leverage in treatment.

People deal with religion quite schizophrenic. They talk about it in one session, you talk about it, and then you see a lot of vulnerability. And then some weeks later, I have the feeling it's gone again. It's being supressed. They don't want to talk about that anymore. (…) I try to use it as a leverage: "how do you pray, what do you feel when you pray?", so you can use it. It also comes up, more in a negative way, when people are ashamed. Than they say stuff like: "I'm doing things that a Muslim shouldn't do" and they are really confused because of that. Feelings of shame. Respondent 5

A therapist can use it, although the focus should remain therapy of course, but I often ask a Muslim or a Catholic for instance "do you pray? How do you see that? What does it mean for you?". For me, that's part of therapy, it's part of psychological guidance. Respondent 12

Respondents note that a prerequisite of nurturing an **open relationship and trust, is sufficient time** with your clients. Professionals often do not have sufficient time, as exemplified in the setting of a GP's office.

You know… you and me, maybe one day we could go to our GP and it is a really bad day and you begin to cry, because you have no one else to talk to and you need one-hour consultation with your GP and the context doesn't allow that. Actually, it's the way the healthcare system, the social system is organized, there is no room for unexpected events. Respondent 11

Our caseload is really high. A new colleague of mine, had 100 to 150 files to follow-up on. I suppose you can't really offer guidance, you just do the administration. Respondent 5

Training and education

All respondents referred to specific training needs in their domains to better deal with problem users with a migration background. Mainly the three **general practitioners** mentioned that in their

educational trajectory they had learned little to nothing about **addiction and psychiatric phenomena.**

> What we learned in the psychiatry course, but also in the courses on general health was very limited. I think we only talked some hours about addiction. The same goes for substitution therapy. I think besides the basics, we didn't learn much. Respondent 4

> I graduated a while ago. I studied at [a university]. I didn't learn anything about these issues. I didn't know anything about it before my work here. (…) I got the time to learn about it. I think it's better now. Respondent 10

One of the GP's is also active in VAD and accounts of efforts to create a network of GP's per province that can inform other GP's and share expertise in the SUT domain.

> We try to attract the new generation of GP's. We've been working on that for a while now. We are aspiring to have one network per province, just one GP who can inform other GP's in the area. If you have a problem, a question, you can contact this person. Respondent 10

Additionally, a respondent notes that GP's often have limited knowledge concerning 'diversity sensitive' care.

> There's bigger attention in training of education of health care professionals but it remains bricolage. I mean, pfff. and sometimes, it's not easy to help people to understand that migrants are more than just being a foreigner, that diversity could concern all of us and that maybe you can be closer in your way of thinking from someone coming from Johannesburg than someone coming from far away in Wallonia. Respondent 11

Three respondents working in a mental health care centre are quite positive about the yearly **'cultural sensitivity' training** offered to all Flemish centres for mental health. Two respondents lament that 2019 was the last year that this training module was offered because the organiser is no longer governmentally funded to do the training.

> New staff members must take some obligatory courses, one of these courses is a course on culturally sensitive care. It's a one-day training organised across the centres for mental health.

> They told us that it was the last year that this could be organised and that most probably there won't be a new course in the future. Respondent 8

MICRO-MESO Crossroads

7.6.5 A mismatch between treatment needs and available treatment

Many respondents across services (centres for mental health, methadone substitution, residential services) report a mismatch between the services they offer and the needs of MEM clients. One respondent explains that he feels that **better knowledge about what different services have to offer is more important than the professional trying to understand the culture of the person sitting in from of him or her.**

> When you look at 'cultural brokerage' in the literature it is mostly about explaining how health services work and trying to explain that to people, rather than the other way around. (…) A large barrier is not knowing the services and not being able to move in the health system. You need minimal knowledge about how services work to be able to trust them. This is even more the case in mental compared general health. And this lacking. Some professionals are too focussed on the cultural issues. Respondent 7

A general practitioner in turn explains that clients entering in residential substance use treatment don't always **understand well enough that treatment is often based on intrinsic motivation and on a therapeutic model.**

> Those that get admitted [to residential care], maybe they don't really understand the idea of being admitted, of the therapeutic model and this can create misconceptions. I have the feeling that, for instance the intake moment, they really check your motivation, that's really from our perspective on addiction. But maybe this person thinks "okay but I'm not here to do it alone, you have to deal with it. I'm here as a patient, as a victim. I am not the one… you are the experts, right?" Respondent 4

Some of the respondents take this argument a bit further by noticing that the therapeutic model of 'treating' problem substance use might not work for everyone and that some people simply want other types of support, both inside and outside treatment. A psychologist explains that clients might **feel that a psycho-analytical model of therapy is not satisfactory for them**.

> For instance: only listening. We learned to be emphatic. But that's not always why people come to us. Someone who listened, but also… a soundboard, someone who adds a bit to our knowledge, psycho-education, or things they can do themselves… Sometimes people want to hear something that works normalising to them… something they can use and helps them. I think that we, that professionals in substance use treatment have learned to be cautious and passive. Respondent 3

A respondent working in a centre for mental health explains that speech therapy did not appear to work among a group of women and that the service is subsequently thinking about installing group therapy.

> We see the Moroccan women, somewhere between thirty and sixty years old, with issues of migration and depression. They are a recognisable group and we are thinking about creating a group offer for them. Because we see that individual therapy doesn't really work for them. Respondent 8

The same respondent notes that a centre that offers support in several life domains might be more helpful to some clients because it aligns more with an integral perspective on dealing with their questions in broader life domains, often related to substance use.

> An integral approach: we can help you with health care, your papers and substitution treatment, everything. That's how it should be. Now, [in a substitution treatment service] the therapeutic offer got really limited because we don't have any psychologists in our service anymore. That's unfortunate. Respondent 8

7.6.7 Language as a gateway and the largest barrier to residential treatment

All respondents observed that when a person does not know Dutch, he or she will most probably not be admitted to residential treatment because it is largely speech therapy oriented. **Language is identified as the largest exclusion criterion for residential treatment by all respondents,** both by participants working in residential treatment as by respondents who tried to refer MEM clients to treatment.

> The expectancy that we have: have little knowledge of the language, a bit of Dutch so you can explain yourself. (…) eventually we do have quite a language-oriented programme. We try to make it non-verbal, but you do need a basis of Dutch. Respondent 2

If you don't speak Dutch, this is a real big problem for [our service]. (…) But here… it's a group programme, also outpatient. People have to come for an intake. Psychosocial guidance. If you can't speak the language… that's a problem. For second or third generation migrants that's not a problem. Respondent 10

In the residential setting you do see that if you speak French for instance, or if you don't know Dutch, that's enough to say: "you're not fit for our service". In the therapeutic community of [a specific service] that's a reason to say: "that's a no-go". (…) That way you lose a lot of clients of course. Respondent 4

Although language as a problem is often attributed to the client – the client does not speak the language – respondents argue that it should not be a reason for not admitting clients and observe that some professionals are **reluctant to work with translators.**

I have to say (laughs), I was really disappointed [in a network meeting of services]. We only came to the conclusion: outpatient services are not a problem, the psychiatric wards of general hospitals [PAAZ] are okay, but residential, no, that does not work. (…) We got as far as guiding a small trajectory of a client in a residential service for six weeks. But then they stopped and said it didn't work, because of the language. While, we [in our outpatient service] had no problem at all communicating with this person. Respondent 6

Moreover, participants noted that using language as a prerequisite to enter residential treatment **deprives some MEM of their right to the treatment they need and want**. Several respondents exemplified that when trying to refer a client – that in their opinion had sufficient knowledge of the language – they were not admitted or were even not invited for an exploratory intake talk.

Some are very rigid. I've had a lot of problems with that, in referring people. (…) They should just accept people that don't speak Dutch. It's pure discrimination, there are many different shapes of discrimination. (…) The number of times they blocked me is uncountable. (…) I write reports for psychiatric services, I explain the problems, I tell them what they need, I did it all, I tell them there's a need to admit a client. (…) Some people cannot stay at home, they need a safe space or room to breathe. Even if I explain this, they just say "no", and that's annoying. You really get desperate as a professional. (…) I think psychiatric services have to get used to these issues. Respondent 3

A participant notes that language, in her opinion is sometimes used as an umbrella to cover other service level problems such as insufficient staff support in their use of translators, resulting in a feeling of inability to work with translators and subsequently, MEM clients.

Language is used as an umbrella, you see that in many different sectors. That's nothing new. We call it 'professional timidity' [*handelingsverlegenheid*]: to what degree do you as a professional have sufficient skills? Do you have the skills, when language is an issue, to deal with that? But also: to what degree does your service give you extra time and finances? Because it takes a lot more time to communicate even if you don't work with a translator, if someone only has limited language skills, everything takes a lot more time. Respondent 5

MESO

7.6.8 Points of access and barriers in first, second and third line work

The first line or entry point to treatment: General practitioners and asylum centres

The researcher asked respondents to point out which organisations they come most in contact with concerning problem substance users with a migration background. Participants in turn explained the role of their own services towards this population. The role of general practitioners (GP) and hospitals came up most often in this context. Some respondents account that the first professionals

people with problem substance might turn to, would be their **general practitioners** and this is exemplified by three respondents.

> [This client] was referred by her general practitioner. The main question was related to misuse of prescribed medication. She was really taking a lot of medication. Respondent 5

> The majority of all our referrals are via general practitioners. I think it's more or less the same concerning that [MEM] population. Respondent 8

However, a respondent notes that not all GP's will necessarily refer clients to treatment when they present with problem substance use. Additionally, a respondent notes that some GP's may be reluctant to work with a translator.

> What I see in our centre for mental health is that people with problem substance use do get to that first line. (…) But general practitioners do not easily and rarely refer to treatment in my opinion. I mean, I think it's really because we as psychologists [in this service] are literally right beside them, that they refer clients to us. Respondent 12

> It is kind of a stereotype, but doctors [think that they] are able to do anything by themselves, they don't need any help. So they are really reluctant to use [or] to rely on interpreters. (…) I think they don't trust interpreters. some of them have bad experiences of using an interpreter, some of them don't know how to acquire an interpreter. Respondent 11

Two respondents note that there are several initiatives to **make first line care more equitable** by means of 'equity standards' for hospitals and by supporting first line workers by means of the newly created 'Vivel' expertise centre.

> We introduced a new instrument: the introductory checklist for equity and a full version of it. (…) The checklist helps you think about how well your policy is adapted for vulnerable populations and how well your service is organised to be really equitable. Respondent 7

> Vivel just started at 1st of September if I'm not wrong. That'll be really interesting – although it will be a small service – because they will support first line zones. Respondent 12

The opioid substitution treatment services (MSOC) are mentioned by all professionals to be the lowest threshold service and consequently have large MEM client populations.

> That's just a low threshold service. Anyone can go to the service. We [MSOC] used to be close to a neighbourhood centre, that was great, being in the same building. Respondent 10

Asylum centres were also identified as possible entry points for treatment. Three respondents note that *Medecin du monde* offer important medical but also psychosocial support to refugees and refer refugees to their services. Additionally, there is the right to psycho-social support among asylum applicants (see below: MACRO – Federal initiatives).

> For persons without a residence permit there's 'doctors of the world', they used to have a programme: trauma and exile. Therapists used to give free support. But it was too much to get it all organised, so they stopped it. That's surely a caveat, Respondent 5

Centres for general wellbeing (CAW) were identified as another important actor. They are defined by the participants as a first line to service that supports clients in several life domains. CAW often

also have in-service therapists. A participant noted that persons who do not have finished the asylum procedure might best be referred to CAW services. Additionally, some participants note that the CAW rather have a systemic and contextual approach whereas CGG are more oriented towards individual therapy and psychoanalysis.

> CAW they have more of a, how would I call it, a holistic perspective. If there's financial issues, issues with your partner and children, you can deal with all of it. They really focus on contextual and systems approaches in therapy. That's good. They really involve the children, the partners or whoever. Respondent 14

> The link and sense of recognition of more vulnerable groups is larger in the CAW's, they have a lower threshold too… CAW's work lower threshold. CGG have higher thresholds: waiting lists, intake by telephone etc. Respondent 3

> All CGG's are encouraged to work more with the context of the client and I think we recently changed something in our policy framework to include the context, on how we should report about it. But I do think that, globally speaking, the perspective of CAW is a bit broader, but there's also large differences between the different CGG. Respondent 8

Lastly, a respondent mentioned that the main referral to residential treatment services took place via friends, family and self-referral. This could point at a caveat in the collaboration and distribution of work between first, second and third line services.

> If you look at our referral data, in the end it's usually contextual referrals. It's users themselves who refer each other to treatment. People usually say that it was a friend or someone they know. That's the biggest group. Respondent 1

The second line: Centres for mental health (CGG)

Four respondents work at **a mental health care centre (CGG)** but the work of these centres was also introduced in the interviews by four additional respondents. These centres were identified as the first low threshold second line service (treatment upon referral) for dealing with mental health related issues. Whereas some explained that these centres are primarily aimed at serving low- and middle-income citizens, other participants had **concerns about whether these centres have the capability and capacity to serve low income vulnerable populations**.

Participants observed that these **Flemish CGG differ substantially in terms of the populations** they attract. This difference across these Flemish services (which in theory all have the same goal and target population) would depend mainly on the available in-house expertise but also on the service capacity (e.g. the number of staff) and whether service coordinators prioritised these populations or not. Additionally, whereas some CGG have special SUT branches, others do not have such a branch, resulting in regional differences.

> We are a second line service. Centres for general wellbeing [*CAW*] are the first line and we are the second line. Child psychiatry etc. would be third line services. We usually only work with referred clients who are dealing with psychological problems that affect various life domains. Respondent 13

> CGG were initially established to help lower socio-economic classes but they have become middle class organisations in terms of culture. (…) Many of the professionals don't really relate to the lower socio-economic classes. They lost the link with the reasons why CGG were established in the first place: to democratise. (…) The confrontation with this vulnerable group was not as comfortable as they thought it would be [when the respondent was working there]. It's also related to what one is used to and CGG are often quite normalising

about what is normal and what is not… well… they are very norm oriented… just like a middleclass. Respondent 3

Some of the participants doubt whether the right answer to optimising the mental health of a region is best answered by offering individual therapy. A participant for instance suggests investing more in what he calls '**community psychology**' in the CGG to be closer to vulnerable populations.

In the end the core of a CGG, is to optimise the mental health in a certain region. Why do these centre over ninety percent of the time answer this question with: "well okay, we'll give therapy". Isn't that bizarre? (…) We could for instance use half or our money for therapy and invest the other half in community psychology. That's what I'm a fan of. In that case, therapy could also really be therapy. Respondent 12

Moreover, CGG are explained to be one of the only mental health services that receive structural governmental funding for translator services.

It's the only service I know of who get funding. There's several different CGG of course. It's not only [our CGG]. All the centres for mental health can do that, the budget is there. But besides these centres, there's little services who get it. Respondent 8

A respondent explains that because these CGG are insufficiently accessible for MEM populations, they enter residential treatment in a later stage of the psychiatric problem at hand.

What you see is that people sometimes land up in residential treatment without having had a stage before that. So they only land up in residential treatment when things have really escalated, that's when they get there. Respondent 7

Several respondents observed that the long **waiting lists** to enter a CGG are detrimental to the treatment trajectories because people cannot be helped immediately and because they might drop-out before they ever get to the centre. Waiting lists are reported to be a problem that affect all (potential) clients, independent of their migration background. But one respondent notes that because the service is confronted with waiting lists, the issue of not reaching MEM populations is put lower on the agenda.

In my opinion, it's important in substance use treatment to be able to react fast at the moment a person has a question. One should strike when the iron is hot. In that case you shouldn't let people wait for a long time. Respondent 6

We have waiting list of ten to eleven months. Sometimes longer. But with this [project aimed at refugees] I could more rapidly see recognised refugees – so refugees who lived in a family and had questions concerning their children, or the parents – they could get help faster. They could have their first session within one month. Now [because the project ended] that's no longer the case. (…) I would like anyone to be able to have their first session more rapidly. (..) This problem [waiting lists] should be solved for everyone. Respondent 13

We [at this CGG] get a lot of clients that should actually get treatment. They need care and support but therapeutically we cannot do an awful lot for them. That population – that you cannot refer to any other service – that's a giant challenge at this moment. Our waiting lists have an irresponsibly long length. But in this situation, well searching for methods to better reach new populations, is not on top of our agenda. Respondent 8

You really need support of your coordinator or director. Or they share a perspective [to change methods to reduce waiting lists] or they just go nagging at the policy level: "we have insufficient therapists, look at our

waiting lists". But of course, you have a waiting list, you want to see everyone individually for each single problem! Respondent 12

The third line: specialised substance use treatment services

A respondent notes – and this is corroborated by several others – that **short stay (crisis) residential** programmes are easier to access for problem users who do not speak the language. Respondents observe that these types of services answer to the needs of a specific client group in need of urgent care and stabilising their life situation, but that these programs do not offer long term support and consequently do not serve all possible client needs. Additionally, potential clients need to be covered by social security which is not always the case among for instance undocumented refugees. Also, these types of centres are not available to the same extent across the Flemish regions.

For those that don't speak Dutch or French, it's hard to get to know them, to support them, especially considering that residential treatment is often based on group therapy (…). For short programmes that's less of a problem, they just get the basics during a week or ten days and they can help you in English. For these short detox programmes there's a possibility for them to get in if they have the right social security document, because these are often NHS recognised services. Respondent 8

As mentioned above, the majority of the respondents notes that **language is the largest barrier to residential treatment, especially in psychiatric hospitals (PZ). However, some respondents also identify waiting lists, the need for motivation and the intake procedures as barriers to treatment**. A respondent additionally mentioned that clients who are deemed to speak Dutch insufficiently are often not even invited for an intake talk.

[A residential service] is really hard to get in. They have really long waiting times and of course alcohol dependency and motivation is not really the best mix. Respondent 14

I have the feeling that for instance the intake forms they have to fill out, that they [residential service] have some resistance to change these procedures. There are some questions in these forms of which we know, okay this will deter people when they have to fill this all out from the start. Can't you just do that at another moment? But they're reluctant to change that. (…) The mere fact of having to put it on paper, for people who can't really… who can speak the language but can't write without mistakes… Respondent 5

What we [as a network of services] promoted and what I tried promoting [in the network] is to at least plan an intake with these clients. You can than judge whether it is feasible or not. I think it's not done… you know I wasn't even done explaining this [in the network] but when the women heard who I was directing my request to – a psychiatric hospital – she interrupted and said, "no Dutch? No". Respondent 6

One participant additionally argues that the **psychosocial support** to the client should be more intensive in crisis units and services.

When I refer someone to a crisis unit, they don't really do a lot with this person. The stay there is not used optimally. I really think that's a problem, the fact a psychiatrist would only visit you once every three weeks, that's a problem. Additionally, the psychiatrist just appears to say the exact same thing as he said three weeks ago. Respondent 3

During the interviews we elicited whether shame and taboo played a role in participating in treatment. One respondent exemplified that the **barrier to participate in shorter treatment programmes was lower compared to longer treatment period**s because clients could more easily explain to family that they would for example be traveling to another country.

A short detox programme is only six weeks. You can explain that: they're six weeks of to Morocco. But going to a programme that takes nine months, that's too long, you can't sell that to your community or family. Than you should be explaining a lot which is why people often say "I won't go there". Respondent 1

Lastly, the issue of **funding** came up in many of the interviews. The respondents critique ad hoc project funding as well as the restrictions in residential treatment settings to only treat dependence of illegal substances.

Often, our clients also have an alcohol problem, or a problem that is benzo related. But the reason for intake has to be relate to illegal substances. (…) For someone who has been dependent on, let's say speed, with a move towards alcohol dependency but has a history of speed use, we could consider taking this person in. Respondent 10

Other referral and support services: mobile (crisis) teams, PSCW and 'self-organisations'[88]

Three respondents note that the **mobile and crisis teams** are important actors in supporting problem users in general and also those with a migration background. However, several downsides are signalled in these initiatives, most importantly waiting lists, understaffing and the results of time constraints such as not sharing information with other professionals for follow-up.

Those mobile teams have waiting lists. And the crisis teams they don't share information about cases. You call them and they go there, they do that very well. And then they go like "person is stabile? Okay". But they don't share information with other teams while that is actually a necessity. Now they need to file a new request to get a mobile team. (…) It's really good they pass by people's house but then you also need guidance at home. The follow-up should be better. Respondent 14

Suppose you had some of these mobile teams in front of an asylum centre, to do early detection, that would be fantastic. But these mobile teams, they already have waiting list, they don't even have enough staff to service the classic population. Respondent 8

Six respondents noted that other important referral actors are the **PSCW services**. These services are also governmentally funded to get training and expert support to help refugee clients. Furthermore, PSCW often have in-service psychologists who could refer clients to treatment.

"ha they told me I had to go to [residential service]". That way they come to our service. Also via PSCW assistant. How does that go… they come via different channels. Respondent 10

PSCW services they could buy a package… their staff would get guidance to work with the target group and the psychologists would do consultations when needed or would support staff in certain cases. You can see it on their website what they offer (Solentra), a package for PSCW services. Nowadays I talk a lot more with people working at OCMW. I explained them just last week how the centre for mental health care works with its first, second and third line. Respondent 13

Lastly, four respondents mention the importance of staying in touch with local **self-organisations** that bring together certain MEM populations (see e.g. https://www.pinvzw.be/). These organisations could help in referring clients to SUT but can also inform about new substance use

[88] In Flanders, persons with a migration background were long inhibited to establish a non-governmental organisation. In the eighties, these restrictions were cancelled. Ever since ONG's set up by persons with a migration background aimed at these populations, have been denominated 'self-organisations' in policy documents. It remains unclear why these organisations are called 'self-organisations' and other types of NGO's are not.

related phenomena in specific communities or the used alternative treatment methods. Nevertheless, a participant notes that their service does not actively approach these organisations.

> I can't really say that we really think about how to reach this group or what our offer towards this group is or if we would change our offer for them. That is often related to personal interests because some people in the team do characterise themselves as experts in this field. Like some therapist will be more inclined to work with translators. (…) I do think that work more with smaller organisations with members in these groups, incorporating them in service policy making, support and stimulate them to participate, could help. Respondent 8

Centralised substance use treatment referral services

Several respondents mention the creation of new centralised referral points (e.g. within the policy initiatives Project 107, see supra) where persons with questions concerning problem substance use and addictive behaviours are welcomed and people can be referred to the right treatment if needed. A participant working at the Antwerp 'Adviespunt Verslaving' explains that the **neutrality** of the service is important and **lowers the threshold** for potential clients because they are not directly linked to SUT services. This service also receives questions from a broad array of MEM populations.

> People with questions concerning addiction are welcome here. They could have a problem themselves but often it's people in the context. One in five people here are people from the context. (…) Our strength is that we are not linked to a single service, we can look at the broad service landscape to choose the best option. I think that frightens people less to come here. If they come here, they don't come to a substance use treatment service, that's less stigma, I think. Respondent 9

7.6.9 Important characteristics of the treatment setting

The use of translators

All respondents talked about their experiences with translators. The two general practitioners accounted to make use of translators regularly. One of them noted that it was considered a regular practice in their service and that the **administrative support** in getting a translator facilitated his work. The other respondent noted that a translator is **especially important during intake** in a methadone substitution service. Contrarily, the participants working in residential services had the least experience in working with (social) translators.

> We do have some people who speak Turkish here and we do try to use translators when possible. We don't have a problem with that. I mean… it's just a part of it. (…) I mean, as a general practitioner I'm really in a good place here. I can use video translation and our secretary will arrange everything. So, by now I understand how it works. Respondent 14

> We regularly apply for translators. Definitely at intake and for the medical intake. After these meeting we often only rely on Google Translate. Respondent 4

> We developed a practical in-service translator service system. For instance… the paper work would already be done… they would be ready for use, the secretary used to do all of that so the therapists wouldn't have to do all that. Respondent 3

The **administrative support** concerning the use of translators was different across the services and the degree of support was directly related to the willingness of respondent to use these services.

So, if you want a telephone translator, you have to register and usually it has to be reserved beforehand. But this is a population that isn't really aware of time so they don't come at five o'clock if you ask them to come at five o'clock when you have reserved the translator. Respondent 10

There's only so much translators. If you plan a new appointment with your client, it becomes really complicated. So, clients can't always get the frequency that they need. Each time, you have to start all over again. Now they have an online portal, I'm starting to get how it works. But still you need to give several possible dates (…). It also blocks a lot of time in your own agenda. Respondent 13

A private therapist mentioned that she did not use translators because it would make the consultations **more expensive** for the clients. Another respondent noted that the centres for mental health are the only services that get **structural funding** for the use of translators.

The people who come here usually don't have a lot of money, but I would have to get the translator payed you see. Do I think that would create a barrier? (..) I do have a list of therapists here who speak Turkish or Arabic. (…) But it's very individual, sometimes people will want someone with the same cultural or Muslim background, and sometimes they'd prefer someone who's further away from their lived world. Respondent 5

Babel (the Flemish phone translator service) and 'google translate' were also mentioned by many respondents as an **alternative to the use of official translators**. The Flemish '*communicatiewaaier*' is mentioned by one respondent as a good tool to reduce language barriers in services and to find solutions for language related problems.

Like in [methadone substitution service] they just use Babel that's a translator via telephone. For the most common language that's okay because you don't have to make an appointment but for the less common languages you do have to make an appointment and that's not always easy. Respondent 12

One participant first accounted that language was considered an exclusion criterion for treatment and later in the interview accounted that there was no need for translators because the service was not confronted with clients who do not speak the language which appears to be contradiction: excluding clients based on language and not being in need of translators because clients at intake speak sufficient Dutch. It is probable that this circular argumentation also exists in other services.

In fact, we never really needed it (a translator), because they simply don't get here, the clients, not the family, they often do speak the language. They can explain things sufficiently. Respondent 1

The mental health care centres (CGG) regularly used translators but mentioned **many pitfalls** in doing so. This in turn appeared to result in some reluctance to work with translators in the future. Respondents mentioned that it is not always easy to talk about a **sensitive topic** such as substance use in the presence of a translator. One respondent mentioned that it created **additional paranoia** in a client. Another respondent mentioned that a male client would not be keen on having **a female translator** in addition to a female psychologist.

You do have to get used to it a little bit, as a caregiver because it is not easy to work with a translator. Also, the conversations aren't really easy. First, it only goes half as fast and sometimes you have to discuss really sensitive issues. Respondent 12

I find it really hard. To ask someone… you don't understand the language, I don't understand what they answer, to ask: "do you use? Do you inject? How much do you use? How long have you been using? Do you have children? Do they know? Does your partner know?" These are really hard question. Respondent 10

I worker with this Turkish man who had fled because he was active in [a Turkish political movement] and he had become really paranoid. So.. a Turkish psychologist? "no no no these are all Erdogan fans...", "but no" I told him, I talked several times with this person and I realised she was really leftist, but not of [Turkish political movement] of course. But it is really hard, he doesn't trust anyone. He can't speak Dutch very well and so he got interned in [a residential service] but that didn't work at all. Respondent 14

I can imagine that for a man for instance, a Turkish man it can be really hard to come to a female psychologist, with an additional female translator (laughs) to talk about his alcohol or gambling problem. That's not easy. Respondent 6

New methods: low threshold community focussed, less language and therapy oriented

All the respondents noted that the currently offered methods in both the mental health centres (CGG) and in residential SUT services are insufficient to meet the needs of diverse MEM populations. One former employee of a mental health centre exemplifies that she tried to install **outreach group therapy** but that this was not encouraged by her coordinator because it was not considered proper 'therapy'. Two other participants working in a mental health care centre agree that CGG methods will have to be rethought at the policy level.

I was organising group therapy outside the service. My superiors said that it wasn't group therapy, that I just talked to these women. It was completely undervalued while I was getting project money to do exactly that. Respondent 3

Speech therapy, group dynamics it really demands an openness to which patient with a migration background might not be used to… or familiar with. They might not be used to just sharing a problem in a group and be vulnerable. Respondent 4

Sometimes you can have ten, twenty, thirty sessions and still feel that what regular services offer is not what these people need. It might be intensive for the little they get out of it. It might be good to search for ways to make this is a bit more efficient. At the moment, it doesn't really seem to be a policy priority to work with these issues. Respondent 8

When inquiring about how practices in SUT services could be enhanced for MEM clients, respondents all refer to diversifying the offer and installing more low-threshold group-oriented methods and **less language-oriented practices**.

I really believe it can be important to use a group instead of an individual approach. Creating and offer for a group. "You can come here to do your laundry, to drink a coffee. You can do that here. And whether you come with only your eyes visible… we don't care. You can do that" I think that's really important, to create a place where everyone feels at home. Respondent 10

Promoting methods that are less language oriented, some creative therapies, it happens but it's still too little. Respondent 5

In a psychiatric hospital there's a part verbal therapies and there's a part that consists of non-verbal therapies. And then I think, come on. You can just offer more non-verbal therapies. You can use some expression, or some sports and keep the verbal therapies limited. If necessary, a bit less in group and a bit more individual. (laugh) but I do realise it's not that easy to change have section in a service. Respondent 6

I think the staff needs to get more diverse. But that's hard of course because you have to get all these people trained first. Respondent 7

7.6.10 Drivers of change in treatment: policy, leadership and ambassadors

Most respondents would adhere to what we could call a generalist or universalist stance in treatment: everyone has the right to the same care and support, and this does not especially require targeted initiatives.

> What we do for them? Nothing more or less than what we do for the Flemish people. In other words: we respect their culture. (…) they get a personal staff member for example, like everyone else. And we try to give attention in the conversations to their own lived experience or background. I think that our strength (residential service) is that everyone is equal here, without an exception. If you ask whether we do something special for these people, no, actually we don't. But we won't discriminate against them. Respondent 10

At the background of a **lack of service policy making**, some respondents demonstrate inner conflict on whether to work radically generalist or more targeted. While their management fails to offer a clear answer to this question, the respondent quoted below subsequently feels that the issue of long waiting lists should be solved for all (potential) clients without prioritising particular groups. She thereby exemplifies the consequences of short-term policy 'patchwork'.

> On the one hand: getting in the service fast, I would like that for everyone. If someone with a migration background comes is – many of them came in via the regular services – they had to wait really really long. But you can well say that for people without a migration background, they also had to wait for a long time. So maybe… maybe the fairest would be that these clients come in via the regular service and that the issue of waiting lists is solved for everyone. But sometimes I do think... for some people with a migration background… once they get here to get help… it's really necessary. But that's no different among people without a migration background. Respondent 13

The majority of the participants emphasised the need to have a **shared perspective** and shared goals at the service policy level. Having this perspective is deemed to be important to set goals and to reduce the risk of only working project-based in the short term.

> It's important to make a choice at the organisational level, at the policy level. That's what we stand for, or you don't. You really have to do that to be able to change. Respondent 1

> It's good that we can do projects occasionally [talking about the refugee project] because than you can also 'freewheel' a bit. But it always stops and that' what might be wrong. If you ask; what's the perspective behind that? You can maybe start without a perspective, but it should be the idea to at least have new perspective in the end? Respondent 12

Respondents mostly referred to **personnel practices** that influence the perceptibility of the service towards MEM populations. A participant with a migration background noted that she attracted many clients with a **similar background** because of her network. A general practitioner adds that having **Turkish speaking staff** helps a great deal with sorting out the administrative side of care. Another participant emphasised that it is important that **staff reflects societal diversity**.

> Half of the clients were coloured, and they mostly came for me. Because they had the feeling that I was someone who spoke their language or would understand their culture. They came in via the network I had built up and were referred that way. So the real task was to get those clients who were referred to me to have them enter our generic services and that did work a bit. Respondent 3

> We have two Turkish speaking staff members here. Now they are actually both on sick leave and you do notice that, you notice things are starting to get more difficult. Respondent 14

To have a mirror of society, at the moment that's not the case in our service. Everyone needs to believe in that a bit, that they need staff that mirrors society a bit (…). A small example, at the moment we only have female intake staff members, but I can imagine if a Muslim comes here, he might think "okay but I don't even tell my own wife, so why would I tell everything to this women?" Respondent 1

Contrarily, a psychologist notes that some clients will **rather prefer that staff does not have the same background** because it could hold them back from seeking help or opening up in treatment. Moreover, one respondent accounts of having fired a social worker who in the opinion of the service board brought in his own **beliefs concerning substance use**, which could have been detrimental for his professional relations.

On the other hand, I remember when I was doing research myself that some people told me: "I don't like it to have someone who has the same origin, it holds me back." So I think people just need a good care giver that is culturally sensitive. Respondent 5

Once we had to fire someone, that was awful (…) They hired a boy, a nice guy. But when he talked about alcohol, he really said "If I see someone drinking alcohol, I will go to them and tell them that that's a sin". Ho! A sin? No no. That's not bringing in your religion. It's not a sin. Respondent 12

All the respondents acknowledged that the **leadership** of the service is key in making change happen. At least five respondents noted that this leadership support was absent in some services because of **organisational stress in other domains** (e.g. waiting list, staffing, transitions) and because of a **negative societal** climate towards MEM. A participant also accounted that in a network of therapeutic communities there was some resistance towards lowering access towards MEM and little belief in the ability to do so.

I had asked if I could take a training on organisational diversity policy, but my superior said: "actually we can't really implement that at the moment". I could take the course for myself but at the moment we can't implement it because of transitions in other domains. Respondent 13

At a certain point – and it's sad to say because I really had nice colleagues there – at a certain moment they thought we were having too much coloured people. (…) The service policy and the coordinator really has an influence (…). This had really changed because of the policy, because of one person, because of one member of the board who, because of a mechanism of resistance, really created a climate of fear. The same climate that we see in society. He just continued that in our service. Respondent 3

[A residential service the respondent had coached] was really managed by 'a manager' at that moment [the moment of the coaching]. And we [the integration service] had a lot of contact with the director who was really involved with the organisational aspects, but he wasn't really interested in what we had to say. The staff members themselves, really demonstrated resistance: "we know what we're doing, the integration sector won't be able to teach us anything". Respondent 5

We really asked around in our network like the network for therapeutic communities and… I can confirm what my colleague just said, that we often got the message: "it doesn't work, you won't get them in". So, we really had the feeling the others just gave up, while we were saying "come on". (…) we wanted advice from our colleagues, but we didn't get any. Respondent 2

Additionally, a respondent noted that he felt that psychologists were too much focussed on speech therapy and subsequently often **resist other methods**. Lastly, a psychologist explained that she felt less apt to participate in the interview because she was not a specialist in SUT, thereby

overestimating her feeling of **inability to work with the population of problem substance users as a 'mental health' worker**.

> Psychologists really have a perception problem…. "A true psychologist should have taken a therapy course" … that's the real stuff, that not true you know. Respondent 12

> I was quite reluctant to participate [in the interview] because uh… I really don't work in substance use treatment, but in a sector close to it, but I really do aspire to (thinks) work more intensive with this target group. Respondent 13

Three respondents noted that they served as '**ambassadors**' for more diverse sensitive care in their service and that this worked to increase awareness and to work with sensitivities and resistance among colleagues. They all emphasised that it is necessary to get an official mandate to take up this role.

> For instance, having these ambassadors, it really works. It really works, because first we only had two [colleagues who were willing to work concerning diversity] in the therapeutic community, but the detox department wasn't getting along, and that's where people enter. So, if it doesn't work over there, they will never get in the therapeutic community. So, it was really nice to get those ambassadors to work in that department. Respondent 1

> It's not easy you know to do something with diversity as a colleague. What you do is never good enough, because you're… you're just a colleague but sometimes you have to put yourself above the system to be able to change something. And that's not always appreciated, it's a double mission. Respondent 3

Two respondents note that besides working with leaders, coordinators and other colleagues, it is important to include MEM in **processes of client participation**. This is important to respondents because the societal climate is often also reflected amongst client populations.

> There're many people who make racist statement. Really. "and why do we get them here? I don't want him or her… that stranger" because that's how they call them here, "they come here and look at them" they can get really defensive. Once they are a client it's like all of that's gone again. Also, towards other clients: they know they come to us and they stop talking about it, no more nagging. But yes… my clients, it might sound bad, but they are all very 'Flemish minded', really, they don't know any nuance. Respondent 10

> When we had those diversity groups, they were really combined of say Muslims and homosexual people. They were together in one group, because it's about being different and not about: you're this or you're that. Respondent 1

Lastly, two respondents emphasised the need to **evaluate** the current working methods and to get funding for evaluation. Nevertheless, only a minority of the participants answered positively to the question on whether they would use and analyse administrative data on client populations to inform service policies.

> If you put money in something, you at least reserve some money to research… how should it be? Respondent 12

7.6.11 Networking & local embeddedness

Networking was identified by all respondents as a driver for better reach of MEM populations. Networking was mainly defined as local embeddedness of the service, taking part in clients and case coordination and making the service knowledgeable towards populations and other services.

Cross-sectoral case coordination is becoming increasingly common in the SUT field. Client meetings involve several organisations that guide the clients to coordinate the service's efforts and to subsequently make their work more efficient. A respondent additionally notes that self-organisations could be included in these client meetings and organisational meetings of SUT services.

> We've been part of client meetings where we discuss the treatment plans, but we have quite a large client group. And when it's about migration background… we also talk about these things and have intervention. (…) It can be the PSCW, a youth service, justice, it can also be us taking the initiative if we for instance note that a case is getting too complex. Respondent 4

> I would rather include it in the existing client and organisational network, rather than creating something new. I do think that self-organisations [NGO's gathering MEM] and those kinds of NGO's should be included more often. I do think so. Respondent 8

A participant suggested that besides the existent local networks that cover local SUT services and the client meetings, it could be interesting to create an **expertise centre concerning diverse sensitive care** where professionals could share experiences.

> The most important issue is that you have a platform for sharing… where you can share experiences, mainly experiences, but also written down and where for instance courses can be offered… training. Also in the basic training, not only evening classes – because now many of the cultural competence courses are in that circuit, or a seminar. I'd rather have a platform where people can go with their questions, where they can share experiences and build expertise by meeting each other. That seems important to me. Respondent 7

Local embeddedness was mainly described by participants as the ability to communicate easily with other services with the goal of referring or getting to know other services, reducing drop-out and lower the threshold for diverse populations. Local embeddedness was also defined as being geographically close to for instance asylum centres but also as the equal geographical spread of SUT services across the Flemish regions.

> We really want to build up a network here. (…) syringe sharing, street workers, general wellbeing services. I gave some training sessions to the PSCW. To explain other services, like if you have a problem you can go there. We get a lot of phone calls from the PSCW for instance. Respondent 10

> The place where people can get a translator to assist them were often very far away from where they lived. There are refugees living in the Ardennes, the service offer over there is almost nothing, I mean…. There are not even people there (laughs) so… that is problematic Respondent 7

Although the majority of the respondents acknowledged that the taboo on problem substance played its role in help seeking and treatment trajectories, they would often nuance it. A general practitioner for example explained that the **local embeddedness of their service resulted in getting the trust** of a locally embedded community. Because of this trust, parents and grandparents would more easily consult the service with questions concerning substance use of their sons or grandsons.

> When people move houses, they can't come here [community health centre] anymore. But they come here, almost crying. "we can't come here anymore, but we've known you for thirty years! It's my brothers and sisters that come here". (…) that is why these grandparents and parents do have the trust to come here with their sons. Actually, it's a shame, it's a real shame. Imagine your son is hitting your granddaughter because he's on

drugs. To search external help… they do come here… some of them… (…) We do have a real relationship of trust with our clients. Respondent 14

Quite contrarily, a psychologist noted that the fact that she had her consultation room in the city centre instead of a community neighbourhood, lowered the barrier for community members to come to the consultation without anyone in the community noticing their visit.

If I had my practice in [another part of the city] I wouldn't know if they'd come here… I mean… they just say, "I'll go shopping" and there's a bit more distance… you can't see on the outside of the building that I'm a therapist. I think it can be more comfortable for people. Respondent 5

MACRO

7.6.12 Initiatives at the federal level

One respondent mentioned that the previous federal government[89] appeared to have only a **limited interest concerning the health of migrants**. Another participant noted that the complicated state structure makes coherent policy making quite difficult and this is exemplified by other respondents.

It is a perfect illustration of the Belgian paradox: "We don't have migrants, we don't have ethnic minorities" (sarcastically). Yes, no we had migrants in the previous government declaration: the word migrant was mentioned once regarding illegal residents (laughs emotionally),for the previous government the only concern about migrants were related to criminality, to illegal migrants. Respondent 11

The state structure makes it really hard to have a coherent policy you know. Respondent 7

At the federal level several initiatives were pointed out that are supportive for the mental health of MEM populations, especially for refugees: **the right to urgent medical care, the right to psycho-social support for refugees awaiting the decision of their asylum procedure, intercultural mediators, video translation and first line psychologists**[90]. Participants did point out ways for enhancing each of these measures.

Concerning the principle of the **right to urgent medical care** one respondent coined that it's broad definition might lead to arbitrariness. Contrarily, a GP coined that the decision whether something is urgent or not should be the sole responsibility of a medical doctor. Additionally, a GP working in a methadone substitution treatment centre accounts that although persons might not have social security, the service will provide them treatment.

There's the law on urgent medical care, but it's quite arbitrary, it's like a roulette. Do you want to give it or not? It's the doctor who chooses. It's a system that doesn't work very well, it leads to arbitrariness. Respondent 7

They don't call it 'highly emergent'. The order of medicine uh… because they wanted to control that… but the order said, "you can't do that" (….) 'highly emergent' is the ambulance you know. Respondent 14

We do have clients that are illegal residents, no one gets to them… (…). I do think that we [methadone substitution centre] are an exception, surely compared to residential centres, I understand that if you don't have social security... well that's an exclusion criterion. That's not the case here. Respondent 4

[89] The interviews were conducted right after the 2019 regional and federal elections.
[90] All actions within the framework of Article 107 of the Hospital Law will be discussed in the 'Flemish regional level' section. Information about Article 107 can be found here: http://www.psy107.be/index.php/nl/

Several respondents mentioned that **refugees / asylum applicants awaiting their asylum decision have the right to mental health care** but that the procedure is too complicated which implies that asylum applicants often do not have the opportunity to get this treatment when needed.

> For asylum seekers there is psychological care, which is written in the law, so in theory they have access to mental healthcare and it is a form of acknowledgement that asylum seekers have a specific need in mental healthcare, although in practice, I mean: it is one session per month, it is only speech therapy so…. and there is a gatekeeping system so it is planned, it could be better. Respondent 11

> For asylum seekers there's the federal funds. They can for instance, from an asylum centre ask for a private psychologists. I did get some questions from these centres. Respondent 13

> What really stands out, among the refugees for instance is that as long as they are in the asylum procedure, they have a right to free mental health care and many of them need that. But they only get to these services once they got the refugee status. Than they don't have access anymore. The procedure takes very long before you get the refugee status, but the procedure to get to mental health care takes even longer. Respondent 7

The project of **intercultural mediators and video translation in hospitals**[91] was evaluated very positively by the respondents. A participant – responsible for these intercultural mediators – explained the added value of these mediators compared to translators. However, these mediators are only subsidised in hospitals and not in for example methadone substitution treatment or centres for mental health because the latter are a regional responsibility. This is experienced as a shortcoming by many of the respondents.

> In Flanders there's translators that are very close to 'translating machines', someone who really translated a message from language A to B without changing the register, without explanations, without interfering when there are misunderstandings… intercultural mediators they will do that, they will change their registers, explain and point out misunderstanding. Respondent 7

> An outpatient service where psychiatrists visit people at their homes together with an intercultural mediator, it exists. I talked to these psychiatrists and they were really enthusiast because they said, "my colleague really gives some insight, he asks questions that I wouldn't have asked" (…) there's no such offer for the centres for mental health. Respondent 13

Some respondents note that they had high hopes concerning the introduction of free **'first line' psychologist** in the community health centres (WGC) to reduce waiting times to enter mental health care. However, three respondents pity the fact that these psychologists were insufficiently locally embedded and that they mainly refer to other services such as CGG and psychologists instead of giving treatment. One of these respondents additionally notes that the fact that these psychologists are only subsidised for treating or referring persons with alcohol related problems, causes confusion among clients and inefficiency in the health system. The latter is exemplified by a professional working in a centre for mental health care.

> Free Clinic, Addic, De Sleutel [Flemish services] they can only treat illegal drugs. Alcohol, codeine or opioid dependencies, fentanyl which is strictly speaking an opiate, they can't treat that strictly speaking so they all come here [centre for mental health, CGG] (…). We can… or private therapists… but there's not a lot of those, who want to work with that. We first thought that the new first line psychologist would relieve this burden because that's one of the three problems that they can work with: intermediate depression, intermediate

[91] www.intercult.be

eating disorder and intermediate dependency on alcohol. But we started referring to them, and they just referred the clients back to us: "can you orient these persons to someone who can work with this?". So that's not a solution for us. There are some barriers embedded in those rules. Respondent 8

The Minister of Health is constantly saying: "we're refunding first line [psychologists]" … but that's just… more of the same, but at the first line. I'm not saying it's bad, but this isn't the breakthrough that we need. (…) And that's when you end up at community work, as a psychologist you should really take up that role: how can you optimise the mental health of a neighbourhood? Who does that? That's work for a psychologist, collective psychology. A kind of community psychology. Respondent 12

We have some psychologists now [at the local health centre] but they don't only work for us, they work for the entire municipality, there's several. So, they come here. That's via de Minister but they only… I think they can deal with alcohol but not drugs. There specified indications they can work with, I think they meet like six times (…), they do an intake and they already say I will guide you a bit and I'll than stop or refer you. Respondent 14

7.6.13 Initiatives at the Flemish regional level

Since the sixth Belgian state reform (2014), the policy domain of SUT largely moved from the federal to the regional level and SUT is since included in the broader mental health domain at the Flemish policy level. One respondent notes that this is resulting in what she calls a ping pong game between policy levels and sectors while political leadership is lacking in this domain.

We need a leader, we need leadership, we don't have a captain in the ship. In the end we all want the same thing (agitated): that the patients are well, that we care, we offer quality care and safe care and appropriate care and useful care for everybody, whatever whether it is a man, a woman, a child, elders, undocumented, documented, I don't care. We need someone or something that could have an overview of what's happening, to identify gaps and to identify overlaps because I think there are a lot of resource that is not used efficiently. (…) The ping pong game between: "ah no, it is a prisoner, yeah but it is mental health… oh it is regional! Yeah, it is an asylum seeker, it is a federal program. Yeah but its health promotion… it is a community problem". It drives health professionals, patients, social workers, citizen who don't understand why, crazy. Respondent 11

The transition of SUT from the federal to the regional level is facilitated by the Department of Wellbeing, Health and Family (*Departement Welzijn, Volksgezondheid en gezin*) and the (health)care agency (*Agentschap Zorg en Gezondheid*). Subsequently, participants referred to much of the work that has been done at this level before the 2019 elections, respectively **article 107 of the hospital law** at the federal level and the introduction of a community based care perspective (*vermaatschappelijking*), **first line psychologists[92], the project 'refugees and asylum' and support to the 'Antenna mental health care'** (*Steunpunt GGZ*).

In the context of MEM in SUT, the integration of the regional 'networks cultural sensitive care' in the newly established '**Antenna mental health care' (Steunpunt GGZ)** is pointed out to be an important move. A respondent accounts that, based on a newly devised '*reflection tool for culture sensitive care'* (*Reflectietool Bouwen aan cultuursensitieve zorg voor zorg- en welzijnsorganisaties*, 2019) the Flemish (health) care agency structurally analyses caveats in (mental) health service organisational models.

I think in the summer they [the department] will look into okay, so we have these four domains [service identity, methods, reach, staff policy], what have we [*steunpunten*] done? They are asking both the expertise hubs

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[*steunpunten*] and the departments [*agentschappen*], okay if you see those four levels: "what do you already do?" Respondent 12

At the core of the article 107 of the Hospital Law is the **reduction of hospital beds.** The underlying idea is that people can be taken care of in their own environments and community-based support settings with the aim of (re)integration in society. Mobile and crisis teams are expected to follow up in case this is needed.

However, several respondents note that the **capacity of these mobile teams and other initiatives to support these clients, is insufficient**. As mentioned above (see: Other referral and support services: mobile (crisis) teams, PSCW and self-organisations) mobile and crisis team across Flanders have waiting lists. Waiting lists undercut the main goal (fast support) of mobile and crisis teams and they results in the fact that services will not focus on reaching new populations such as MEM.

The biggest problem [for centres for mental health] is that the 'socialisation' [*vermaatschappelijking*] of care means that treatment periods are getting shorter and shorter. People leave us when they still have some problems. They then enter in outpatient treatment. But that offer is insufficient for these people. But you do take them in because there's nothing else. You don't have any turnover. These are people that stay there because they have the type of problems that you can't easily delete. Respondent 8

Additionally, SUT was integrated **in the mental health domain** and moved from the federal to the regional level. Although most respondents agree that this is a positive move, some note that it is not an easy transition because the mental health sector and SUT are not yet used to this collaboration.

For now, the collaboration hasn't been perfect. They were always the first ones to say, "yeah if someone is addicted, we don't work with that because addiction really is a disturbing factor [to the process]" And now we have to start collaborating with that sector. I do think it's logical, but the water is really deep. (…) I do understand it you know: there are waiting lists and there already is sufficient work, so addicted people… they can just stay in substance use treatment. So… yes… on the other hand it could also induce innovation or give a new drive. Respondent 4

Centres for mental health have also been funded ad hoc for **psycho-socially supporting recognised refugees**[93] in Flanders (by AMIF). A respondent accounts that **ad hoc funding** is detrimental for good external dissemination of this type of service and that the funding is insufficient to cover the real needs. Additionally, these project are mainly aimed at vulnerable recognised refugees and not asylum applicants or undocumented migrants.

We started in February 2016 I think but we only knew in January, February 2017 if we would continue to have funding. And it's always been like that. A project apparently can only get renewed two times. Than the project stops, and you can't do the same things anymore, besides if you rewrite the goals. So, we started to do that and we could continue to do the work but the annoying issue here is that towards external partners… we couldn't say whether we were going to do it or not. So, it stopped in 2018. It was only in the spring of 2019… that we knew we would get new funds… and we only got 10 hours (laughs) [a week] to do this work [liaise with asylum centres and follow-up]. Respondent 13

7.6.14 Regional spread of SUT in Flanders

Article 107 (*vermaatschappelijking van de zorg*) facilitates the support to two types of local networks aimed at centralising SUT: (potential) SUT clients centred and local SUT service centred

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networks (*zorgcircuits- en netwerken*). Respondents were very positive concerning these networks in Antwerp, South-West Flanders and Ghent-Eeklo-Meetjesland because they allow practitioners to share expertise (e.g. between mental health and SUT) and client knowledge. A large downside was identified to be the time needed to take part in network meetings but also the fact that some regions are insufficiently covered.

> We have a meeting where all professionals involved with substance use meet each other. It's about clients, about youth, justice, police, youth workers, general wellbeing worker, those kinds of services, but also [a residential service] and the methadone substitution treatment service. They're all there, so we know each other. Respondent 10

> In the past, we weren't really part of it. Now It's more well accepted to consider problem substance use as a psychiatric disorder, while in the past… it wasn't so clear how it was seen. The disadvantage is that we have a lot more meetings now, that take a lot of time. Respondent 1

> If we're together at the forum, I do notice that in Ghent, or well East-Flanders, we do have a broad array of services, many methods and ways of meeting. Eh.. I think we're really innovative… we're doing good. There's a lot of outpatient and inpatient care. The number of psychiatric beds in the Ghent area is the highest, I think in Europe or even worldwide. Respondent 4

For some regions, redesigning SUT in a local network perspective was a continuation and optimisation of what already existed such as in the municipal regions Antwerp, Ghent and Ostend. For other regions it meant subdividing existing networks. One respondent mentions that a good and constant balance between central and decentralised availability is important to have regional coverage of a diverse set of services (e.g. inpatient, outpatient). He also notes that not all regions are served with the same types of treatment. Some regions have enough outpatient coverage and no residential services whereas in other regions, it's the other way around. Participants explain that this means that some areas in for instance **West- and East-Flanders, Limburg and Antwerp are underserved.**

> The decentralisation… (…) of the regions which in itself could be useful. It will result in better regional coverage (…). But it's spread unequally, the offer. There are many blind spots if you look at Flanders there's really some inequalities. If you look at Meetjesland, Ronse, Aalst… You still see that the offer of care is unequally spread but additionally the offer that is available is very much dependent, not on scientific evidence, but on a specific perspective or a societal 'pillar'. If you look at the offer of [a residential service] or a trajectory in [another residential service]. One can ask… is it high threshold, low threshold? What's the perspective? What do they expect from the client? So there's really big differences that in my opinion are not always based in scientific evidence or research but they rather departs from a belief… a perspective… (…). The fact that in some regions you only have high threshold and no low threshold care… I don't think that's good for the quality. The regional differences really are too big and the reasons to work in a certain way… aren't always objective. Respondent 4

> We [in this area] have a bit less substance use treatment here you know. In terms of psychiatry we're good, but residential care is not evident here. We only have ADDIC, which is why there's also a large influx in the centres for mental health and why the waiting lists are getting longer. Looking at the province, the offer is insufficient. (…) Zottegem, Aalst, Ninove, it's one large blind spot. For Antwerp we'll be getting a small satellite service in Boom. (…) But I was more of a fan to get one in the North of the province. Kalmthout, Essen, Wustwezel, it's the far west out there, there's nothing there. Respondent 8

> South-West-Flanders that's Kompas. In Veurne there's additionally a service from De Sleutel. North-West-Flanders that's mainly MSOC (opioid substitution) and the outpatient De Sleutel centre. So I do think that North-

> and South-West-Flanders has an outpatient offer. For the high threshold services that would be De Sleutel but they don't have a residential service (…). You know, they make the decisions in Oostende but do these always work here? Maybe they don't? Respondent 10

Lastly, a respondent working in a residential treatment service exemplifies that services in specific residential treatment, as opposed to locally embedded low threshold treatment often serve the whole Flanders region and that this seems to clash with the local network perspective.

> The province used to organise meetings concerning specific groups. There was for instance a group concerned with addictions. So, everyone, psychiatry, outpatient, we [inpatient], everyone working with addictions was involved. That's all gone to waste because the Limburg province has been separated in two pieces. We are part of one region on paper, but of course we do not limit ourselves, we cover Flanders entirely. Respondent 1

7.6.15 Limitations

The studied sample was not exhaustive or representative in terms of geographical coverage and types of consulted SUT services. Full representation of provinces or types of treatment services was impossible given the short time frame of the interview period (June 2019) but also given the fact that little professionals in residential treatment answered to our request for an interview. Only the Flemish Brabant province was not represented in the respondent sample.

Concerning the types of treatment, there was a clear overrepresentation of respondents working in a Centres for Mental Health (CGG) (n=4). Three respondents worked in two different residential treatment centres, one mainly in methadone substitution treatment (MSOC) and one in a community health centre (*Wijkgezondheidscentrum*). Although the researcher did contact these services, no professionals in psychiatric hospitals (PZ), psychiatric wards of general hospitals (PAAZ), day centres and crisis units were able to participate in an interview. Moreover, no social workers (e.g. street workers) or psychiatrists were interviewed, although their accounts could have given an additional value to our research results.

This research project was aimed at understanding professional and policy perspectives, which is why the researcher did not approach MEM SUT clients or substance users with a migration background. Consequently, only a short part of the results section is located at the micro client perspective. Only one respondent had a migration background and no target group specific organisations were contacted to partake in this research project.

These results are only a partial reflection of the state of substance use treatment in Flanders. First, the interviews were conducted relatively short after the transition of SUT from a federal to a regional policy domain. As a result, many of the discussed topics are time-dependent. Second, the interviews were conducted shortly after the 2019 Federal and regional Belgian elections, resulting in the fact that the respondents were working in an rapidly changing environment.

7.7 Discussion of the interview results

SUT is a domain in transition in Flanders: theoretically it is moving towards community based (*vermaatschappelijking*) (Vandeurzen, 2015) and recovery-oriented (*herstelondersteunende*) care (Vanderplasschen & Vander Laenen, 2017). Organisationally the SUT domain is slowly integrating into the mental health domain in Flanders with its networks of care (*zorgcircuits en –netwerken*).

This transition implies on the one hand that some of the presented results may no longer hold true in a couple of years. On the other hand, this time dependent 'picture' of a domain in transition uncovers some important caveats and possible ways forwards for the new Flemish government.

The focus of the interviews was often predominantly on the broad domain of substance use treatment (SUT) instead of specifically on MEM (sub)populations in SUT. Nevertheless, the caveats in SUT services that are detrimental to the end users often crystallise among more vulnerable MEM user groups. **From a client-centred perspective we observe that not all persons with a similar migration background will have the same needs while from a population perspective there is a need for the acknowledgement of (sub) population vulnerabilities and to identify targeted opportunities to enhance their wellbeing.**

In what follows we will discuss the issues raised in the interviews at the (potential) client and provider (micro) level, at the organisational SUT (meso) level and at the policy (macro) level.

At the (potential) client (micro) level, respondents mainly identified that the **reasons for problem substance use are similar** among persons with a migration background compared to 'Belgian' counterparts. Additionally, they point out that **trauma and the feeling of being excluded** are more prevalent among the latter populations. Some participants note that this is a neglected issue in the SUT domain and that there is little expertise in the SUT domain concerning subsequent treatment methods such as EMDR (Eye Movement Desensitization and Reprocessing) and CBT (cognitive behavioural therapy) that may specifically effective for dealing with migration related issues such as trauma.

Whereas the reasons for substance use might be similar, the way of searching help among these populations appears to be different. Participants in this study point out that questions for support are rarely directed to specific substance use treatment services but that they are often signalled via a **detour in three ways. First, a question may come in via other than SUT services** such as via psychologists or via centres for mental health and even integration services. **Second, requests for support are often formulated by family members or other significant others**, instead of by the persons themselves. Third and last substance use related requests may be **'hidden behind' other requests for help**, such as issues related to depression.

Additionally, participants note that there often appears to be a mismatch between client needs and the treatment offer. This may partly be due to a **lack of knowledge about services** among some populations such as exemplified in previous research among European nationals and refugees in Flanders. However, many participants critique the **mainly speech therapy-oriented care** and plead for more community-oriented methods as well as more detox or crisis services.

At the micro provider level, respondents pointed out that **trust** is of uttermost importance in providing good treatment, especially among MEM populations who may have a larger distrust towards services compared to 'Belgian' counterparts as well as 'epistemic' distrust towards treatment methods or the health system. Furthermore, they identified the need for a **client-centred, open, authentic and reflexive** provider attitude and subsequent **training** and noted that professionals might sometimes not take the time to deconstruct and understand life stories and subsequent requests for help. However, clients also hackle the fact that they often do not have the **time nor funds** for such an enterprise, especially considering the **time-intensiveness** of working with

a translator in case needed.

At the level of MEM populations, respondents mainly pointed out that **undocumented migrants and asylum applicants** awaiting the decision of their asylum procedure are at greater risk for post-traumatic stress and other mental health issues and often do not receive appropriate care before receiving a legal status in Belgium. Refugees who were unsuccessful in obtaining a legal status on the other hand do not have the right to any type of treatment and can only enter services that do not require these types of documents such as for instance some methadone substitution treatment services and the services of *Medecin du Monde*.

Professionals in residential treatment more often focussed on issues related to **second and third generation migration backgrounds** (e.g. Turkish and Moroccan) during the interviews whereas those respondents working in methadone substitution treatment would bring up **Russian-speaking populations and European migration backgrounds as hard to reach populations**.

At the meso SUT service level, we identified the main points of access as well as barriers, characteristics of accessible SUT services and drivers for change.

Concerning the points of access, it is worth mentioning that the classical threefold division between first, second and third line[94] will need revision because it is stirred up by the introduction of a community-based treatment perspective (*vermaatschappelijking*). The introduction of first line psychologists, mobile teams, the transition from residential to community based care and the implication of other life domains (e.g. housing, education, employment) in the mental health domain could imply that other services (e.g. asylum centres, OCMW, integration services, CAW) need to take up additional tasks such as questions related to problem substance use and referring clients, supporting clients in some life domains due to problem substance use and offering basic support to substance users with treatment needs.

At the first line, participants considered **GP's, asylum centres, CAW and PCSW** as important access points to treatment. At the second line, we identified that **centres for mental health (CGG)** hold a large potential for supporting MEM substance users. However, respondents in these centres across Flanders reported to have long **waiting lists** and the fact that CGG are often insufficiently capable of dealing with these clients because not all centres have this expertise.

At the third line of specialist substance use treatment services, psychiatric hospitals (PZ) appeared to be quite inaccessible mainly for persons who do not or insufficiently speak Dutch. **Language** appears to be used as an exclusion criterion in these services. Respondents nuance that **short stay** residential (crisis) treatment is more accessible compared to long stay treatment but that there is insufficient regional coverage of these services.

Subsequently, many respondents suggest that the turn towards **community based SUT requires redefining what psychiatric and psychological care should look like** but also to reconsider how persons who need chronic support will be supported. At the moment, **mobile and crisis teams** are very much welcomed by the participants but appear to have waiting lists and insufficient capacity to follow-up of the client group that is growing due to shorter residential treatment periods. Long waiting list were identified as one of the reasons for not prioritising MEM (sub) populations in

[94] http://www.lmnregiogent.be/zorgniveau

service policies.

Supporting the use of **translators and intercultural mediators, facilitating more low-threshold care and developing treatment methods that are less speech and more community oriented** were identified as ways forwards to increase the access for vulnerable client groups such as MEM clients. A prerequisite for changing this treatment culture at the organisational level is **leadership** that supports these changes and can install consequent **service policy** by means of working with mandated '**diversity ambassadors'** in treatment.

At the macro policy level, participants in the interviews were positive about the identified initiatives at the federal level (**the right to urgent medical care, the right to psycho-social support for refugees awaiting the decision of their asylum procedure, first line psychologists**) and at the Flemish level (the **project 'refugees and asylum' and support to the 'Antenna mental health care' and the operationalisation of Article 107 of the Hospital law**) policy level. However, participants note that many initiatives are 'project based' by means of short-term funding. They additionally note that the **cross-cutting need of additional funding** for e.g. centres for mental health, mobile and crisis teams results in the fact that reaching MEM is not prioritised in their service agendas.

The issue of language was a recurring and cross-cutting issue in all the interviews. All respondents plead for **more and more coherent funding of translators, intercultural mediators and video translation outside the medical domain** (a federal domain) and outside the centres for mental health (currently provided to a limited extent by the Flemish government).

Lastly, all participants note that the **variable regional coverage of SUT services in Flanders creates inequalities** because some regions only have outpatient services whereas others only have (short or long stay) residential treatment. Additionally, residential services often have different perspectives on recovery of substance use. Moreover, because of waiting lists, clients cannot choose to which service they will go, creating a disparity in the ability to choose a service based on the treatment perspective paradigms.

The regional caveats identified by the respondents are in line with the overview of psychiatric hospitals, psychiatric units of hospitals, centres for mental health mapped by www.geopunt.be (methadone substitution treatment service are not listed here because they are a federal responsibility). Although not mentioned in the interviews, this regional spread could in the future be compared to the location of asylum centres and local asylum initiatives as well as to the real MEM concentration in specific areas to inform tiered substance use treatment policy making.

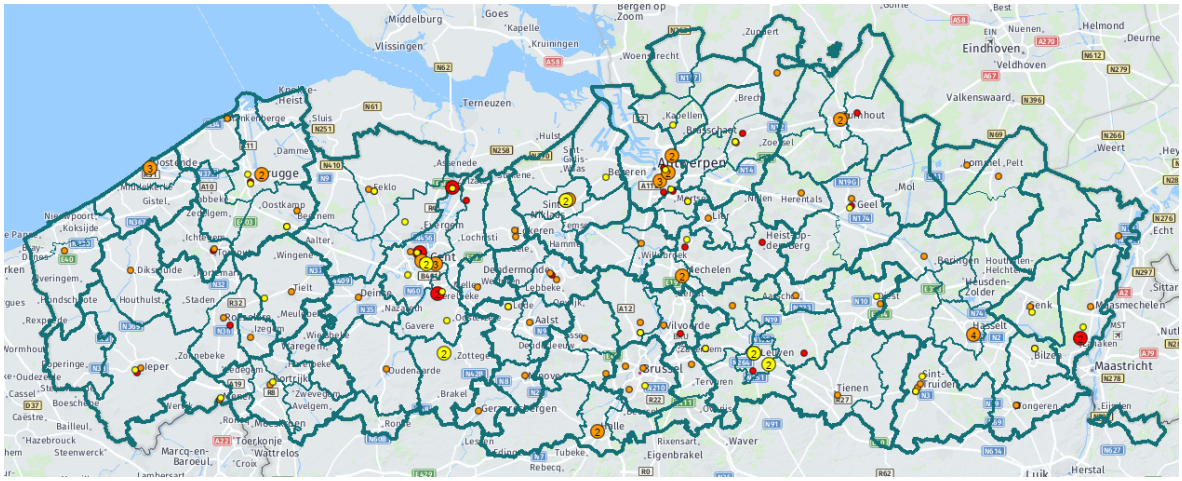


Figure 11: Regional coverage and availability of substance use treatment in Flanders (www.geopunt.be, consulted August 18th 2019)

In conclusion, combining the ecosocial and intersectional perspectives (De Kock, 2020; Krieger, 2014) allowed us to identify that barriers to treatment are not located at one or the other level (micro-meso-macro) (see i.e.: Scheppers et al., 2006).

Waiting lists for instance, as a result of insufficient funding, result in the fact that services feel unable to focus on or prioritise additional target groups such as MEM. A lack of funding on the governmental level results in a feeling of inability on the organisational level (meso-macro). Similarly, (potential) clients may not speak the language but professionals and services may be reluctant to work with them (micro-meso) because they have insufficient expertise and resources to work with these clients. In this case too, the barrier is not only located at the micro level of the client. Quite contrarily, the language barrier is far more complex because it consists of an intertwinement of micro, meso and macro constraints and choices. The same goes for the 'trust' phenomenon described above. Being excluded in a residential service (meso) based on insufficient knowledge of the language may induce epistemic distrust on the part of the client. In other words, the client can lose trust in the treatment system (macro) because of experiences at the meso organisational level that will reflect back in the therapeutic relation (micro).

Whereas barriers are often attributed to the client (e.g. language, culture), the same barriers can equally be attributed to services and policymaking (De Kock, 2019a). This change in perspectives highlights the accountability of governmental and organisational policy making, besides only focussing on the responsibilities of targeted MEM populations.

7.8 Survey results: Inspiring practices in Flanders[95]

A full description of the survey questions and answer options can be found in chapter 5.3.1 (The survey disseminated to the EU-28 countries was translated ad verbatim to Dutch).

The survey was open for a period of 1 month (1st April - 30th of April 2019). The survey request was sent out to 1260 e-mail addresses by the Flemish Expertise Centre for Alcohol and other Drugs (VAD) and a reminder was sent out two weeks before closing the survey. Respondent categories and numbers of e-mail addresses are listed in table 35. It should be noted that professionals often belong to several of the categories and will have received the request twice. Additionally, the coordinators of the newly established regional treatment network (article 107) were not included. However, all relevant specific SUT services (who are members of these networks) were contacted individually.

Specific SUT services (umbrella = VAD)
Outpatient centres, guided housing [*beschut wonen*], medico-social care, psychiatric Hospitals, prevention and early intervention, psychiatric units of hospitals, therapeutic communities, crisis intervention, day centres, self-help groups (n=129)
Prevention workers at centres for mental health (CGG) (n=56)
Local and intermunicipal prevention workers (n=19)
None categorical health services (umbrella = Steunpunt Geestelijke Gezondheidszorg)
Provincial network mental healthcare (n=6)
Networks mental health care (youth and children) (n=6)
Psychiatric hospitals (n=37)
Psychiatric units of hospitals (n=66)
Centres for Mental Health Care (CGG) (n=71)
Wellbeing (umbrella = SAM + VVSG)
CAW's (n=11)
OCMW's (n=297)
NGO's working around poverty (n=44)
Health
Intercultural mediators in hospitals (n=45)
Local Health centres (n=37)
Integration / Minorities
Regional and Flemish Integration Agencies (n=8)
PICUM (Platform for International Cooperation on Undocumented Migrants) (n=6)
'self-organisations' (NGO's gathering persons with a migration background) (n=90)
Local authorities
Responsible for the prevention contracts (n=51)
Others
Purposively sampled and personal contacts via PADUMI project (n=97)
Mobile teams (n=31)
Belgian substance use treatment services subsidised by the Federal Institute for Health Insurance (INAMI / RIZIV) (n=218)

Table 34: Categories of survey respondents in Flanders, Belgium

115 respondents participated in the survey. 88 respondents were excluded because the questionnaire was filled out only partially. A first reason for drop-out appeared to be that after the second question respondents saw the whole questionnaire. We subsequently subdivided the questionnaire in two pages shortly after its launch. Another possible explanation for the high dropout is that respondents started filling out the questionnaire without understanding the scope of the survey.

Of the remaining 27 respondents 2 were excluded because the described inspiring practices were not MEM specific and an additional 2 were excluded because the inspiring practice was not feasible to implement in a SUT context.

[95] This subchapter was co-authored by Fred Laudens and Lyssa Toyinbo

Respondent pool and inspiring practices

The remaining 23 respondents were mainly male (61%), aged between 35 and 44 year (35%) and had over 10 years of experience in their domain of work (74%). Respondents identified predominantly as mental health care provider (30%), staff member/management function (30%), prevention worker (9%), health care provider (9%) and first line care provider (9%).

52% of the respondents worked in an organisation delivering specific alcohol and drug related services. The remaining respondents work in a general health and mental health care context. The respondents work territory was located in all 5 Flemish provinces, though the provinces of East-Flanders and Limburg were overrepresented in the included survey responses.

The 23 identified and the total of 17 unique practices are listed in table 36. The practices that were most **often identified were (aspects of) 'interculturalising' a SUT service, the use of intercultural mediators, applying the 'tuppercare' approach for prevention goals and the 'trauma and asylum' project supported by the Department of Wellbeing, Health and Family and AMIF.**

A full account of all practices and ways to implement them are reflected the publication '*Wegwijzer voor een toegankelijke en interculturele drughulpverlening / Recueil sur l'accessibilité et l'interculturalité des services pour usagers de drogues'* (available online at www.belspo.be and in a book format via www.gompel-svacina.eu). In what follows, we will only describe the main characteristics of these practices.

Practice	Short description
Interculturalising a SUT services (n=6)	Actions that were implemented in a residential SUT service: **Increasing knowledge about transcultural cooperation, adapted food, distributing leaflets in different languages**, etc. based on a 'diversity trajectory' supported by VIVO. (Katarsis) Implementation of different actions: **presentation of our offer in communities, website translated into Arabic, adapted food, possibility of prayer moments**. (ADIC vzw) In the department for younger drug users, we have an **employee with an migration background**, which clearly has an added value for the treatment. (Karus ontwenningsafdelingen kasteelplus) By means of a **collaboration with the municipal integration service**, the client and the health care professional will be guided through the legal and administrative process when the client has legal status issues. (CAD Limburg) **Outreach to heroin users with former USSR background**: The methadone programme was confronted with illegal purchasers (sometimes under threat) of methadone. Using an outreach method, these men were approached to join the regular programme. The participants of the current programme were supported in refusing to sell their own substitution medication. (CAD Limburg) **A combination of drug prevention in mosques, cultural associations, and tuppercare** in their own language. Referral to substance use treatment via ONG's. Training of the staff to work with drug users with a migration background. (vzw De Eenmaking/El Wahda/ Birlesim,…). (De Kiem) (Noens et al., 2010)
Mind-Spring©	A psycho-educational group offer of several sessions for refugees and migrants in their own language. (Halle municipality & CAW East-Flanders)
Project 'trauma and asylum' (n=2)	Trauma treatment for recognised refugees and unaccompanied minors. Professionals could contact the service for their expertise with refugees and (case related) support. (CGG Mandel en Leie, supported by the Department of Wellbeing, Health and Family) Different co-workers are employed to mentor clients with a migration background in different organizations e.g. a local housing initiative for asylum seekers and Public Centres for Social Welfare. If needed they refer them to mental health care. (CGG Noord-West-Vlaanderen)

Support to refugees with severe psychiatric problems	Specific and specialised (residential) treatment and care for adult asylum seekers (with a high chance of recognition) with serious psychiatric problems, including after care at home. (POZAH)
'When children grow up'	Educational support to parents with a Turkish and Moroccan migration background. Audio-visual and supporting material to be used during a training session in Turkish and Arabic. (VAD / CAD Limburg)
Asylum and substance use treatment coordination	Implementation of the guidebook: "Een alcohol- en drugbeleid in asielcentra". Arrangements between social-, medical- and specific SUT services in the prescription of medication and the monitoring of cannabis and/or alcohol use. (VAD / CAD Limburg)
Translation during treatment	Working with interpreters, patient information in multiple languages and targeted health promotion. (WGC De Sleep)
Intercultural mediation (n=4)	Making intercultural mediation available in hospitals (face to face) and in primary health care (via videoconferencing), follow-up and evaluation at the federal level, training. (Federal government) Every patient has the right to language assistance (7 available foreign languages). The use of a social interpreter from the Integration and Integration department and intercultural mediation. Mediation in culture, expectations and habits are one of their many tasks. (ZNA) The use of interpreters and health care workers who are familiar with culture-sensitive care in the emergency psychiatry unit. (UZ Gent) Intercultural mediators directly and indirectly support patients by interpreting, bringing in the cultural aspects and mediating. (Hospital Oost-Limburg)
Traject guidance refugees / housing café	Volunteers help and assist recognized refugees with housing by contacting landlords, home visits, the installation and integration in the new home. (Centre for General Wellbeing, CAW Centraal West-Vlaanderen)
Tuppercare (homeparties) (n=2)	The Tuppercare method is an accessible way of working by means of volunteers that organise information meetings at home, where it is possible to discuss drug related issues in a familiar environment. (CGG VAGGA, De Kiem)
The 'threshold measurement' (*drempelmeter*)	The 'threshold measurement' can be used to get an idea of how accessible an organisation is to vulnerable groups, including migrants and ethnic minorities. (Stad Hasselt)
Social support	General assistance, distribution of food, language courses for migrants without a valid residence permit. (vzw De Tinten)
PACCT©-method (*psychiatry assisting the cultural diverse community in creating healing ties*)	This practice consists of CBCs (community-based consultations) and ETCs (ethno therapeutic consultations). CBCs are round table discussions with all stakeholders, including the client system. The aim is to clarify and/or create the request for help in order to arrive at a shared problem description and solution that is supported by the entire system. In order to increase the chance of a successful treatment, it is important for all parties involved to have a clear understanding of what is going on, so that everyone can play their part properly and in with mutual respect. Within this process, Solentra plays the role of mediator. ETC's are therapeutic sessions; these sessions concern the transcultural psychological guidance of the child/teenager and his family (e.g., at PTSD, unprocessed mourning). An important basic attitude is the recognition of the burden, but also of the resilience of these people.

Table 35: Inspiring practices aimed at enhancing substance use treatment for migrants and ethnic minorities in Flanders

Domain, setting, operational level, reach and timeframe of the practice

Respondents located the practices mostly in the domain of **treatment** (n=16), **prevention** (n=13), **referral** (n=11) and to a lesser extent **early intervention** (n=6) and **harm reduction** (n=5).

The implementation setting of the practices was mostly **alcohol and drug specific** (n=10), **mental health** (n=8), **welfare** (n=7) and to a lesser extent **healthcare** (n=5).

Concerning the operational levels of the practices, respondents located it mostly at the **level of the client** (n=11), **clinical encounter** (n=11), **provider** (n=10) and the **organisation** (n=9) whereas the **health system/policy** is only mentioned four times (*Afspraken hulpverlening aan asielzoekers, Interculturele bemiddeling [n=2] & Drempelmeter*). The nature of these four inspiring practices seems to indicate that respondents interpreted this question as related to the funding level instead of the operational level (a city municipality, federal government).

When asked in which geographical entity practices are used a **city or several cities** (n=13) are the most common followed by **provinces and regions** (n=8). One practice is implemented at the regional Flemish level (Trauma & Asylum) and another at the federal Belgian level (intercultural mediators). A majority of the practices (n=18) was **still in use** in April 2019.

Target group of the practice

The target groups of the practices were mainly identified as **second, third and fourth-generation migrants** (n=14), **recognised refugees** (n=11) and **asylum applicants** (n=11). 8 practices target **non EU-migrants**, 7 **intra-European migrants** and 6 are aimed at reaching **professionals** working in SUT.

Goals and conceptual quality

The goals of the practices were mainly described as increasing the **accessibility of services** (n=18), increasing **the reach of specific populations** (n=12), improving **organisational capacity** (n=12), improving **provider competencies** (n=11) and to a lesser extent improving **retention** (n=9)

In the open ended question on why the practice was initiated most respondents identified gaps at the level of:

Accessibility (n=10):

- *We received signals from our network of welfare organisations that services do not reach vulnerable people. That's why we created this tool (Treshold measurement – Hasselt municipality)*
- *We live in a neighbourhood with a lot of MEM. We do not see them in our services. That's why we decided to lower the threshold for this target group (Diversity - Katarsis)*

Population reach (n=5):

- *In our prevention work we have limited reach of groups such as those who speak other languages, women with a migration background and people who are less involved in community life (Tuppercare – CGG VAGGA)*
- *For different asylum centres it was not clear what were the SUT possibilities that CAD/MSOC could offer for asylum seekers (Agreements between SUT and asylum centre – CAD Limburg).*

Provider competencies (n=3)

- *Keeping in mind the multiple problems of migrants (PTSD, acculturation problems,…) and their limited influx in the mental health care service, improving expertise with regard to migrants was of great benefit (Project trauma and asylum – CGG Mandel en Leie)*

The capacity of existing services (n=2).

- *Clients referred by the drug court without a legal status and with no knowledge of the Dutch language have no access to the SUT services. We provide sensible day activities and volunteer work for this target group (General help [food and language] – OST)*

None of these practices explicitly intended to overcome issues related to **retention in treatment**.

Concerning who defined the reasons for initiating the practice, most respondents (n=14) answer that **their service defined it**. Three respondents refer to a **policy study**. None of the practices was based on a proper needs assessment although two respondents do refer to consulted literature[96].

Eight respondents indicated that their practice was based on **previous successful practices, interventions or projects**. Eight respondents indicated this was not the case whereas seven answered they do not know whether it was based on a previous practice. **This means that over half of the respondents initiated the practice without knowledge of similar expertise in Flanders.**

Implementation, evaluation and challenges

Only eight respondents mentioned the existence of a **manual of their practice**. Two manuals are available **online**[97]. Other manuals are internal documents or can be obtained upon request.

When asked what the outcomes of the practice are, the majority (n=20) of respondents **reported outcomes**. Almost all respondents (n=19) mentioned positive outcomes. **Two respondents indicated that the practice had not been evaluated yet.** One respondent **did not know** of any results. It is unclear from these accounts though, whether and how the practice was evaluated systemically.

The most important positive outcomes were client satisfaction (n=5), service quality (n=5), reach (n=4), accessibility (n=2) and organisational change (attitude & openness) (n=2). Two respondents mentioned some negative outcomes though they also had positive outcomes.

Concerning the open ended question on challenges and pitfalls of the practices, respondents mainly **identified issues concerning limited funding & resources (n=6), vulnerability of clients (n=5), cultural issues (n=5), communication and language issues (n=4), sensitising and supporting SUT professionals (n=3), intra organisational transmission of competence (n=1) and continuously focussing on these populations (n=1).**

7.9 Conclusion and Reflection

As mentioned in the discussion of the interview results, this chapter is only a partial reflection of the state of substance use treatment for MEM in Flanders because of changing governments at the time of writing (October 2019) and the transitional state of SUT (its integration in the mental health domain and as a regional responsibility, changing perspectives toward community-based care / *vermaatschappelijking*).

Moreover, from a client-centred perspective we observe that not all persons with a similar migration background will have the same needs while from a population perspective there is a need for the acknowledgement of (sub) population vulnerabilities and to identify targeted opportunities to enhance their wellbeing. We equally noted that policy planning in substance use treatment is ideally based on tiered models (Ritter et al., 2019) based on varying data sources including a minimum of harmful substance use prevalence, treatment need and demand data in addition to information from targeted surveys, an overview of the available services and other types of data revealing for instance socio-economic status.

[96] Rapport Koninklijk Commissaris Dhondt 1989/90

[97] Tuppercare: http://docplayer.nl/12313948-Voorhet-werven-en-voorlichten-van-moeilijk-bereikbareautochtone-en-allochtone-ouders-over-het-gebruik-vanalcohol-drugs-en-gokken-door.html & Drempelmeter: https://www.hasselt.be/nl/drempelmeter

However, there is very little information available in Flanders and the information that is available is quite diverse. To structure and make sense of this very complex conundrum and to be able to reflect on ways forward, we will summarise the identified information at the levels of treatment need, demand, access, referral and retention. We will then summarise the recommendations made in bot literature and by the interviews respondents at a micro (client), meso (organisational) and macro (policy) level. These recommendations will be further elaborated in the chapter 10.

Over 20% of the Flemish population has a migration background. In 2017 and excluding the neighbouring countries, these individuals mainly had Moroccan, Turkish, Italian, Polish, Romanian and Bulgarian backgrounds. Persons with a migration background often have worse socio-economic statuses (education, health, housing) and persons with a non-EU background self-describe their health status far worse compared to Belgians. Several Belgian and international studies indicate that these socio-economic differences can contribute to mental health issues and substance use. Moreover, the issue of social inclusion among problem users with a MEM background will become increasingly important in the light of the new recovery perspective. Moreover, this perspective largely relies on the social capital of problem users in overcoming problem substance use.

Currently, the National Health Survey has a too small sample to inform policy and research about the prevalence of recreational and harmful substance use in these populations. When looking at the available data in specific substance use treatment (2012-2013) (Blomme et al., 2017), we observed a large overrepresentation of non-Belgians in low threshold methadone substitution treatment centres (MSOC) (15%), and a large underrepresentation of this population in residential (respectively 1.8% and 2.2%) and crisis services. Additionally, there were twice as many individuals with a non-EU nationality compared to EU-nationalities in treatment, revealing a large underrepresentation of EU nationals in Flemish SUT.

The analysis of treatment demand data (TDI) (2012-2014) (De Kock, Blomme, et al., 2020) similarly demonstrates that European nationalities are underrepresented compared to non-EU nationalities and that the latter have worse socio-economic statuses in treatment. Nevertheless, both populations are underrepresented in most and especially residential Flemish SUT. The Flemish Integration and Migration monitor reports that the health and socio-economic status of persons with a European migration background is better compared to non-EU nationalities.

Given the fact that there is no data on prevalence, we can only rely on hypothesises for explaining the large underrepresentation of non-nationals in residential treatment and their overrepresentation in low threshold outpatient treatment (mainly methadone substitution treatment services, *MSOC*). Overrepresentation in the services is explained by the fact that they are low-threshold and often do not require that a client has a social security number. Concerning the underrepresentation of EU-nationalities in residential services, the hypothesis that European problem users would make use of residential services in the home country is unlikely given that many low-income EU countries have a smaller array of SUT services and / or have more restrictive drug policies compared to Flanders.

The reason is more likely to be found in both individual health seeking behaviours as well as the Flemish health system considering that the underrepresentation is less pronounced in Brussels and Wallonia.

Concerning access, we identified four potential reasons for the underrepresentation of non-nationals in residential treatment. First, the fact that **language is an exclusion criterion** in most residential SUT services is a valid hypothesis for their underrepresentation in these services. Second, we discerned in the 2012-2014 TDI data analysis that non-nationals were **less often referred by GP's** compared to 'Belgian' clients whereas qualitative studies indicate that this population will rather resort to a GP with problem substance use. Third, we pointed out that in Flanders the number of persons **postponing treatment due to financial reasons is larger among the group of non-EU nationals** compared to Belgians and this could be a contributing factor for underrepresentation in residential treatment. Fourth, Mortier (2017) found that detainees with a Turkish and Moroccan migration background were less often referred to residential treatment compared to Belgians, possibly pointing out **referral bias**. These reasons may conjointly and together with other factors cause underrepresentation of non-nationals in residential SUT services but they work conjointly in mechanisms for varying MEM populations will need to be studied in future research.

Additionally, the **specific character of residential SUT services** should be stressed because these characteristics contribute to the selectiveness of these service. The 11 Flemish SUT services subsidised by the Federal Institute for Health Insurance (INAMI / RIZIV) that offer residential (besides outpatient) care are focussed on 'revalidation' and therefor have a clearly delignated target group and offer therapeutic-pedagogical interventions, in collaboration with other sectors and with a recovery oriented perspective (VVBV, 2018). Nevertheless, there is a need to consider how residential service aims and methods can be broadened to also include clients who do not speak the language.

Three of these hypotheses could relate to referral bias: Less referral by GP's, less referral for detainees and the exclusion based on language. In the defence of residential treatment, it should be noted that they offer quite intense programs for highly motivated individuals and that services consequently have legitimate reasons for employing inclusion and exclusion criteria to have good results with clients. Nevertheless, residential treatment methods, as coined by interviewees, need revision considering the introduction of a social recovery-oriented perspective in Flemish SUT policy and considering the growing needs of those one in five persons with a migration background in the Flemish population.

Moreover, both the interviews and the survey demonstrate that current efforts towards MEM (sub) populations mainly focus on increasing access of services and reaching these populations while retention (service quality and treatment outcomes) are less a focus. Only one survey respondent noted that the implementation of service wide diversity policy resulted in increased retention of clients with a Turkish migration background. Two studies (Derluyn, 2008; Mortier, 2017) did point out that drop-out is larger among specific (sub)populations. **This implies that further research into service quality and reasons for drop out is warranted.**

Knowledge about the available services in specific (sub) populations have proven to inevitably also play their role in reaching the right treatment setting. Based on our current results and previous research (De Kock, Decorte, Schamp, et al., 2017) the hypothesis that there is a mismatch between treatment need and treatment offer merits further inquiry.

In the literature, the interviews and the survey we identified quite similar needs to enhance access to SUT for MEM. These priorities can be summarised as follows.

At the micro level of the clients, participants in the interviews noted that the first question for help is often a context question (from e.g. family) and / or that the 'core' question might be covered up by another request for help (e.g. depression) and directed to a service that is not especially substance use treatment related. Moreover, the results of trauma and feelings of exclusion are hypothesised to be contributors to problem substance use by both previous research and the interviewees in the current study. This ofcourse depends on specific migration experiences and will vary across varying MEM individuals. These results imply that treatment networks may need to prioritise:

- **The creation of network mechanisms to identify context and indirect requests** for help presented in services outside the SUT domain (e.g. asylum centres, integration centres, CAW, OCMW, e.g. to the example of CAD Limburg);
- **Informing and sensitising subpopulations** (e.g. European nationalities, second & third generation, recognised refugees, undocumented migrants) about the SUT services available to them e.g. by making use of the Tuppercare principle;
- **Sensitising first line workers** (e.g. GP's, asylum centres) about referral to treatment.
- **Installing prevention and early intervention efforts in asylum centres.**

The 'mismatch' between treatment needs and the available treatment should additionally be evaluated critically. Many participants note that language is an exclusion criterion in most residential services while questions are raised concerning the dominant focus on speech therapy as compared to community-based treatment and systemic treatment approaches. This is not only the case for residential treatment but also in centres for mental health care.

Moreover, about half of the participants in the survey identified as mental health workers which implies that there is large potential for expertise exchange between SUT and mental health workers. Furthermore, services that regularly (want to) use translators and intercultural mediators, experience financial and organisational barriers. These same barriers are identified as reasons for not making use of these service and appear to be a root cause for not wanting to use them. Consequently, following issues should be prioritised:

- Including **less speech oriented and more community-based methods** in residential treatment as well as centres for mental health;
- Broadening **SUT and mental health collaboration by sharing expertise** (e.g. concerning EMDR, low threshold methods, substance use treatment specific methods, training on working with translators etc.);
- **Regional coverage of short stay (detox, crisis) residential treatment** and linking coverage to local asylum centres and initiatives. But also cover regional caveats as identified in the interviews and similar to those mentioned in the VVBV Memorandum 2018.
- **Lowering the threshold for the use of translators and mediators** across all Flemish services and funding these initiatives.

At the level of the provider, the participants in the interviews note that trust, client-centred care, openness, authenticity and reflectiveness are key in successfully supporting (MEM) clients. However, having and practicing these skills is to be preceded by some prerequisites at the organisational and policy level. The results of the survey on the one hand demonstrate that there are certainly inspiring practices available at the client and client-provider encounter level, but that support at service and policy level is indispensable, more specifically:

- The availability of **continuous training and coaching** of professionals;
- **Having enough time for client contact and sufficient funds for training, quality of care and to reduce waiting lists.**

At the level of SUT and other services the emphasis in previous research (e.g. Noens, 2010, El Osri et al. 2012) and the presented empirical data is to focus on **outreach and networking** in SUT services. As mentioned by survey respondents and evidenced in international research (e.g. Guerrero et al. 2017) this change in perspective requires **leadership that is positive towards these changes**. Consequently, SUT services might benefit from:

- **Broadening the new network centred approach** (within the framework of article 107) by **including self-organisations**, **asylum centres, integration services and other services that** have more contact with MEM (sub)populations;
- Supporting and initiating *service wide diversity sensitive policy* by means of mandated 'diversity ambassadors' at four levels: identity of the organisation, staff policy, methods, target groups

At the federal and Flemish policy level, interviewees identified the following initiatives as relevant to SUT for MEM: the right to urgent medical care, the right to psycho-social support for refugees awaiting the decision of their asylum procedure, first line psychologists, the project 'refugees and asylum' and support to the 'Antenna mental health care' and the operationalisation of Article 107 of the Hospital law. Whereas the theoretical backdrop of these measures is applauded, the implementation side often appears to lag behind. Subsequently and to enhance the embeddedness of these initiatives, the following recommendations are made by the respondents:

- **Faster procedures** (follow-up and referral) for requests for psycho-social support by refugees awaiting the decision of their asylum procedure;
- **Long term** (as opposed to project based) – implementation of first line psychologists and broadening the indications they work with to illegal substances;
- **Long term** (as opposed to project based) implementation of 'trauma and asylum' support for recognised refugees in the centres for mental health;
- **Structural support** to interrelating the networks resultant of Article 107 of the Hospital Law with the integration sector and wellbeing services.

In conclusion (and as referred to in 7.7), combining the ecosocial and intersectional perspectives (De Kock, 2020; Krieger, 2014) allowed us to identify that barriers to treatment are not located at one or the other level (micro-meso-macro) (see i.e.: Scheppers et al., 2006).

Waiting lists for instance, as a result of insufficient funding, result in the fact that services feel unable to focus on or prioritise additional target groups such as MEM. A lack of funding on the governmental level results in a feeling of inability on the organisational level (meso-macro). Similarly, (potential) clients may not speak the language but professionals and services may be reluctant to work with them (micro-meso) because they have insufficient expertise and resources to work with these clients. In this case too, the barrier is not only located at the micro level of the client. Quite contrarily, the language barrier is far more complex because it consists of an intertwinement of micro, meso and macro constraints and choices. The same goes for the 'trust' phenomenon described above. Being excluded in a residential service (meso) based on insufficient

knowledge of the language may induce epistemic distrust on the part of the client. In other words, the client can lose trust in the treatment system (macro) because of experiences at the meso organisational level that will reflect back in the therapeutic relation (micro).

Whereas barriers are often attributed to the client (e.g. language, culture), the same barriers can equally be attributed to services and policymaking (De Kock, 2019a). This change in perspectives highlights the accountability of governmental and organisational policy making, besides only focussing on the responsibilities of targeted MEM populations.

8. Substance use and treatment among MEM in Wallonia and Brussel

Carla Mascia

The first parts of this section (from 9.1 to 9.4) describes the literature regarding substance use among MEM in Wallonia and Brussels. The literature on this topic is spare. Existing academic literature questions access to health and ethnic health more broadly (as opposed to specifically studying SUT). Moreover, scholars tend to focus on specific areas such as cities. This choice makes sense since MEM are mainly located in urban areas (as opposed to smaller localities) (Myria 2016) but it also carries the risk of overlooking non-urban areas.

The grey literature in turn is diverse: there are dissemination articles (Dauvrin Marie, Geertz Charlotte, Lorant Vincent 2010), public report (Stévenot et Hogge 2017), NGO reports (Pierre Chauvin, Isabelle Parizot, Nathalie Simonnot 2009) and a white paper (Deswaef 2015).

In addition, when it comes to organizations and professional practices, existing research tends to focus on hospitals (Marie Dauvrin et Lorant 2014; M. Dauvrin et Lorant 2016) or professionals with expertise in the field of migration and health (Marie Dauvrin et al. 2012; Priebe et al. 2012). While these studies do not directly address substance use and treatment among MEM, they do give us some necessary contextual insights.

Consequently, we introduce this chapter by the various contextualizing the Health in Wallonia and Brussels (9.1.1), presence of MEM in Wallonia and Brussels (9.1.2), diversity among patient and professional practices (9.1.3) and the policy framework (9.1.4). Sections 9.5, 9.6 and 9.7 are respectively based on semi-structured interviews with professionals, and an online survey disseminated in April 2019 to identify inspiring practices to increase reach of, acces for and retention of MEM in substance use treatment.

8.1 CONTEXTUAL ELEMENTS

8.1.1 The health status of MEM in Wallonia and Brussels

On the basis of data collected within the framework of the National Health Interview Survey (2013), van Roy and her colleagues (2018) studied the impact of the various factors on health and healthcare among non-Belgians. The report points out some regional disparities. It appears that, compared to Flanders, MEM in Brussels and Wallonia have significantly lower self-rated health: "*participants from Brussels (24%) and Wallonia (25%) are more likely to assess their health as bad than participants from Flanders (21.3%)*." (van Roy et al. 2018, 42). These disparities among regions are consistent with reported chronic disorders since less Flemish respondents (28.4%) reported at least one chronic disorder compared with respondent in Brussels (32.1%) and Wallonia (31.9%).

Regarding mental health, the report points out certain disparities among regions, especially regarding positive mental health and depressive disorders. Positive mental health is measured thanks to 4 questions ('did you feel cheerful', 'did you have a lot of energy', 'did you feel exhausted' and 'did you feel tired'). On this basis, a score is calculated and the higher is the score, the higher is the vitality. There is a notable difference between the average score of the Flemish respondents (64.71) and the Brussels (55.93) and Walloon (55.57) respondents. In addition, the probability of having a depressive disorder varies across regions: "*respondents from Brussels (17.5%) and Wallonia (16.7%) appear to be more likely to have a depressive disorder than respondents from Flanders*

(14%)" (van Roy et al. 2018, 56). However, there is no significant difference across regions in the probability of having an anxiety disorder or a sleep disorder.

Van Roy and her colleagues signal regional differences regarding alcohol use: participants from Brussels (7,8%) and Wallonia (7,4%) declared excessive alcohol consumption significantly more often than the Flemish participants (6,2%). Moreover, the authors of the reports point out that:

> "*The Brussels participants seem to have thought most often (26.9%) about reducing alcohol consumption compared to the Flemish participants (16.3%) and the Walloon participants (19.3%). The relation between regions and this idea is significant (p<0.001). Even after checking for the other socio-demographic variables, Brussels and Walloon participants appear to have had this idea significantly more often than Flemish participants (OR=1,869; p<0,001 and OR=1,237; p=0,018 respectively)*." (van Roy et al. 2018, 92).

8.1.2 Presence of MEM in Wallonia and Brussels

We only have a partial picture of the presence and repartition of MEM in Brussels and in Wallonia. Based on nationality, we have a – partial – overview of the presence of MEM in Brussels and in Wallonia. At the national level, the average of the presence of the foreign-born population is 20%. However, this is an average and there are disparities depending on the area. The foreign-born population tends to concentrate in cities such as Brussels and, in Wallonia, Liège, Charleroi and Mons (Myria 2016).

Moreover, existing research suggests that the repartition of MEM varies across regions: in 2017 migrants represented 45% of the population in Brussels and 15 % of the population in Wallonia (Lafleur et Marfouk 2019). While it is difficult to have detailed data about the repartition of migrants and foreign-born citizens in Wallonia, the IBSA (*Institut Bruxellois de Statistique et d'Analyse*) provides a detailed picture of the foreign population in Brussels. In 2016, almost one inhabitant out of three had a foreign nationality. These are mainly EU citizens (23% of the Brussels population) and third-country nationals represent 12% of the Brussel population. Moreover, almost half of the population (56%) had a foreign nationality at birth[98]. Indeed, if we look at nationality at birth, non-Belgian EU-citizens are most prominent: they represent 44% of the Brussels population while third country nationals represent 31% of the population (Hermia et Sierens 2017).

If we focus on the repartition of foreigners inside Brussels, it appears that there are significant disparities. The "poor crescent" (*croissant pauvre*) - the poorest districts of the Brussels Regions which are located in the northern and western inner neighborhoods and form a crescent around the city centre - tend to gather North Africans, sub-Saharan Africans (IBSA 2016a; 2016b). EU-15 citizens gather in west inner, wealthier, districts and south-west districts. Southern member states nationals (Italy, Spain, Portugal, and Greece) and nationals from neighboring countries (France, Luxembourg, the Netherlands, and Germany) represent almost 60% of EU nationals (IBSA 2016d). With the enlargement of Europe, the presence of foreigners from the new members state (mainly Romanian, Polish and Bulgarian citizens) has increased from 3,4000 in 1997 to 84,200 in 2016, contributing to further diversification of the Brussels population. These populations tend to live in the districts near

[98] These data rest on the first nationality registered by the National Registry, which is assimilated by the authors of the report on nationality at birth.

the European institution but also in a number of districts in the "poor crescent" areas and their northern and western neighborhoods (IBSA 2016c).

8.1.3 Diversity among patient and professional practices

Growing migrant population and intercultural situations

In Brussels and in Wallonia, health professionals are confronted with a growing number of intercultural situations: "*The majority of health professionals reported being exposed to intercultural situations more than once a week (33%)"* (M. Dauvrin et Lorant 2016, 4).

On this point the grey literature gives us some insights. In Brussels, the association of general practitioners (FAMGBT) raise various specificities of the Brussels Region in a white book (FAMGB 2013). In Brussels, diversity became important and is one element – with the number of hospitals and patient turnover - which impacts practitioners' practices. The white book highlights that Brussels is a region that faces poverty. Brussels for instance has an important population of homeless people and undocumented migrants. In 2009, more than half of the beneficiaries of the procedure that fund healthcare to undocumented migrants (Urgent Medical Aid "AMU") were located in Brussels (13,426 of the total of 23,360 Belgian beneficiaries). As raised by another report of FAMGB (FAMGB 2018), the precariousness of a constantly growing population, with an important migrant population result in a growing prevalence of medico-social problems and the corresponding care needs.

In Wallonia, according to a report of Cresam (2015) on access to mental health care for migrant populations, there was in the 2000s an increasing number of asylum seekers. Consequently, migrant-friendly initiatives were designed. Thus, initiatives were initially designed for the public of asylum seekers, which explains the dominant focus on asylum seekers. However, it is important to note that, despite the increase of the migrant population due to the arrival of asylum seekers, the migrant population remains a minority at the Wallonia-level: in 2015, 88,2 % of the mental health care patient are Belgian nationals and 80% speak French. When we focus on the mental health care structure dedicated to migrants, the population of asylum seekers rises to 50%. Moreover, we do not have the numbers but the report identifies an increase of undocumented migrants in the migrant-specific mental health structures (CRESAM asbl 2015).

Challenges with more diverse patient populations…

A study of mental health professionals across Europe, including professionals of Brussels, highlights the challenges professionals face with migrant clients: complications with diagnosis, difficulty in developing trust and increased risk of marginalization. Complications with diagnosis are considered by professionals as linked to language barriers, different belief systems, cultural experience and previous traumatic experiences. The difficulty of building trust, according to these professionals, is linked with a lack of trust regarding authorities and unfamiliarity with the health system (Sandhu et al. 2013). Moreover, as in the grey literature, two groups are considered as highly vulnerable: asylum seekers and undocumented migrants.

Undocumented Migrants and problematic access to Urgent Medical Aid

In 2009 a study of Medecin du Monde in Brussels reveals that 88,3% of undocumented migrants did not have access to health (Pierre Chauvin, Isabelle Parizot, Nathalie Simonnot 2009, 86). While in Belgium there is a procedure for granting access to health care to illegal aliens in Belgium, the Urgent Medical Aid, Medecin du Monde reveals in the same study that 58,% of undocumented migrants entitled to reimbursement for medical care in Brussels did not know it.

Moreover, the Urgent Medical Aid procedure is complicated and might be a burden to access to health for undocumented migrants. A Memorandum (2012) done by various associations list obstacles: lack of information and communication, difficult access to CPAS (organisms in charge of delivering Urgent Medical Aid), difficult access to care and the requirement of a residence which is problematic for homeless migrants. The memorandum also identifies a bench of good practices: providing online information in various languages or developing online applications, collaboration between CPAS and hospitals, establishment of collaboration agreements between the various actors involved in delivering care, providing temporary attestation or document in order to allow migrants who introduced an Urgent Medical Aid application to access to health care rapidly.

Moreover, the Belgian Heath Care Knowledge Centre (KCE) study Urgent Medical Aid and propose a reform of the system that can be summarized in nine point: facilitate the request for medical assistance, rationalize social enquiry, standardize the procedure, harmonize the treatment covered, rationalize the use of health care, facilitate the funding system, ensure continuity of care and medical information, improve communication, monitor care practices and costs (Roberfroid et al. 2015).

Undocumented migrants are not the only migrants that face problems related to their migratory status: asylum seekers too. A report (Hezukuri 2017) on access to mental health treatment in Wallonia reveals different barriers, such as language. One specific to asylum seekers is their location. They are hosted in the centre during the asylum procedure. Consequently, they have to leave the centre to access to treatment, which leads to a burdensome procedure. Consequently, various mental health structures specialized in migrants' needs go on site. Moreover, this public is mainly concerned by their asylum application and getting the refugee status. So, care is not their priority, which is difficult to handle for mental health care professionals.

… and (selective) responses

Despite the fact that the professionals interviewed by Sandu et allii (2013) raised language, belief systems and cultural experience as a barrier, these are not systematically addressed by professionals. Dauvrin and Lorant (2014) point that cultural competence is not a shared belief among health professionals in Brussels and Wallonia. Moreover, cultural adaptation covers a variety of dimensions (adaptation of communication, negotiation of values and health beliefs). Health professionals in Brussels and in Wallonia tend to consider that they have to adapt to language but when it comes to the other dimensions of cultural adaptation, health professionals do not consider they have to adapt. In other words, "attitudes to responsibility for the adaptation of health care depend on the nature of the adaptation required: when the adaptation directly concerned communication with the patient, health professionals declared they are the ones to adapt, but for cultural preferences the responsibility seems to fall on the patient's shoulders." (Marie Dauvrin et Lorant 2014, 7). This might be explained by four factors: the legislation that mention the obligation to communicate with patients but do not mention values, the training that does not deal with cultural competence, the organizational cultures and language problems (Marie Dauvrin et Lorant 2014).

The literature suggests that the solution to the challenges faced by health professionals and the lack of cultural sensitiveness should not be limited to the individual level but should also include the organizational, institutional and political level (Sandhu et al. 2013; M. Dauvrin et Lorant 2016). In this

respect, a study of cultural competences among health-care professionals in Wallonia and Brussels highlights the "findings partly support the hypothesis that healthcare staff were more likely to be culturally competent if their most central colleagues were culturally competent". (Marie Dauvrin et Lorant 2015, 207). Thus the authors of the study suggest an approach to enhance cultural competences that "identifying the most central individuals and training them in cultural competence" (Marie Dauvrin et Lorant 2015, 208)

The need to develop a health care system that is more aware of the diversity and challenges it is crucial. Indeed, difficulties to access to health care system for MEM lead to a situation of creation of "ghetto of care" within MEM concentrate, as it is already partially the case (Marie Dauvrin et al. 2012).

However, this is it not a black or with pictures. Certain elements that are benefic to MEM access to health. Studying addiction treatment of socially marginalized group in Brussels, Webel and her colleagues (2013) raised some point are positive: services accept self-referral which facilitates access to addiction treatment for socially marginalized group and Brussels has a high rate of a multidisciplinary team. On the flip side of the mirror, services are not completely free of charges and there are no group specific programs or services, which can be detrimental to access socially excluded group.

8.1.4 A complicated policy framework

The political, legal and administrative fragmentation is identified as a burden to the implementation of recommendations or policies aiming at reducing ethnic health inequalities (Marie Dauvrin et al. 2012). While Dauvrin (2012) and her colleagues highlight fragmentation at the federal level (e.g. the North-South divide), this applies also at the regional level. As pointed by an Eurotox report (Stévenot et Hogge 2017) , there is also a fragmentation of policies inside the South divide. There are various entities, which are partly competent and elaborated various plans is detrimental to MEM health. More precisely, the 6th reforms of the state, in 1992, decentralized heath competencies to the federal entities. Following this decentralization, the main francophone political parties concluded agreements regarding these new competencies, "accords de la Sainte Emilie", in 2013. Following, every federal entities are sovereign regarding these competencies but with a willingness to collaborate in order to guarantee the coherence of public health services between Wallonia and Brussels (Stévenot et Hogge 2017). Without going too much into details, let's have a brief overview of the situation regarding substance users or treatment.

The Brussels Region has a plan regarding prevention and health, addressing drugs and addiction: "Bruxelles Prévention & Santé". Parallel, Brussels francophone community (COCOF) has elaborated a program on health (Plan Santé Bruxellois). Consequently, the consultation between the authorities responsible for these two programs are core. Beside these two programs, the COCOF has elaborated another program: le "plan stratégique de la santé". This plan defined prior public, notably migrants (Stévenot et Hogge 2017).

When it comes to Wallonia, governments have been slow to address health and promotion of health: the focus was on economic and fiscal topics. In 2018, a new program of prevention has been elaborated. This program "Plan de prévention et de promotion de la santé" rest on the concept of « health in all policies ». One of the aims of this plan is to reduce social health inequalities, whereby

origins of patients might be addressed. Parallel to this plan, there plan the fight against poverty (plan de lutte contre la pauvreté) related to health inequalities. (Stévenot et Hogge 2017).

8.2 Understanding substance use and treatment among MEM in Wallonia and Brussels: a decade of research

Similarly, to the national level, there are few peer-review articles on drug use among MEM and substance use treatment in Wallonia and Brussels. This might be due to the difficulty to study ethnicity since there is no ethnic coding. As pointed by Lorant and Bohpal (2011, 236) "In Belgium, ethnic coding is spare. The Belgian Census had no question about ethnicity and the only available information is nationality or place of birth".

Due to the lack of literature on drug use and substance use treatment, this section do not make the difference between academic research and grey literature.

8.2.1 Non-nationals in treatment

Blomme et al. (2017) explores the representation of migrants and ethnic minorities in Belgian substance use treatment on the basis of an analysis of the Treatment Demand Indicator in the INAMI report (2012 and 2013). Their departure hypothesis was that the presence of MEM in substance use treatment should equal or approximate their presence in general society (Vanderplasschen et al., 2003, p. 19). Their analysis of the presence of non-Belgians in substance use treatment revealed differences between Brussels and Wallonia and among types of substance use treatment.

In Wallonia, similar to the Flemish region, there was an over-representation of non-Belgians in the medical-social reception centres (MSOC). There are twice as many non-Belgians in the MSOC (21, 8%) compared to their representation in the Walloon population statistics (9.7%). Such over-representation in the medical-social receptions centre contrasts with the representation of MEM in other types of services. Non-Belgian are underrepresented in outpatient services: they are 6,2 % in 201, compared with the Walloon population (9,7% in 2012). Non-Belgian are slightly represented in crisis services (15,1% in 2012 and 16,9% in 2013). Regarding therapeutic communities, data reveals a slight over-representation in 2012 (11.5% compared to 9.7%), but in 2013, data fell just below their average (8,7 %).

In Brussels, there is also an over-representation of non-Belgians in the medico-social reception centres. 72% non-Belgians in 2012 and 68,3% in 2013 find their way to medico-social reception centres, compared to a representation of 32,5% (in 2012) and 33% (in 2013) in the Brussels population. The authors note that the considerable representation of non-Belgians in MSOC contrasts with their scarce presence in other services. The clientele of residential services only had a representation of 20,2% (in 2012) and 28,1 % (in 2013) of people with another than the Belgian nationality. Outpatient services acknowledge the same tendency: 20,3 % in 2012 and 20,6% in 2013 patient had a non-Belgian nationality. 18,9% non-Belgians in 2012 and 31,5% in 2013 find their way to a crisis service.

Finally, in both regions, non-Belgians with a non-EU nationality are much more than non-Belgians with an EU-nationality

8.2.2 Non-nationals and injection drugs in Wallonia.

Sacré and her colleagues (2010) conducted a participatory research study on injection-substance users in Wallonia. The aim of the project was to identify discrepancies between treatment need and demand among injecting substance users in Wallonia. The goal was twofold: the researchers studied the needs of the services for injecting substance users and the needs of the users themselves.

In this research MEM are described as “hidden”. By “hidden” the authors of the report refer to substance users that are not present or less present in the services for various reasons: because the services do not match with their expectancies, they do not feel at ease, access to these services is problematic or they do not know of the existence of such services.

Researchers interviewed substance users in Charleroi and in Liège. Respondents were mainly men (77%), mainly from North Africa (58%) and Eastern Europe (15%); researchers interviewed few people who had just arrived in Belgium, most of the respondent were residing in Belgium at least 6 years (72%)). This public was in a highly precarious situation: most of them live in squat (50%) or in friends’ house (27%), are social beneficiaries (46%) or survive thanks to some “bricolage”(42%).

The interviews revealed that (undocumented) migrants who are injecting-substance users face high level of marginalization since drugs are taboo in some migrant communities. Thus, migrants face rejection by their “cultural” community. Moreover, they are stigmatized by the others: as migrants they are associated with criminality. Researchers point out a climate of social tension, allowing to lump together migrants, undocumented migrants and drug dealers. The authors note that injecting substance users with a migration backgrounds are more often poly-consumers compared to other groups (women, young). However, MEM substance users provide themselves with syringes in the same way as substance users: in pharmacy without a migration background.

However, the authors point out that the stigmatization of MEM substance users hampers their access to services and that they experience less support in their social networks. Moreover, the authors consider that MEM are highly exposed to risks and are not well-informed regarding harm reduction (reduction services).

8.2.3 Substance use in the Congolese Community in Brussels

The PADUMI (patterns of substance use among migrants and ethnic minorities) study (De Kock et al. 2016) intended to qualitatively understand patterns of substance use among various subgroups in Belgium. The research study used a community based participatory research (CBPR). In Brussels, the PADUMI research-team studied people with a Congolese migration background.

The researcher studying the Congolese community face high refusals rate due to fear of being reported to judicial authorities or the policies. Moreover potential respondent did not want to create a “bad image” of the community. Finally, many potential respondents did not consider themselves as substance users.

The interviews reveal that alcohol is among the drugs that are socially accepted while other substances (e.g. cannabis) are less tolerated in the Congolese community in Brussels. However, the misuse of alcohol is taboo, too.

Regarding the use of treatment and other facilities, information regarding treatment and facilities does not seem to penetrate the whole community. Interviews reveal, however, a difference between those who do not know existing services or treatment, those who do not want to go to services and those who have tried some treatment.

Interviews highlight specific barriers Congolese substance users in Brussels face. The first obstacle is the taboo surrounding drug use inside the community: in case of substance use problems, the issue is often kept secret. Shame and fear of being the subject of gossip are two other obstacles. Some interview also reveals that some respondents do not trust existing care facilities or consider that such services suit better people with a "white" culture. Other respondents also consider that they do not need help and substance use is not an issue. These various obstacles result in a lack of knowledge and information about the prevention and the signs of problem substance use.

The authors of the study conclude with specific recommendations for this community: there is a need for active prevention and to dissemination information about substance use treatment and facilities in the areas where Congolese people live. Moreover, there is a need to find Congolese community actors willing to deal with drug and alcohol issue. This requires some organizational help since the researchers notice that existing Congolese associations have very limited resources.

8.3 Empirical findings: the perspective of professionals

As mentioned in chapter 7.5, the main aim of the interviews were:

1. Understanding challenges and pitfalls related to the substance use treatment trajectories of MEM from the perspective of a provider and policy perspectives.
2. Identifying the existing practices addresses towards MEM.
3. Identifying professional's recommendations to local, regional or federal policy making.

The researchers defined a common interview guide from the Flanders and Wallonia. This interview guide was translated in French and Dutch. The full interview guide can be found in annex 2.

8.3.1 The data

Interview respondents

The researcher purposively sampled francophone experts (both professionals and policy staff members) via professional partner Fedito Wallonie and Fedito Brussel. We aimed at representativeness in terms of provinces, types of treatment (outpatient-inpatient, residential-ambulant), gender and professions in a sample of at least ten respondents.

IDENTIFIER	PROFESSION	ORGANISATION	Region
Respondent 1	General practitioner	Methadone Substitution Treatment, Independent	Brussels
Respondent 2	Coordinator	Medical Centre for substance users, prevention	Brussels
Respondent 3	General Practitioner	Network of general practitioner	Brussels
Respondent 4	Social Assistant	Network of general practitioner	Brussels
Respondent 5	Coordinator	Network of general practitioner	Brussels
Respondent 6	Head of Unit	Residential susbtance use treatment	Brussels
Respondent 7	Contact point	Prevention service	Brussels

Respondent 8	Nurse	Prevention service	Brussels
Respondent 9	Professor	University	NA
Respondent 10	Researcher and coordinator	Health promotion in Brussels	Brussels
Respondent 11	Coordinator	Health promotion in Brussels	Brussels
Respondent 12	Psychologist	Independent	Namur
Respondent 13	Psychiatrist	Mental health hospital	Namur
Respondent 14	Pychologist	Mental health service	Namur
Respondent 15	Social assistant	Mental health service	Liege
Respondent 16	Supervisor	Platform of migrant association, prevention	Charleroi -Mons
Respondent 17	Director	Prevention centre	Charleroi - Mons
Respodent 18	Director	Prevention centre	Charleroi -Mons

Table 36: Francophone Respondents

As a result, we interviewed 18 respondents during 15 interviews. Respondent 3, 4 and 5 as well as respondents 7 and 8 and respondents 10 and 11 were interviewed together. The interviews lasted between 50 minutes and 2 hours. Full representation of provinces or types of treatment services was impossible given that the short time frame (June 2019) of the interview period but also given the fact that professional did not answer to our request for an interview or did not show up during the appointment.

In Brussels, there is a lack of representation of respondents working in residential treatment. This might be because MEM substance users with a precarious legal status are mainly present in low threshold services, due to unconditional access policy of these services. Consequently, professionals working in residential centres were not identified (and did not identify themselves as having expertise with MEM substance users). Regarding the fact that there are no respondent working in hospital, this is due to a problem of recording. Interviewed selected and did an interview in workers of a hospital but the soundtrack of the interview was barely audible.

In Wallonia, there is an over-representation of respondent working in Mental Heal services. This is because there are five mental health services specialized in the therapeutic and psychosocial support of foreigners. Those are highly visible when it comes to the question of MEM service users' treatment. Moreover, as suggested by one respondent, MEM substance users with precarious legal status gather mainly in Brussels and are brought in contact with low threshold organization.

> Une des problématiques qu'on rencontre sur le terrain dans le bas seuil à Bruxelles depuis 15 ans c'est l'augmentation des populations issues de l'immigration clandestine ou non (respondent 2)

On the contrary, in Wallonia, it seems that professionals face MEM are mainly asylum seekers in reception centres. Those are referred by reception centres to mental health service. The imbalance

between Wallonia and Brussels regarding the MEM population and the possible link with the use of different services by this population remains a hypothesis. But it might explain the over-representation of respondent working in mental health services in Wallonia.

The aim of the research project was to identify the challenges and pitfalls related to the susbtance use treatment trajectories of MEM and the good practices to address such issue. It should be noted that only one respondent had a migration background.

Lastly, one should not that our research strategy targeted professional and services working with MEM. The experts were selected thanks to our professional partners who selected services in contact with MEM. This implies that our respondents were in contact with the federation for institutions for substance users. However, general practitioners working in the neighbourhood with a large migrant population are also (potentially) in contact with MEM substance users. Those professionals might not be present in networks of professionals specialized in substance user treatment. Due to the short time frame, research focus on professionals identified by professional partners. Consequently, the research strategy was not the most effective to select general practitioners working with MEM. To diminish this bias, the interviewer encounter members of a network of general practitioners.

8.3.2 Analysis and coding strategy

The analysis was a qualitative analysis, aiming studying the sense and logic rather than counting and quantifying (Paillé et Mucchielli 2016). The coding strategy was a thematic analysis in order to identify the various themes and examine it (Paillé et Mucchielli 2016, 236). The interview done in Wallonia and Brussels were coded manually, following a similar path to the analysis of the interviews done in Flanders.

First, all information in the interviews was coded following the content of the interview and inductive themes were added through the process of data analysis. At the end of this process, we had the following codes: public, consommation, parcours migratoire, situation sociale, langue, représentation, confiance, accueil, temps, prescription, se documenter, formation, disponibilité du personnel, GRH, financement, vie en communauté, exigences institutions, réseau, condition d'accueil, Urgent Medical Aid, Fedasil, institutionnel, loi, définition du soin, transnationalisation soins, enjeu santé publique, enjeu moral, initiatives, recommandations.

Second, all codes referring to pitfall and challenges were assigned to a micro-level (client or professional), a meso-level (SUT service) and at the macro level (health system or policies). The analysis done on these various codes and level aimed at linking pitfalls and challenges to opportunities and practices. Consequently, the codes referring to existing practices, ideas or recommendations to address these challenges were assigned to two other categories: inspiring practices and suggestions to policy level. This categorization allowed us to structure the results section.

Micro level	Meso level	Macro level	Inspiring practices	Suggestions
Public Consommation Parcours migratoire Situation sociale Langue Représentation	Confiance Accueil Temps Prescription Se documenter/ formation Disponibilité personnel GRH Financement Vie en communauté Exigences institutions Réseau	Condition d'accueil AMU (Urgent Medical Aid)Fedasil Institutionnel Loi Définition du soin Transnationalisation des soins Enjeu de santé publique Enjeu moral Initiatives	Initiatives	recommandation

Respondents were keen to talk about their difficulties but were – as explained below– reluctant towards a developing a specific approach for MEM users. This result in the lack of balance between the number of codes identifying pitfalls and challenges and those referring to inspiring practices and suggestions

8.4 Results

8.4.1 Results at the client and subpopulation level

Respondents were asked by interviewers to identify the characteristics of MEM populations present in their services and how it could – according to the respondent – contribute to problem substance use or the course of treatment trajectories. This question was targeted at identifying the characteristic of MEM population in term of nationalities, migration backgrounds and other specificities such as gender, drug use, and legal status. All respondents were reluctant to identify substance users according to their migration background and/or nationality. According to them, identifying characteristics of MEM substance users is dangerous since it might lead to categorizing a priori MEM substance users as specific.

> Moi j'ai envie de dire, il ne faut pas faire de différence. A priori sans doute que leurs besoins sont les mêmes que ceux de notre public, donc quand je réfléchis pour un toxico, je réfléchis pour un toxico d'origine belge, d'origine étrangère, 'fin pour moi, ils sont toujours enveloppés, quoi qu'il en soit, parce que des humains avec des besoins similaires. Après, s'il y a des spécificités à prendre en compte, parce

> que t'es migrant et qu'en fonction de ta culture, de tes habitudes, et cetera, et cetera, bah il faut arriver avec des choses plus spécifiques. (Le respondent 18)

During the interview, some differences among substance users appear. Respondents were worried about drug use or about access to substance use treatment for some groups of MEM. Respondents mention: undocumented migrants, asylum seekers, Eastern Europeans, Georgians, migrants coming from Maghreb. However, while respondents identify these various groups, they consider that the real characteristic of these substance users is not the migration background or the nationality but is the precariousness of the situation.

In this respect, respondents define the characteristic of MEM substance users and their specific need in a pragmatic way, making a difference between MEM who can find a way to get care and the others, who do not and requires attention. According to respondents, MEM substance users who have access to health insurance, who speak French or who manage to find a doctor who speaks their language are considered similar to Belgians. This might explain why the majority of our respondent did not mention second and third generation: they have legal status and speak the language or can rest on their community. Thus, they are not considered as facing different obstacles than Belgian substance users. The quote below illustrate this logic: MEM who manages to have access to care is not considered as different from nationals.

> On a un autre médecin d'origine espagnole qui travaille à...du côté d'Anderlecht, fatalement il a des patients avec qui il parle espagnol, donc fatalement dans le tas il y a des...voilà. Donc on a eu une série de patients comme ça d'origine étrangère, mais qui ont toujours été suivis exactement comme n'importe qui d'autre. On n'a jamais eu le sentiment qu'il fallait faire quelque chose de particulier. (respondent 4)

Consequently, the interviews focus on substance users that respondent consider as being in the situation of need. Respondents are more worried about vulnerable and isolated MEM drugs because they tend to face various barriers to access to health care. As explained by a respondent below migrant population recover a variety of profiles but what is challenging is that they have difficulties to access to care:

> Une des problématiques qu'on rencontre sur le terrain dans le bas seuil à Bruxelles depuis 15 ans c'est l'augmentation des populations issues de l'immigration clandestine ou non, donc les Européens, pas les mettre à côté hein, il y en a énormément: Portugais, Polonais, Français, des gens de l'Europe de l'Est et des populations d'Afrique du Nord, d'Afrique subsaharienne, de Syrie, des pays en guerre, et cetera qui sont en Europe en situation d'errance. Et par rapport à ces publics on a développé depuis 10 ans maintenant de l'expertise spécifique, donc ces publics étaient par ailleurs pris dans le cadre de nos conventions, mais posaient toute une série de questions aux équipes et présentent de par leurs caractéristiques toute une série de barrières hein, qu'elles doivent, qu'elles doivent traverser: barrière de la langue, barrière de l'accès aux soins, barrière culturelle, barrière économique, sociale, et cetera. (Respondent 2)

Vulnerability, administrative status and migratory career

Thus, despite these national differences regarding drug use, it is less the nationality or country of origin *per se* than vulnerability that is conceived as a central characteristic that might have an impact on substance use, treatment trajectories and access to substance use treatment by respondents. Consequently, interviews focus on substance users in the most precarious situations: asylum

seekers, undocumented migrants, homeless migrants, 'transmigrants' or posted workers. Asylum seekers and undocumented migrants were often discussed.

According to most of our respondents, vulnerability is linked to precarious administrative status. Being without legal status has dramatic consequences on migrants' lives, which impacts on drug use. Respondents working with undocumented migrants describe that, due to the absence of legal status, substance users have bad life condition, are excluded from the society and they lack opportunity to improve this situation. In this context, different respondents consider that drug is a way for undocumented migrants to support their living conditions.

> J'ai l'impression que c'est une génération no future. Je ne sais pas si tu les as vus, dans leur tête c'est "voilà je veux des papiers ici, je veux travailler ici, je veux me marier ici" et ils peuvent être dits 1000 fois "bah non ça ne va pas aller", non c'est voilà. Et puis leur seul moyen de survivre c'est un, c'est aller vers le rivotril pour le consommer. (Respondent 8).

Asylum seekers also face the consequences of the legal procedure. Respondents working with asylum seekers point that they have to wait for the decision of the CGRA. In the meanwhile, asylum seekers are hosted in reception centre, deprived of any control on their live. As described below by a respondent, such situation is detrimental to their mental health

> C'est pour la santé mentale, je parle. Déjà si on vous met 4 mois dans un centre communautaire, vous qui n'êtes pas victime de violence organisée ni rien de tout, et cetera, après 4 mois ça commencera à faire un peu, voilà. Mais si vous êtes là beaucoup plus, il y a une sorte de dépression qui commence à s'installer, mais qui est en lien avec cette sant', 'fin avec la vie communautaire. Et cette dépendance totale, que rien n'est décidé par toi. En fait tu perds tout le contrôle. En fait, vous avez passé, imaginez, 3 ans à survivre, vous imaginez l'énergie qui a été mise en place, et cetera, de vos ressources pour échapper aux bombardements, aux violences, aux viols, aux machins, et cetera, machins, machins, machins, tout le chemin vous avez tout fait, tout vu, vous arrivez enfin ici, ah... On vous prive de tous les trucs, des points d'appui que vous aviez eu, en fait. J'ai un monsieur qui m'a dit: j'ai l'impression d'être dans une voiture avec les mains liées au bord d'un ravin. Et j'ai aucun contrôle sur le volant (Respondent 14)

Asylum procedure and long delay are also pointed by respondents. Waiting for an answer from the CGRA is stressful and can worsen the mental health situation.

> Le délai est trop long, il y a du surtraumatisme quand les gens attendent depuis 2 ans et qu'on ne leur a pas encore répondu. (Respondent 13)

In addition, trauma is also raised by respondents. More precisely mental health professionals working with asylum seekers raise that they were also victim of trauma during their journey

> C'est des gens multi-traumatisés, y compris dans les gens de Gaza, ils ont vu ces bombes, qui ont vu des corps déchiquetés, des membres de leur famille qui sont morts, donc c'est de l'auto médication. Donc c'est une des caractéristiques du trauma (Respondent 12)

> Puisqu'on s'était rendu compte qu'il y avait beaucoup de traumas, que la migration était un problème psychique parfois et que ça peut déclencher des maladies et tout ça. (Respondent 13)

Language

Respondents identify various barriers to drug use treatment at the client level. While they do not weight each barrier in the same way, interviews' analysis reveals a consensus when it comes to language. According to a respondent working in residential structure, while language is not a prerequisite to be admitted in residential treatment, it undermines the ambiance among patients and lack of comprehension might be difficult to experience for MEM substance users. As our respondent explains, MEM substance users who do not understand the langue of other patient raise tensions:

> Dans certains cas, ce que vient traiter la drogue c'est un sentiment de persécution que peut avoir quelqu'un dans la vie en général, indépendamment de sa culture, indépendamment aussi du contexte que je dirais politique dans lequel son pays est pris. Le fait de ne pas parler la langue attise le sentiment de persécution. Quand quelqu'un parle arabe et que vous ne parlez pas arabe, et que vous êtes un petit peu susceptible, disons, pour dire les choses avec modération, très vite vous pouvez penser qu'en arabe il parle de vous et ça crée des problèmes et des tensions assez importantes, assez lourdes dans un hébergement qui fait que très rapidement, ça devient ingérable entre eux, entre les patients. Le problème n'est pas plus simple avec nous. C'est à dire, tant que tout va bien, ça va, mais ça va rarement bien pendant un hébergement. Il y a des choses à discuter, il était question de visite, des questions de sortie, et aussi à l'occasion des questions de consommation pendant le séjour à discuter, si on ne sait discuter de ça, je ne vois pas comment on sait dis… (Respondent 6)

While langue is considered as the first barrier, a respondent raise that it is not the main barrier. This respondent explains to us that even if language complicated the treatment, it should not be an umbrella to hide other organizational problems.

> La langue tu vois… c'est le premier frein, mais c'est aussi la première chose à laquelle on s'arrête, tu vois. Et donc derrière, tu dois aussi interroger "oké, mais vous êtes des acteurs de toxicomanie, vous vous inscrivez, vous avez signé la charte de réduction des risques, des anti-prohibitionnistes, vous avez une vision de la santé, c'est : qu'est-ce que vos institutions mettent en place pour dépasser ce frein?" C'est ça la question à poser. Là tu n'as pas beaucoup de réponses… Ah mais, les interprètes… Combien de fois vous mobilisez un interprète ? (Respondent 2)

Indeed, dealing with the language barrier requires additional work and/or organizational flexibility. Services can work with social interpretation service (SETIS). However, this is time and energy consuming:

> C'est un travail complexe au point de vue organisation, il faut commander l'interprète, confirmer et il faut que la personne... Parce que c'est différentes structures où vous êtes thérapeute, la personne vient d'une structure d'accueil où le service médical fait demande de prise en charge à nous. Mais vu que c'est eux qui payent, c'est eux qui doivent commander l'interprète, donc l'interprète se déplace sur nous, de chez nous. Et ça doit être confirmé pour l'interprète auprès de la structure. Vous imaginez si une personne est malade où il est en congé, tous ses trucs tombent à l'eau, ou bien vous n'avez pas de patient qui s'amène, vous avez l'interprète qui est là. Ou bien l'interprète ne vient pas, parce qu'il n'était pas confirmé, et nous on doit faire le lien entre tout le monde pour être sûrs que tel jour, telle heure j'aurai le patient et l'interprète. Juste cette organisation-là, ça me prend énormément de temps. (Respondent 14)

Besides working with an interpreter, our interviews reveal a variety of solutions developed by services with regard to the langue issue: respondents translate folders or rest on their own staff, use

translation web site or mobilize other patients that can translate. While it might seem a kind of "bricolage", it shows the ability of our respondent to find creative and flexible solutions to the language issue.

> Eux ils ont des plages d'accueil en Farsi et en Georgien. Et ils ont 2 moments dans la semaine ou dans le mois, je ne sais plus, où ils un après-midi médico-social avec un interprète et tous les patients qui parlent cette langue-là sont vus à ce moment-là quoi. Tu vois, dans un truc où ils peuvent un peu s'exprimer dans leur langue. (Respondent 2)

However, respondents working in the mental health domain consider that it is important to work with competent interpreters. According to them, translation in the mental health domain is really specific and requires specific competences. The interpreters should be able to listen to the difficult situation of patients and be able to report patients' feelings or declared symptoms. This might be difficult since words are not always totally equivalent in another language.

> Et pas seulement la traduction bricolée comme on fait quand on n'a pas moyens, un membre du personnel qui parle la langue, ça machin, il faut des traducteurs qui ont, qui ont été formés pour ça, franchement. (Respondent 13)

This does not mean that respondent working in other domains do not care about the person who translates. Respondents are attentive to the choice of the person who translates since the latter has a great power on the content of the discussion or the message. As described below, respondents chose carefully who translate:

> Et la première brochure que moi j'ai fait traduire en turc, je ne l'ai pas validée, parce que je n'étais pas tout à fait, tout à fait sûr de la personne qui me l'a traduit. Et comme moi je suis incapable de lire, je me suis dit « oh oh, non, on va trouver quelqu'un d'autre », quelqu'un en qui j'ai une confiance totale et absolue, ce qui n'était pas le cas de la personne, donc voilà. (Respondent 17)

Representation of doctors and drugs

Two respondents raise that language is part of a culture and words echo to cultural representations. A word means something in French, but the signification might differ in another langue. Thus, language issues also draw broader cultural representation of sickness, drugs, etc.

> Une autre spécificité c'est la langue. Tu travailles avec quelqu'un qui ne parle pas français, qui n'a pas le même repère culturel que toi sur ce que c'est être malade. Ce que c'est d'avoir des voix dans la tête. Ce que c'est de prendre un médicament ou de s'automédiquer, parce que ça fait 5 ans qu'il est en Europe, qu'il est nulle part. (…) Tu as la barrière de la langue qui est particulière. La barrière culturelle, sur qu'est-ce que c'est être malade, qu'est-ce que c'est de prendre un médicament. Il faut se rappeler qu'en Afrique, hein, un médoc ça s'achète sur le marché quoi. Il n'y a pas de médecins hein pour prendre du travail du tramadol ou du valium ça se paye au marché de... (Respondent 2)

Another respondent link self-medication and representation of medications: some MEM substance user consider that medication is not "bad" since they are given by doctors.

> Comment amener quelqu'un pour voir un médecin pour qu'il soit suivi, quand on a déjà du mal à lui expliquer que ce qu'il fait, c'est mal? 'Fin c'est mal, on se comprend quand je dis ça. Que c'est mauvais pour sa, que c'est mauvais pour sa santé et que finalement, ce n'est pas tant en tant que médicament qu'il utilise le produit, mais un… comme une drogue finalement quoi (Respondent 8)

Moreover, respondents, and mainly psychiatrist, raise that psychiatry is misunderstood by MEM substance users. Certain migrants consider that psychiatrist are for “mad” people and fear to be labelled as such. Consequently, migrants can be reluctant to go to a psychiatrist,

> Et très souvent, les gens savent expliquer et il faut savoir que dans beaucoup de pays aussi, ils préfèrent être considérés comme ensorcelés que d'avoir le diagnostic de fou, or quand ils viennent voir les psychiatres, ils se rendent très vite compte que nous on est les spécialistes des fous et donc ils ont l'impression qu'ils vont être étiquetés fous. (Respondent 13)

New/Unknown drugs and consumption

Another challenge is that migrants use drugs less known by professionals. As explained below by one of our respondents, MEM substance user is precarious situation might use cheaper substance.

> Ces migrants-là dont on parle consomment des molécules, ce n’est pas de la cocaïne, de l’héroïne, c’est trop cher pour eux. Donc ils s’assomment avec des produits pas chers ; de l’alcool, comme le cannabis, du rivotril, du lyrica, des molécules qu’ils connaissent (respondent 2)

Different drugs or drug use is a challenge for our respondents since they must adapt to it. For example, a respondent told us that they found that some eastern European migrants use bigger needles for injection. The needles they provide were not suitable and this public did not come. New consumption is not an issue *per se*, but as stated by a respondent below, they lack resources to adapt to it.

> Un groupe de migrants, sans doute d'origine slave, on avait identifié qu'ils étaient sans doute Roumains, était installé pas très loin d'ici, dans des tentes, des squats, et qu'eux consommaient on ne sait pas trop quel produit, mais en injection et pour avoir accès à des seringues, eux, ils les achetaient dans une pharmacie, parce qu'ils avaient que nous on existait, qu'on délivrait des seringues gratuites, mais le modèle de seringue que nous on délivre, ce n'est pas du tout le modèle de seringue auquel eux sont habitués. Parce qu'en Roumanie, ce sont des personnes qui consommaient déjà des drogues en injection, mais là-bas les seringues qu'ils utilisaient ne sont pas du tout les mêmes que nous on met à disposition. (respondent 18)

At the time of the interview phase, many respondents were struggling with migrants using benzodiazepines, e.g. medication. Some respondents tell us that sometimes migrants discover these medications during their migratory route.

> Le produit consommé à la fois chez eux, à la fois ici, parfois ils le découvrent ici, parfois ils le découvrent là-bas et entre ils se passent parfois des trucs. Autre chose c’est que tu as des des, des cas de consommation de certains produits comme le lyrica, qui sont induites dans les camps en Grèce. Donc quand un Érythréen traverse sur un bateau et que la moitié du bateau coule et se noie devant lui, qu’il raconte ça, il dit: ‘moi j’étais choqué, on m’a donné des médicaments’. Bah les médicaments qu’il reçoit, parfois il cherche à continuer à se traiter avec ces médicaments -là et donc on a des médicaments qui sont induits, ces nouvelles molécules sont induites dans le pays d’origine, sur la route de l’exil ou ici (Respondent 2)

8.4.2 Results at the provider level

Trust

Many respondents emphasize the issue of trust. According to respondents, building trust requires times but it also creates the necessary condition to speak about drug use. The respondent below

points that some front-line services are not only dedicated to drug use, thus building a relation of trust allow workers of these organization to dare to talk openly about drug use.

> C'est ça qui, c'est quand je dis entrer en contact avec la personne, c'est instaurer un lien de confiance assez fort que pour pouvoir après aborder cette thématique, parce qu'on entend que, bah voilà, il a demandé s'il y avait moyen de se voir, puis il a sous-entendu qu'il prenait du rivotril et tout ça, donc…(Respondent 8)

Two respondents note that building trust with substance users is not specific to MEM substance users. However, building trust with migrants or substance users with a migration background is more complicated.

> Comme avec les drogues heu déjà ce profil c'est des personnes qui peuvent être très marginalisées, qui sont dans la rue depuis des années, qui consomment et qui sont fuyantes aussi donc parfois il faut des semaines et des semaines et des semaines voir des mois ou même des années avant vraiment d'avoir une relation de confiance heu qui s'installe. Alors évidemment, quand on ajoute le facteur migration, c'est d'autant plus compliqué, je pense (respondent 15)

> Il faut quand même établir un climat de confiance beaucoup plus qu'avec un patient belgo-belge je vais dire. Il faut essayer vraiment de comprendre le trajet (Respondent 13)

The stake of trust is strongly highlighted by professional working with asylum seekers, often suffering from trauma. In this contest, patient might have difficulties to trust new doctors. A respondent suggests that trust is also linked with the difficulty for migrants to differentiate doctors from migration officials. Asylum seekers that are mainly in contact with migration officers and for them it is not clear who is a migration official and who is a doctor.

> Au début on a souvent, ils pensent qu'on fait partie de CGRA. Quand on leur explique, c'est avec le temps qu'ils, qu'ils deviennent moins méfiants et qu'ils comprennent que nous n'avons rien à voir avec le CGRA. Quand ils voient des caméras, et cetera, ils pensent qu'ils sont filmés en permanence. Et toute l'information va directement au CGRA, ils pensent qu'il y a plein de... 'Fin, ils viennent tous de pays un peu, un peu comme ça, pour eux c'est normal. (Respondent 14)

Another respondent underlines that MEM substance users suffer from discrimination and feeling of rejection and – sometimes – trauma. Consequently, building trust requires time.

> Ces gens ont souvent été renfloués, exclus, déjà dans leur culture souvent, dans leur pays, et donc la question de l'accueil pour moi, (…) , ces gens doivent raconter des choses traumatisantes souvent et il faut un climat de confiance, c'est… Il n'y a rien à faire, donc ça prend vraiment beaucoup de temps (Respondent 13)

Another factor is that MEM with a precarious resident permit are highly mobile. Asylum seekers might have to move from the reception centre to another, which result in the end of the collaboration with services outside the centre. This is counterproductive since this substance users had already built trust with a professional.

> C'était un jeune homme qui voyageait de centre en centre en fait. Et donc il avait eu une chouette approche avec un psy à tel endroit, mais on l'a rebougé de centre, on l'a remis à un autre, donc comment refaire confiance à quelqu'un ? Comment refaire du lien (Respondent 3)

Regarding undocumented migrants the situation is even more complex since there is – per definition – no records of their journey and they might be expelled. Consequently, they move to avoid police control and threat of expulsion. This is in turn detrimental for the care giver.

> On doit tisser des liens avec ces gens-là pour qu'ils puissent nous faire confiance, voilà. Mais le problème c'est que justement, avec… les personnes issues de l'immigration, c'est qu'ils bougent tout le temps. Par exemple, Il est ici à Charleroi, il se planque et dès que la police a localisé, il doit quitter, dans l'immédiat. Et quand il quitte, voilà, il doit changer de numéro de téléphone (Respondent 16)

Trust is not only a one-way relationship. Professional or staff might also have difficulties to trust substance users. This was mainly in the case of practitioners working with undocumented migrants or asylum seekers, in a context where they cannot establish a long-term relationship. When migrants ask for medical prescriptions, practitioners might refuse to do it because they do not trust migrants. For example, practitioners consider that the dose asked by the MEM substance user is too high and it might be dangerous. While this is clearly a matter of precaution and a good practice, the flip side is that it might also complicate access to health.

> C'est à dire des gens qu'on ne connaît pas, qu'on ne va pas revoir, donc pour lesquels on doit quand même prendre beaucoup de précautions, parce qu'enfin, ils n'ont pas du tout l'air de se rendre compte, mais les doses de méthadone qu'ils demandaient, 80mg, vous avalez ça, vous êtes morte hein Vous en avalez une, vous êtes mortes et ils en demandaient 10 ! C'est… Aucun médecin ne va jamais prescrire ça à quelqu'un qu'on ne connaît pas. Comment vous voulez faire ça? Quelqu'un que vous ne connaissez pas, vous savez qu'il est dans des conditions de merde, vous ne pouvez pas imaginer pire, et vous allez lui donner de quoi assassiner autour de lui 9 personnes et mourir avec? (Respondent 3)

Discrepancies between low threshold and the residential treatment

Low threshold services and psychiatrists interviewed highlight discrepancies between expectations of services. Low threshold services do not ask to stop drug consumption, since the priority is to reduce risky behaviours. Residential services might ask to decrease consumption, which can be problematic – or realistic - for substance users.

> À partir du moment où dans une institution spécialisée pour des toxicomanes, pour des alcooliques, vous exigez que la personne ne prenne plus de méthadone, vous fermez vos portes à toute une partie de la population des consommateurs en Belgique. (Respondent 6)

> Par exemple quand on regarde la méthadone, en fait dans les structures bas seuil à Bruxelles comme la MASS, Lama, DUNE, Transit, la méthadone est vue comme un outil de réduction des risques et un médicament qui stabilise la personne. Une fois que la personne rentre en cure, en post-cure, la méthadone doit être diminuée tout de suite et arrêtée en post-cure, parce que c'est considéré comme un traitement de substitution qui doit s'arrêter au plus vite possible. Et parce que ça s'arrête au plus vite possible, oui, qu'est-ce qu'il se passe, la personne rechute. Et donc, les cures par exemple, ça dure 3 semaines, et donc tu ne vas pas me dire que quelqu'un qui a 100mg de méthadone il va descendre jusqu'à 0 en 3 semaines, c'est intenable pour rentrer en post-cure. (respondent 8)

Stereotypes

Professional and frontline staff might also have a misconception of MEM substance users. Many respondents highlight that MEM substance users combine two negative stereotypes: they are substance users and they are migrants. As stated below, precarious migrants might be labelled as "difficult public".

> Donc c'est vraiment un public qui n'est pas sexy pour les équipes, que ce soit en santé mentale, en toxico, ou même ailleurs. Et je dirais même plus, moi je ne demande pas plus loin, je dis que c'est là, même pour les acteurs de la santé, c'est un public qui véhicule des stéréotypes. Et doublement. Non seulement, il est consommateur de drogue, mais en plus c'est un sans-papiers qui vient d'un pays en général musulman, qui est… on suppose qu'il va être agressif dans son entrée en matière avec l'institution. Et c'est vraiment des gens qui véhiculent beaucoup de stéréotypes dans la manière dont ils s'adressent aux institutions. (Respondent 2)

This issue does not only concern mental health professionals or health professionals but also pharmacist, social workers delivering Urgent Medical Aid, frontline volunteers. According to respondents, most precarious substance users sleep in emergency shelter and go to medical permanence for asylum seekers. Moreover, MEM substance users live a precarious life and face barrier language. Such situation of precariousness might result in displayed aggressiveness or conflict. However, pharmacists, staff and volunteers of reception centres are not prepared to deal with drug issues and tension arising from precariousness of substance users. This lack of knowledge might nourish the stereotype of 'difficult" substance users among professionals, volunteer or pharmacist.

> Donc on retrouve souvent chez ces patients des phénomènes d'automutilation, qui se coupent, ils se blessent, ils se griffent, le cas dont je te parle c'était un homme qui s'était cousu les lèvres, qui est arrivé avec du fil, tu vois, en consultation à Médecins Du Monde, qui demande des médicaments, qui veut ces médicaments tout de suite, parce qu'il dit "je n'en peux plus, je suis à bout, donne-moi mes médicaments", dans une langue qui n'est pas le français. Donc expliquer la souffrance, ne pas comprendre ce qu'il se passe, de la guerre, du clash, de l'agressivité, de part et d'autre, de la défense, du truc. Donc c'est souvent une situation qui pète à l'accueil, qui peut générer de la crainte dans un temps 2, un temps 3 chez les intervenants, de la crainte chez le patient, donc c'était… Ce ne sont absolument pas des situations détendues, fluides où le gars vient poser un truc, c'est tout de suite lever le bouclier. C'est des patients, dès que tu as passé le cap de cette demande en traitement, cette réponse médicamenteuse où tu les reçois, tu les entends, ça se, ça se détend très vite (Respondent 2)

8.4.3 Results at the treatment service level

Human resources

Some respondents consider that front-line organization lack of workers to deal with drug use. As described by a respondent, professional working with asylum seekers are confronted with high numbers of migrants. Thus, these front-line professionals attempt to do their best but lack of means to address the more complicated issue, such as drug use.

> C'est clair que les conditions de l'accueil sont vraiment déplorables, dans le sens où les gens défilaient deux par deux devant un médecin et une infirmière qui faisaient comme ils pouvaient. Ah oui, c'étaient 2 infirmières, c'est juste, même pas de médecin sur place, 2 infirmières qui font comme elles peuvent (respondent 5)

In the field of substance use treatment services, a respondent points that a major challenge is avoiding exhaustion of workers. MEM substance users are in a precarious situation, consequently workers have difficulties to find a solution and, consequently, might feel useless.

> Comment tu fais, dans une équipe, pour qu'une équipe ne s'essouffle pas avec un sans-papiers qui n'a pas de maison, pas de logement, pas d'institution autre que le Samusocial, la soupe populaire, et de

> temps en temps un séjour à Transit, pour tenir, tu vois. Qu'est-ce qu'il fait? Pendant 2, 3, 4, 5, 10 ans, qu'est-ce qu'on fait avec lui? Et ça, ça essouffle les équipes, ça essouffle les équipes. (Respondent 2)

Scarcity and diversity of funding

There is almost a consensus among professionals to point that there is a lack of financial resources implement initiatives or projects aiming at enhancing MEM substance users access to treatment. The respondent below explained that she noticed some specificities regarding drug use of MEM but she did not dare to look too much into it because she does not have enough resources to implement new projects.

> On a tout intérêt à se dire "oui, ne fouillons pas ", parce qu'on pourrait se donner l'envie et on n'a pas les moyens quoi (respondent 18)

According to one respondent after the six reforms of the state, funding has been allowed differently which result in a situation where professional struggle to find which institution might fund their project.

> [Le] fond Assuétude, qui était un fond bien utile qui a disparu avec la sixième réforme de l'état, qui était un fond qui était doté annuellement de 3 000 000 euros, je pense, ou de 1 000 000 euros, dans lequel on pouvait aller piocher hein, des projets, le matos, ce fond a disparu, c'est un problème aujourd'hui, parce qu'on ne sait plus trop vers qui se retourner pour soutenir ce type de projets, (Respondent 2)

This respondent also highlights that, at least in Brussels, migrant population is growing in Brussels, which results in a situation where organization lack of means to provide care to precarious migrants.

> L'équation c'est ça, c'est que malgré la rareté des moyens et le secteur dans un état de délabrement, mais pas que nous hein, au niveau des moyens… Alors ce serait mentir de dire que la dotation n'a pas augmenté, mais elle n'a pas augmenté suffisamment proportionnée à l'augmentation de la demande sociale. Tu vois, donc quand tu vois le budget Cocof en santé, sur ces 5 dernières années il a augmenté...il y a une augmentation. Donc on n'a pas d'austérité en santé à Bruxelles ou en Belgique, ce n'est pas vrai. On a une stabilisation, mais par contre on a une hausse des besoins de santé de la population et de manière très marquée à Bruxelles pour certaines populations et certains opérateurs aussi du coup. (Respondent 2)

Facing the lack of financial resources, respondents who launched project targeting MEM population acknowledge they find different sources of funding, sometimes being creative. Some respondents consider different institutions, such as the European funding or Foundation Roi Baudouin. While introducing projects to get funding might be a solution, this remains a precarious solution. A respondent point that these sources of funding are not stable ones and do not guarantee the stability of programs.

> Dans le milieu psychosocial, ce sont des projets de 1 ou 2 ans et puis après 2 ans, on ne sait pas si on va continuer, donc le personnel on fait quoi vis-à-vis de lui? Donc on a des gens, des patients qui sont dans une précarité psychique, sociale, tout ce que vous voulez, et vous mettez le personnel qui travaille avec eux en précarité aussi.(Respondent 13)

> C'est la difficulté des financements récurrents. J'en avais marre de chercher des sous, avoir des cacahuètes (respondent 12)

Other respondents raise that the problem is deeper, and they raise criticism towards the institutional allocation of resources.

> Le problème c'est que la coordination des services où chacun garde ses sous et ne dépend pas d'une mégastructure, ça ne marche pas. Parce qu'en fait le financement là, on ne touche pas à ça. Donc le mécanisme de financement en Belgique, qui est soit le financement de service, tout ce qui est plutôt psychosocial, ou pour tout ce qui est médical, c'est plutôt ce financement-là, n'encourage pas la coordination, point (respondent 9)

8.4.4 Results at the policy level

Lack of coherence at the institutional level

This point is linked with the difficulties to find financial resources to deal with MEM substance users. As stated below, various entities are partially competent regarding health care or drug use. This result in an institutional complexity which is difficult to address drug use issues in its various dimensions.

> Bha en fait, ce qu'il se passe, c'est que heu… donc t'as le niveau fédéral, t'as le niveau régional, le niveau communautaire et puis en région comme dans les communautés, t'as encore des sous-niveaux, je te disais en COCOF, t'as quelqu'un- nous ici on va s'occuper de se qui est réduction de risque prévention, notre collègue, de tout ce qui est pris en charge, et puis t'as encore un bout de la prise en charge dès que tu te retrouves dans des hôpitaux par exemple où t'es sur du niveau fédéral. Donc t'as une découpe comme ça, institutionnelle, ça c'est une chose. Mais ton problème de santé publique, si tu veux l'endiguée, lui il s'en cale de la découpe constitutionnelle. (respondent 10)

Lack of coherence among policies

Respondent also point that it is problematic to provide treatment to migrant substance users who are targeted by a (restrictive) migration policy. Many respondents point that migrants with a precarious administrative status face administrative violence, which is detrimental for their access to health. As described below, asylum seekers are hosted in reception centre, far from city centre and social contact.

> Pour certains c'était parce que voilà, ils étaient blessés, et cetera et pour pouvoir vraiment continuer leur chemin, ils ont dû prendre du tramadol ou je ne sais pas trop quoi, et cetera et devient accro. Ici ils arrivent, ils se retrouvent dans une situation de violence administrative. Enfermés dans des centres soi-disant ouverts, mais ils n'ont pas de ticket pour sortir de ce centre. Et pas d'argent pour acheter les tickets de bus. Ils ont 7 heures par semaine ou... Ça fait une belle jambe de dire que c'est un centre ouvert, mais s'il n'a pas d'argent, il ne sait pas sortir. Et seulement le centre est au bout du monde, il faut marcher 7km pour arriver au village le plus près. Tu n'es pas très motivé de sortir en tout cas (Respondent 14)

Moreover, the policy of reception centres regarding drug use is a real burden. Reception centres do not accept drug consumption. This raise various issues: prevention and harm reduction is complicated since, as explained below, talking about drug use and harm reduction means acknowledging it.

> Parce que les équipes sont un petit peu en difficulté, en difficulté par rapport à ça. Parce que la réduction de risques c'est aussi accepter la consommation quelque part et que si nous, on peut se le permettre, euh pour eux c'est beaucoup plus délicat. (…) Bah voilà et donc si eux commencent à faire éventuellement de la distribution de matériel ou de de de l'échange de matériel, ça veut dire qu'ils

> acceptent la consommation de la personne, qu'ils sont au courant de la consommation de la personne et qu'ils n'en font rien quelque part (respondent 17)

Second, this also raises the issue of disciplinary transfers for the MEM substance users. Transferring substance users in another reception centre is detrimental for the trust relationship among practitioners and asylum seekers and is a problem for the continuity of treatment.

> C'est que c'était un jeune homme qui voyageait de centre en centre en fait. Et donc il avait eu une chouette approche avec un psy à tel endroit, mais on l'a rebougé de centre, on l'a remis à un autre, donc comment refaire confiance à quelqu'un ? Comment refaire du lien, comment essayer de, d'instaurer un fil là-dedans, donc effectivement les politiques migratoires sont, ne sont pas dans...dans quelque chose de, du lien, en tout cas qui est notre façon de travailler qui est vraiment (Respondent 3)

Undocumented migrants have also difficult access to health since they are only entitled Urgent Medical Aid. Urgent Medical Aid guarantees minimum access to healthcare for people in an irregular residence situation and is delivered by CPAS (Centre Public d'Action Sociale) (Giladi 2018). However, respondent working with undocumented migrants are really critical of effective access to healthcare for undocumented migrants.

> C'est à dire pas d'AMU, pas de carte médicale. Tu donnes une ordonnance, et le type part avec ton ordonnance et il doit trouver 10 balles à chaque fois qu'il vient pour payer son traitement. Et s'il a besoin de neuroleptiques d'un examen, tu ne sais pas, parce qu'il n'y a eu… Donc c'est, non non, c'est… L'accès aux droits et la fictivité des droits en Belgique c'est cata, c'est dur. (Respondent 2)

Secure access to *Urgent Medical Aid*

As stated above, access to Urgent Medical Aid might be really difficult for MEM substance users without a residence permits. Urgent Medical Aid is delivered by the CPAS. Facing numerous Urgent Medical Aid refusals, a responded attempt to signal the problem the competent authorities:

> Ou au mois, là aussi, et ça c'est vraiment, 'fin c'est sur Charleroi, mais c'est dans d'autres CPAS aussi, il y a très régulièrement des refus d'aide médicale urgente qui sont totalement injustifiés, ça arrive souvent. Et j'ai interpellé l'échevine de la santé ici il n'y a pas tellement longtemps en disant justement "bon oké, la ville ce n'est pas le CPAS, mais qu'est-ce que la ville peut faire comme pression éventuellement au niveau du CPAS, parce qu'ils sont quand même bien à boucher hein". Pour dire qu'il faut que ça cesse. (Respondent 17)

Another service chose another way by attempting to set up an agreement with the local CPAS to secure access to health:

> Alors on essaye, mais moi, sur les, les, les AMU, ça fait 5 ans qu'on se bat pour voir une convention (…) . Mais maintenant, on a une convention avec eux, donc on les a remerciés et s'inscrit dans une logique de prise en charge de ce public-là (respondent 2)

8.4.5 Practices to enhance substance use treatment of MEM substance users

Respondents were reluctant towards a specific policy or unified set of measure targeting MEM substance users. Interviews results highlight that respondents consider that MEM should not be treated in a different way than Belgians and plead for a generalist perspective, where MEM specificities are integrated. They tend to consider that substance use treatment should be adapted

to the need of substance users and policy should be more oriented at facilitating access of MEM to existing structures. Thus, we found that, even if is not highly unified and visible practices, there are still inspiring initiatives to enhance access of MEM to health care.

Outreach

Mobile team

Mobile team are acknowledged as a practice which has proved to be an efficient. This allows reaching isolated MEM substance user.

In Charleroi, the Medibus gathers various services, which allows economy of scale. This is worthy for little services who often lack of resources.

> [l'equipe se] disait "allez, on est prêts à monter dans ce bus et à aller offrir de l'aide aux gens éloignés", mais on se disait aussi "oui, mais si on fait ça, on laisse tomber nos permanences au centre-ville et il y a de la demande et du besoin, donc à nous 2 tous seuls, ça ne va pas être possible, il faut qu'on trouve du renfort". Et on a trouvé renfort près d'une équipe d'éducateurs de rue, près du centre IST Sida et près du relais santé ici à Charleroi. Et donc, c'est parce qu'on se met à 5, chacun on peut détacher un peu de personnel chaque semaine, à raison des 2 sorties semaine, et on a choisi des lieux où on va retrouver les gens, donc les lieux où on va avec le bus. Et voilà comment on s'organise. (respondent 18)

Moreover, a side effect of the Medibus has been to strengthen collaboration between services.

> Je dirais qu'on a la chance ici finalement sur Charleroi, d'avoir mis entre autres le Médibus en place, parce que c'est un truc qui a été très fédérateur. On se connaissait relativement bien dans le réseau, et cetera, mais à partir du moment où on s'est réellement mis ensemble sur le terrain, ça nous a permis de très sérieusement renforcer notre collaboration. Et de mieux se connaître et de mieux connaître les ressources des uns et des autres et de pouvoir plus facilement en fait faire appel aux uns et aux autres (Respondent 17)

Beside the Medibus, there are various initiatives to enhance prevention inside asylum seekers in reception centre. In Charleroi, prevention services organize awareness campaign in reception centre. In Namur, the Center of Mental Health (SSM) developed in collaboration with the reception centre: they organized workshops with the staff of the reception centre and prepared a short list of questions to ask to newcomers to enhance early detection:

> Souvent ils envoient quand la personne vient demander. Mais les personnes fragiles ne demandent pas nécessairement. Ou ils demandent trop tard, c'est pour ça on a fait une séance d'informations avec, on a distribué un, un questionnaire qui s'appelle Protect, très simple hein, 4-5 questions, pour vraiment... Des questions précoces des personnes vulnérables qu'ils fassent un screening au début de quand les personnes arrivent au centre (Respondent 14)

Moreover, a psychiatric hospital developed the ELEA project. This project allows psychiatrists to reach asylum seekers in centers thanks to mobile team. This avoids asylum seekers to travel to the hospital only if they really need psychiatric care. This also contribute to building trust, which is a real asset according to the psychiatrist:

> Mais quand c'était Eléa, c'était devenu très fort les centres et là, je disais, mais moi, je ne vais pas me déplacer. Je veux bien qu'un membre de l'équipe d'Eléa se déplace pour aller voir l'analyse de la demande sur place, mais moi ce n'est pas possible, sinon je perds plus de temps en kilomètres, et donc globalement, depuis que je travaille là-dedans, ça fait 20 ans, les gens viennent, parce que moi je n'ai

> pas la possibilité d'aller, mais je pense que le fait d'avoir eu ce qu'on a eu… Eléa c'était une équipe mobile en fait, c'était une équipe qui a été pensée pour qu'on puisse aller là où sont les gens. Et on voyait déjà que ça créait du pré-lien. Ça c'est intéressant aussi, je n'y ai pas pensé, c'est quand ils avaient vu les gens une fois là-bas, puis les gens viennent ici, ils retrouvent la même personne, ils sont déjà rassurés. Ils sont… La même personne de l'équipe qui leur disait "bah bonjour, comment allez-vous blablabla", donc ça ça crée déjà de la continuité en lien, déjà de la confiance, et donc des équipes mobiles c'est vraiment génial. Ça c'est vraiment le pied hein. (Respondent 13)

Despite the promising results of this project, it was interrupted due to difficulties with funding. In Brussels too, other organization stop to collaborate with federal reception centre due to financial reasons.

> Donc ça c'est une des grosses critiques qu'on peut faire à Fedasil, moi je ne veux plus travailler avec eux. C'est qu'ils ne nous payent pas, ça on peut critiquer vertement, donc le délai de payement des opérateurs s'étale sur plusieurs années, sur des projets de 2016, 2015-2016, on est en 2019.(Respondent 2)

Community work

While it is not directly linked to substance use treatment, IST-SIDA launch a network of migrant association few years ago. The networks do not gather professionals but various associations and even churches. Building such network is time and energy consuming: it requires to identify the various community leaders, to meet them and convince them to join the network.

> C'est-à-dire que à chaque fois je devrais être au courant de ceux qui sont partis dans la région… et je devrais savoir la personne de confiance dans la communauté, dans chaque communauté, prendre son numéro de téléphone, à le rencontrer, expliquer, si il faut, re-expliquer et la troisième fois, j'ai essayé de regrouper tous les heu… les patrons de cafés, les commerces, a l'époque il y avait les cabines téléphoniques, là ça n'existait pas avec Whatsapp, tout ça. A l'époque il y avait les sites internet, donc toutes communautés elles étaient là-bas. Et moi, je devais trouver une place- je me suis fait une place, pour rencontrer les gens. C'est comme ça que j'ai créé mon petit réseau en mettant ensemble les chefs des églises, les chefs de cafés, les chefs des associations et les chefs des cafés. Mais, ça m'a pris beaucoup de temps (respondent 16)

Such networks are highly effective to reach migrants, even if they are not in the streets or sent to practitioners by a reception centre. Indeed, such networks allow to reach MEM who are not used to go to the doctors, it also allows to build trust with MEM and inside migrant communities.

> On travaille avec plusieurs associations, plusieurs structures voilà. Et ça, ça m'aide à avoir- à toucher le public (respondent 16)

Once a year, the organization gather all the association in a conference about the health of migrants. This year one of the panels was about drug use and treatment

Enhancing access to existing structures

While respondent acknowledges that there are various structures who provide substance use treatment, precarious migrants might fight to find their way. To address such issue, various low-threshold service launched projects.

In Charleroi, low threshold organization specialize in IST prevention work in collaboration with the other services. They take appointment for precarious patients and are always available by phone in case of need. Thus, they actively play an intermediary role between the patient and the services.

> Donc les gens nous appellent, nous on fait un counseling, on analyse la situation et puis on prend rendez-vous pour eux à Marie Curie ou on le dirige éventuellement vers l'autre hôpital ici à Charleroi. Et on là aussi en première ligne pour les demandes de traitements post-exposition. Donc quand il y a un risque sévère (…) C'est moi qui le reçois, puis qui m'arrange avec Marie Curie pour qu'il puisse avoir un rendez-vous infections, ou s'il n'y a pas d'infectiologue disponible, comme c'était le cas hier, bah je l'envoie aux urgences. S'il y a un problème aux urgences, ben c'est les urgences qui m'appellent, parce que je règle un petit peu la situation en quelque...que je vois et donc… Et pour pouvoir faire ce travail-là de la façon la plus correcte possible, j'ai envie de dire, le téléphone est ouvert 24h/24. (respondent 17)

Brussels, low threshold service goes a step further. It works with volunteers to smoothen contact with the various actors involved in care. Considering that highly precarious and isolated MEM substance users face many barriers, this service actively help substance users to get in touch with the various services. The aim is to make sure that the patient will effectively go to the various services, ease the various contacts and build a network around the substance user.

> Les fonctions d'accompagnateurs mobiles circulent d'un dispositif vers d'un dispositif d'accueil, d'un squat, à un centre ambulatoire. Donc ils font du lien, ils ont un caseload de patients qui est prévu, mais ils ne substituent pas aux missions d'accueil psycho-sociales des services. Sinon après, si tu as un travailleur DAS, s'il a 15 patients qu'il voit régulièrement, bah il ne voit que ces 15 là et donc, il doit avoir connecté ses patients au service existant et s'assurer que les services existants les prennent correctement en charge. Ça c'est le boulot d'un 'accompagnateur' (Respondent 2)

Enhancing network of practitioners is also possible for migrants in reception centres. A general practitioner network developed a project in collaboration reception centre in order to build networks of general practitioners close to reception centre. The aim of this project was to integration asylum seekers in existing networks of practitioners in order to facilitate their integration in the health system.

> Donc on s'était dit on va essayer de mettre ensemble, pour quand on a vraiment des idées comme ça, et l'idée c'est de faire des petits réseaux locaux d'une part et puis de mobiliser quelques médecins chez nous, qui allaient se rendre disponibles pour voir, pour libérer un temps de consultation à une heure précise pour pouvoir voir le patient (Respondent 3)

Sharing knowledge about drugs

As described above, migrants might have specific drugs and professionals can be lost. Moreover, workers in the reception centre also lack of knowledge about substance users. Two of our respondents developed guide or protocols about the specificities of drugs, treatment and migrants. These are useful for practitioners working in little organization, alone or with little resources to do research.

> Respondent 5 :On avait quand même élaboré tout un dispositif (…), on a mis tout en place, un parcours d'intégration, on a essayé de ficeler un parcours type de l'accueil, 'fin de l'arrivée des migrants à un centre d'accueil, 'fin de dispatching, jusqu'à son centre où il est re-dispatché. Et c'est un petit peu de…

> Respondent 3 : Oui, nos médecins ont écrit et ont passé des heures dessus de réunions ensemble, ils ont écrit un protocole avec vraiment voilà jour 1, on fait comme ça, jour 2 on fait comme ça, comment est-ce qu'on fait nos prescriptions? Est-ce qu'on vérifie, 'fin comment est-ce qu'on vérifie… Enfin, ils ont fait tout un protocole, un travail de je ne sais pas combien de pages, mais beaucoup.

Two other respondents put in place working group in which different services meet and find solutions to take care of MEM substance users, despite their specificities and the issue linked to it. Below, the respondent explains that he, with others, launched a working group to discuss the misuse of benzo by migrants in precarious situations.

> Donc aujourd'hui, avec la FEDITO on a pris une initiative au niveau du Lama, de mettre en place un groupe de travail sur les benzodiazépines, parce que (..) ces migrants-là dont on parle consomment des molécules, ce n'est pas de la, la cocaïne, de l'héroïne, c'est trop cher pour eux. Donc ils s'assomment avec des produits pas chers; de l'alcool, comme le cannabis, du rivotril, du lyrica, des molécules qu'ils connaissent et donc on a mis en place, avec tout le travail, pour que ce public-là puisse être pris en charge de manière égalitaire avec les autres patients. (Respondent 2)

Working together: interdisciplinary teams and 'intervision'

As mentioned above, migrants – especially undocumented migrants and asylum seekers- face various barriers and drug use is only a part of a more complex situation. To face this complexity, gathering workers with different backgrounds or gathering services is fruitful. Some respondent work with an interdisciplinary team: constituted by social assistants, practitioners and/or psychologists. Below, a respondent acknowledged the added value of working with psychologists and social workers.

> On avait déjà le psychologue, 2 postes en disant il nous faut des gens qui sont intéressés et la plupart qui ont postulé, ce sont des assistants sociaux qui avaient déjà des expériences, soit dans les centres, soit de travail avec des populations plus émigrées, plus étrangères et donc par hasard ça s'est fait comme ça. Mais ce n'était pas nous qui avions dit au départ. Mais à postériori je me suis rendu compte que c'était intéressant, parce que c'étaient des gens qui étaient déjà habitués à travailler en réseau, habitués à passer des coups de téléphone et à essayer de trouver des solutions et en plus ces deux-là, elles parlaient 3 langues chacune. Ce qui est, ce qui était très aidant. (respondent 13)

Another way to overcome the various barriers faced by precarious MEM substance users is to gather services in one place. This enhances access to health care for precarious substance users since every service is available and gathered in one place.

> L'idée est d'accueillir les publics les plus vulnérables dans une offre plus plurielle, pluridisciplinaire, intégrée, rassemblée dans une même entité géographique, parce que sinon, même si tu as un réseau waouw, super couverture de soin en Belgique, ben ta femme toxicomane migrante, elle ne va jamais mettre les pieds chez un gynéco si tu ne vas pas avec ou si tu ne délocalises pas une consultation de gynéco là où tu la reçois… L'intégration des soins, ça marche pour aussi permettre à ces publics très exclus des soins, très vulnérables, d'entrer en contact avec des professionnels de la santé quoi. (Respondent 2)

8.4.6 Some points for reflection

A respondent raised a point that attracts our attention since it synthetizes many of the complaints made by others during interview. This respondent told us that certain migrant are highly mobile, which is a challenge for national (or even regional) service user treatment and national health policies. These mobile substance users travel across different countries, encounter different health

care system and tradition, which represent a challenge for the continuity of care and for national professionals. The latter are used to prescribe a certain amount of methadone or other drugs and are surprised by the important dose of medication asked by migrants. Such demands might be linked to the national cultures of care:

> *C'est qu'on avait des patients, je prenais le cas de monsieur *****, qui est un Irakien, qui a fait les pays nordiques, Berlin et Bruxelles, et en 3 semaines le gars se heurte ou traverse 3 logiques de soins sur la même molécule et donc il ne comprend pas pourquoi c'est plus compliqué à un endroit ou à un autre d'avoir des barrières liées à la peur de soignant ou au tabou du soignant sur 'attention à telle molécule ou attention à celle-ci ou attention à celle-là'. (respondent 2)*

To address effectively such challenges this respondent pleads for a new approach of care. He considers that national services should consider the challenges linked to the mobility of their patient. Moreover, he pleads for the internationalization of networks, guidelines and good practices.

> *On pourrait imaginer aussi dans les cas de bonnes pratiques, c'est d'avoir des, c'est dommage que l'Angleterre c'est le Brexit, parce qu'on aurait pu imaginer des interreg sanitaires entre Bruxelles, Calais, Paris, qui sont les dernières étapes avant la Manche et les villes Ramsgate, Londres, j'en sais rien, parce que ces gens vont arriver dépendants là-bas, avec certains types de produits, certains types de molécules, donc d'assurer des relais quoi et de dire « ben voilà, quand tu arrives en Angleterre, tu as tel endroit, tel endroit, tel endroit, tu peux aller sonner, toquer et obtenir un traitement. Ne pas être paumer, être en manque… »(respondent 2)*

8.5 Survey results: Inspiring practices in Brussels and Wallonia

An online survey was set up and distributed by the project partners. This dissemination was intended to be directly broad and the survey was sent to actors not only in the specialized addiction sector.

The survey and the invitation message had been translated into Dutch and French. No eligibility criteria for completing the survey (e.g., respondent status in the evaluation process) have been defined, in order not to unnecessarily reduce the number of respondents. The standards applicable to eligible projects were indicated in the invitation message and in the introduction to the survey (available upon request to the first author).

The design of the survey questionnaire made it possible to design its results in the form of practice sheets including the name of the intervention, its objectives, its functioning, and the types of evaluations. Respondents were asked to complete one sheet per inspiring practice.

The French-speaking questionnaire began to be completed 34 times. An important drop out appeared, since the first exclusion criterion, namely the incompleteness of the survey, led us to eliminate 21 on the French-speaking side. One explanatory hypothesis is that many respondents started answering the survey before they fully understood its meaning, and eventually did not feel concerned by the questions. In summary, on the French-speaking side, 13 surveys were completed.

8.5.1 Respondent pool and inspiring practices

Among these 13 respondents were the gender balance was respected: 6 women and 7 men. They were aged between 30 and 56 years and 9 of them had over 10 years of experience in their domain of work. There is an over-representation of respondent working in Brussels: 8 are located in Brussels,

2 in Namur, 2 in Hainaut and one in East-Flanders. Regarding their position, respondents identified predominantly as a health care provider (5), social worker (2), care provide (1), researcher (1), unemployed (1). 3 respondents tick the box “other”. The practices developed were mainly implemented in Brussels (7 practices).

While it is difficult to draw conclusions or analysis from 13 practices, it still can offer us some insight on what is actually done (mainly in Brussels) for MEM substance users. The table below describes the main information the survey allowed to grasp.

Practice	Short description
No name (n+2)	Diapason developed collaboration with fedasil, intercultural mediation and adopted an unconditional access policy. Relais santé attempts to enhance access to Urgent Medical Aid (AMU), to provide to patient information about Urgent Medical Aid, support of patient, collaboration with CPAS, find a way to provide medication to substance users without Urgent Medical Aid, free consultations
Mobile team	The asbl Lama developed mobile team, outreach, formation and networking activities. The target-public is mainly asylum seeker, but the attention is also directed towards migrants.
Therapeutic interview	A Mental Health service receives migrants (even transit migrants and those waiting for legal status) and develops therapeutic follow-up, support and orientation of migrants or person with a migration background. The target public is intra-EU migrants.
Ergotherapy journalism	A person declares to mix journalism and ergotherapy and wrote on drug use.
Intercultural mediation	The hospital Brugmann (SPF Santé) developed intercultural mediation to enhance retention of migrants and, notably, refugee.
Medecine	Medical health centre ("maison médicale") in Brussels adopted an unconditional access policy. This centre provides curative and preventive treatment of health and mental health issue.
Psycho-medical treatment	Babel asbl receives unaccompanied minor. It provides support in various field (medical, administrative, housing, school issue). The Babel asbl works with interpreters and set agreement with SETIS (offering translation services). Workers attend to training regarding foreigners' right and medical care in context of exile and implement exchanges with Algeria and Tunisia
No name	The respondent, working in the mental health domain, declares he began the survey because he is sometimes in contact with migrants and face langue issues, trauma and precariousness of migrants. But he did not described initiatives to face these issues.
No name	Research (unavailable online) aiming at enhancing retention. The declared target group is refugee.
Folder and audio for newcomers.	The program of French course for adults (FLE) in the social cohesion service of Andenne work on the development of tools to learn French by migrants themselves: folders about various topic (health, CPAS, administration). These folders aims at helping migrant to formulate request in various context. These folders are translated in seven languages (Russian, Arabic, polish, English, Spanish, Albanian, Chinese), available in paper and audio formats. These folders will help migrants.
ELEA (Equipe de Liaison et d'accompagnement)	The neuro-psychiatric hospital launched an early detection and care programs for asylum seekers and reception. A mobile team of 3 workers (psychiatrist, social workers, nurse) was set up to reach asylum seekers and refugee in reception centre with mental health problems, including drug abuse. The aim was to facilitate access to mental health treatment and mental health services (outpatient and residential services). The ELEA project also aim to strengthen the expertise of reception centre and the various services (implementation of translation tools, knowledge of the legislation and trauma, knowledge in ethno psychiatry)
No name	The CeMaViE (Centre Médical d'Aide aux Victimes de l'Excision) is part of the Hospital Saint-Pierre. This centre specialised in the care and treatment of women victim of genital mutilation. The team has a multi-disciplinary approach. Beside medical treatment, the centre also do medical certificate for asylum procedure.
No name	Transit is a low-threshold emergency reception and accommodation centre. This centre adopted an unconditional access policy in order to reach precarious substance user: the centre is accessible without appointment and without requirements, neither administrative nor financial.

Table 37: Inspiring practices aimed at enhancing substance use treatment for migrants and ethnic minorities in Brussels and Wallonia

8.5.2 Insight in existing practices

Types of practices

It is not clear to what extent some practices will enhance reach, access and retention of MEM. Some respondent did not give sufficient information to understand the link between substance use treatment and their practices. However, some answers did provide useful insights.

What is striking is that, according to the survey responses, these practices (6) were developed mainly to address a gap or an existing need. Six practices were developed following the observation made by the service or the staff that nothing was done regarding migrant substance users. Similarly, 2 practices were developed to address the needs identify by migrants themselves. This suggests that existing practices targeting MEM substance users are developed from the bottom to address an institutional gap. Such hypothesis is consistent with the academic literature: there is not a lot attention at the policy level (Lorant et Bhopal 2011).

The need to address where mainly identified through observation inside the service (in 8 cases). Practices were thus mainly developed based on observation (in 8 cases) than the basis of existing studies (in 3 cases). While it is difficult to generalize from the 13 answers, we should point that, during the semi-structured interviews, one respondent regrets the missing link between research and practices.

> Des bonnes pratiques c'est aussi je pense, ne pas chaque fois réinventer l'eau chaude, donc c'est d'aller consulter des guidelines, des bases de données, des éléments sur lesquels tu peux essayer de modifier l'existence à partir de trucs qui ont déjà été identifiés il y a 15 ans par des chercheurs, donc c'est de fait vivre avec la recherche que vous vous faites à l'unif, de faire que ce soit un outil vivant au service des professionnels (répondent 2)

Our semi-structured interviews might help us to understand why there is a gap between existing research and practices inside services: there is a lack of incentive measures to build bridges between practitioners and researchers. All rest on the staff of the services and no funding is allowed to build collaborations.

> L'absence aussi d'incitants des équipes de participer à la recherche. Donc si vous voulez développer ou implémenter des innovations, il faut qu'il y ait une dynamique de recherche dans les équipes. Mais quelle est l'incitant d'un service ambulatoire ou hospitalier de s'impliquer dans la recherche, ça leur prend du temps (respondent 9)

Targeted public

The practices we gathered through the survey gather various MEM substance users. We should point out that none of the practices targeted second generation migrant. The practices targeted mainly substance users or migrant (10) and less professionals (2). Among these 10 practices targeting substance users, 3 target asylum seekers, 2 precarious substance users, 2 refugees, 1 European intra-migrants, and 2 newcomers who do not speak French.

This is consistent with our semi-structured interview: the MEM substance users are considered as requiring specific attention when they are in a precarious or isolated situation. Consequently, second and third generation are more assimilated to Belgian.

Aim of the practices

The practices aimed mainly at enhancing access to substance use treatment (5), improve retention (2) and improve service provider capacities (2). To reach these goals there is a wide variety of practices that are implemented: collaboration with FEDASIl, work with mobile team, cultural mediation, work with interpret or development of language tools.

8.6 Conclusion

The literature on drug use among MEM is sparse and there is no unified policy to solve ethnic health inequalities. The field of substance use treatment is no exception. However, our interview results highlight that this does not means that there is a lack of attention for this issue among services and professionals.

Our interviews reveal that our respondents were reluctant to target MEM as such, considering them "only" as migrants. According to our respondent, MEM substance users should not be treated in a different way than other substance users. However, our respondents acknowledge that precarious MEM substance user face various barriers to access to treatment. Thus, they focus on the precariousness of the situation and the barrier, rather than on the nationality or country of origin.

Such framing explains why existing practices target mainly precarious MEM substance users and aims, mainly, at enhancing access of these substance users to mainstream treatment. While this answer to an existing need (as suggested by our interviews and the scare literature), this leave aside the (potential) barriers faced by the second and third generation and by migrants that are not in isolated and precarious situations. In addition, the focus is on reach and the question of retention of substance users is not so problematized by our respondents. We should, however, be cautious regarding these two points since we had an under-representation of residential structures in our sample. It is not astonishing that our respondents, since they mainly work in the harm reduction domain and in frontline services, emphasize the need to reach people and not on retention.

Another important point is that it would be erroneous to consider that professionals and experts are blind to the difficulties faced by MEM substance users to access (substance use treatment) services. They identified during the interviews various challenges related to the situation and need of MEM substance users.

At the micro level of the clients, participants in the interviews noted that language is a barrier. While many respondents point out that they found solutions to overcome this barrier, it seems that there are different attitudes towards language issue. While low-threshold services seem to find creative solutions to deal with the language barrier, professionals working in the mental health domain rather focus on the quality of the translation and therefor prefer working with live interpreters, which is administratively burdensome and complicates access because of the organisational requirements (making appointment, waiting times etc.). Additionally, a respondent raised that the langue barrier might be problematic for residential treatment: when substance users do not speak French, it causes tension among residents. These different approaches concerning language and how to deal with it might explain why MEM who struggles with French tend to be overrepresented in low-threshold services where translation does not require burdensome administrative and organisational procedures.

Moreover, our respondents stress the level of precariousness of MEM drug users and link it with legal statuses and the (burdensome) administrative procedures precarious migrants have to go through to access health. In this respect, the unconditional access policy adopted by low-threshold services (mainly MASS / MSOC) might be a factor explaining the overrepresentation of MEM in these services. Our respondents also identify MEM substance users' representation (of drug and psychiatrist) as a challenge. Finally, another challenge in the treatment of MEM substance user is the kind of substance they use, those are often unknown.

At the level of the provider, the participants in the interviews noted that trust is key in successfully supporting (MEM) substance users. The latter suffer from discrimination, administrative violence and, sometimes, trauma. However, skills to deal with migrants such as cultural sensitiveness are not considered as central by many professionals (Marie Dauvrin and Vincent Lorant 2014) and our interviewees suggest that professionals rather develop these skills in their daily practices than by means of organisational support (e.g. training). Consequently, we suggest that frontline workers of low-threshold services (mainly MASS / MSOC) are more prone to develop such skills, since they are mainly in contact with non-Belgian populations(Blomme, Colman, et De Kock 2017). In the same line of thinking, professionals working in other services, facing less MEM drug users, might not or to a lesser extent develop such skills. As a result, MEM could tend to remain in low threshold services.

Moreover, our respondents point out that building trust requires time and it might be difficult to build trust with mobile MEM substance users. Mobility of substance users is worsened by the precariousness of the legal status. Finally, we should note that building trust do not only relate to the trust in the professionals. On the contrary, professionals may also have difficulties to trust clients, which impacts in the way care is delivered. Professional and frontline staff might also have a misconception of MEM substance users. According to the street-level bureaucracy approach (Lipsky 2010), sterotypes and categorization of clients are not only explained by individuals' ideas and consideration but also by broader organizational condition, as explained below.

At the level of SUT and other services, the lack of funding to efficiently deal with MEM drug user-specific need was raised by many respondents. This lack of (financial and human) resources covers various dimensions. Some of our respondents considered that the lack of means to implement long-term programs or initiatives jeopardises their work. Other respondents point out that the existing working conditions foster stereotypes among workers in their contact with migrants. This is in line with what has been described by scholars studying front-line workers in administration: because of a lack of resources, frontline workers tend to categorize the public and, on this basis, treat the clients they deem to be prior or more worthy to help (Lipsky 2010), potentially leading to high level of discretion in the provision of accessible health. As described by our respondents, MEM drug users are often victims of various stereotypes and are labelled as "difficult" patients by services. This can potentially explain why MEM drug users are underrepresented in certain services.

At the policy level, interviewees point out the discrepancy between the federal attempt to enhance access to health care for migrant drug users on the one hand and the restrictiveness of federal migration policy on the other hand. Restrictive migration policy prevents certain populations to access their rights, including the right to health care. This is most strikingly the case for transit migrants and undocumented migrants. Moreover, Belgium is a (complicated) federal states and

various bodies are (partially) competent when it comes to health and substance use treatment. Our respondents raise the lack of coherence among the entities.

Our respondents had elaborated and implemented various initiatives to address the problems. We should note that our respondents were reluctant towards a specific policy or unified set of measure targeting MEM substance users. Consequently, there are a wide range of practices, even if they are not highly unified and visible. Moreover, the interviews and the survey tend to demonstrate that these practices aim mainly a reaching and increasing access to general SUT. Mobile teams, collaboration with receptions centre are example of such practices. In parallel, our respondents also identify various practices targeting professional such as InterVision and sharing of experience.

However, there is a real stake: the stability of these initiatives. Indeed, our respondent raise the lack of coherence among policies (targeting mainly the restrictiveness of migration policy) and lack of resources. These factors hinder the development of long-term initiative to enhance access, reach and retention of MEM substance users.

9. Discussion and conclusion

Migrants and ethnic minorities (MEM)[99], especially refugees and asylum applicants (Horyniak et al., 2016; Karl-Trummer et al., 2010) but also intra-European migrants and persons with a second, third and fourth generation migration background are often more exposed to trauma and social inequality (Marmot and Bell 2016; Pickett and Wilkinson 2010; Verhaeghe et al. 2014; Boone et al. 2016) when compared to non-MEM counterparts. These are important risk factors for mental health problems and can influence problem substance use (EMCDDA, 2019).

Significant disparities in the provision of (mental) health care and substance use treatment for MEM compared to non-MEM counterparts have been documented extensively across the continents (M. Alegría et al., 2008; Saloner & Lê Cook, 2013; WHO, 2010a). However, these studies are limited in Europe (Dauvrin et al., 2012; De Kock, Decorte, Derluyn, et al., 2017; Derluyn et al., 2008).

A large caveat in literature and research is a lack of statistics about the presence of MEM in substance use treatment (SUT) because scientifically sound ethnicity related indicators, as studied in for example the educational (Agirdag, 2015) and labour domain (UNIA, 2017) and integration (Noppe et al., 2018) in Belgium, are not standardized in substance use treatment (De Kock, 2019b).

In the substance use treatment domain – as is the case in the other EU member states, Turkey and Norway – Belgium uses the European Treatment Demand Indicator (TDI), a European registration instrument that allows for comparing standardized data about service users entering substance use treatment across European member states (Antoine et al., 2016; Montanari et al., 2019). However, in the third TDI protocol (2012), the only migration related indicator - 'nationality' – was omitted. Consequently, this indicator was also omitted as an obligatory variable in Belgian national registries in 2015.

The first objective of the MATREMI project was to inform Belgian substance use treatment policy on how ethnicity and migration indicators are monitored in the EU-28 member states as well as in other policy domains in Belgium.

Research question 1: How can we better **register and monitor** MEM service user presence in Belgian substance use treatment?

[99] The use of the combined terminology 'migrants and ethnic minorities' is proposed by the European Regional Office of the World Health Organisation (WHO EU, 2010) and is equally used in the European ETHEALTH report for equal health and health care (Derluyn et al., 2011), the EMCDDA's review of drug prevention targeting these populations (2013) and the White Book on Accessible Health care (Suijkerbuijk, 2014). We have argued elsewhere that this combined terminology allows to consider 1) the individual history of migration, 2) the feeling of belonging to an ethnic group as well as 3) the societal denomination and categorization of belonging to such minorities (De Kock, Decorte, Vanderplasschen, et al., 2017). This conceptualisation takes Ford and colleagues' (2010, p. 3) proposition to define 'ethnicity' as "a two-dimensional, context-specific, social construct with an attributional dimension that describes group characteristics (e.g., culture, nativity) and a relational dimension that indexes a group's location within a social hierarchy (e.g., minority vs. majority status)" a step further in proposing three instead of two dimensions. These three aspects (individual migration experiences, subjective belongingness, societal denomination) are especially important in studying problem substance use in these target groups because they allow for a layered understanding of the aetiology of problem use and help-seeking behaviour.

- Which migration and ethnicity related indicators are used in 1) TDI registration in the EU members states and 2) the domains of labour, integration and substance use treatment in Belgium?
- Can we use the identified registration methods to inform registration in Belgian substance use treatment, and more specifically TDI?

Second, streamlined action in substance use treatment policy and practice within the framework of an integrated and integral drug policy have not been implemented in Belgium yet (*Een globaal en geïntegreerd drugsbeleid voor België. Gemeenschappelijke verklaring van de Interministeriële Conferentie Drugs*, 2010). Moreover, the 2015-2016 EMCDDA prevention profile, considers Belgium as a member states with 'limited preventive efforts targeting migrants'. Additionally, an EMCDDA background study reports that substance use treatment is generally not prioritised in delivering healthcare to newly arrived asylum seekers (Lemmens et al., 2017).

The second MATREMI objective was subsequently to identify inspiring practices in or aimed at substance use treatment to increase reach and retention of and accessibility for (potential) MEM services users in Belgian substance use treatment.

Research question 2: Which inspiring practices in the EU-28 member states and Belgium in particular, exist to increase substance use treatment reach and retention of and accessibility for specified (potential) MEM service users?

- How do SUT professionals experience service delivery among MEM?
- What are the main goals: reach, access and / or retention?
- Which are the targeted populations?
- In which domain are these practices located (prevention, treatment, harm reduction)?
    - (how) Are these practices evaluated?
    - Which caveats can be identified and translated into recommendations for research, policy and SUT practice?

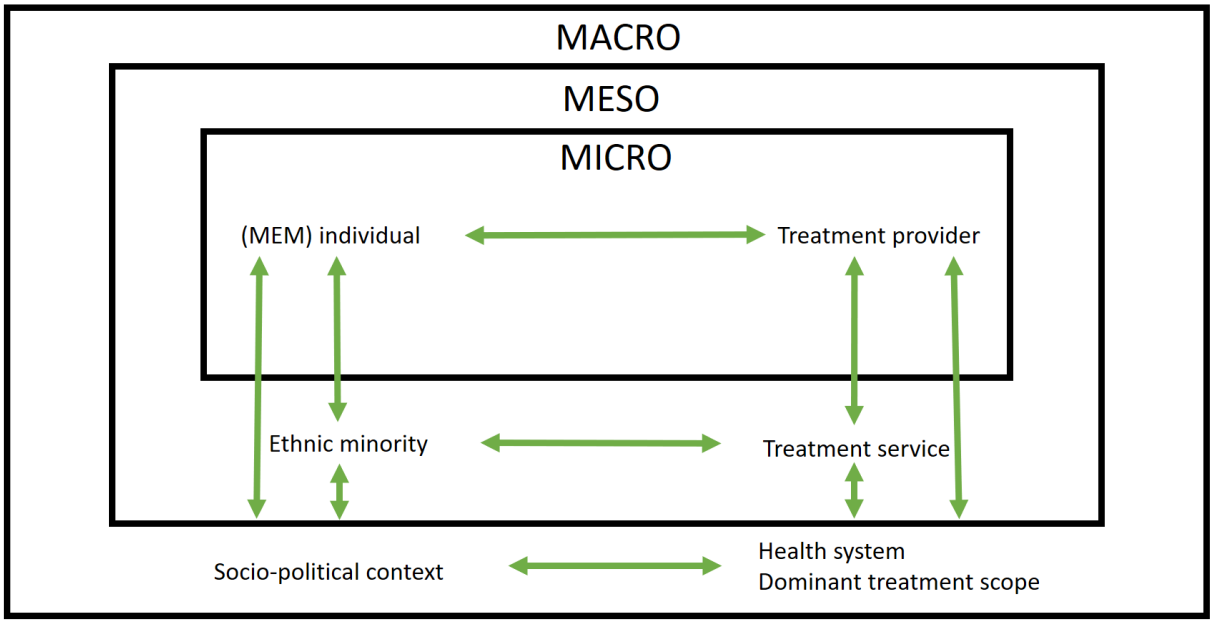
Several methods were used to answer these two main research questions over a period of 8 months:

- **Two European online surveys** (April 2019) to identify, on the one hand, ethnicity and migration-related indicators and, on the other hand, inspiring practices in substance use treatment;
- **Two Belgian online surveys** (in Dutch and French) (April 2019) to identify inspiring Belgian practices;
- **A targeted and narrative overview of literature** (May 2019) of Belgian and European (grey) literature on prevalence of substance use and treatment (2009-2019).
- **An e-mail survey** (August 2019) addressed to all Belgian substance use treatment services subsidised by the Federal Institute for Health Insurance (INAMI / RIZIV) to identify the registered migration and ethnicity related indicators.
- **Semi-structured qualitative interviews** with 32 professionals (June 2019) in Belgian substance use treatment to identify pitfalls and inspiring practices in substance use treatment.

The results of our empirical work are summarised below. We start out by outlining the results concerning registration (of migration and ethnicity related indicators) (9.1), followed by an evaluation of the state of (mental) health among MEM in Europe (9.2). Next, we discuss the knowledge about prevalence of substance use among MEM in Europe (9.3) and Belgium (9.4). Then,

we move on to discussing substance use an treatment among MEM in Belgium (9.5). Next, we discuss our empirical findings among professionals in substance use treatment in Flanders (9.6), Brussels and Wallonia (9.7) based on semi-structured interviews and at the background of the identified (grey) literature. Lastly, we summarise briefly the results of the European survey on inspiring practices to increase reach, retention and access for MEM in European substance use treatment (9.8).

This study departed from and equal rights and ecosocial perspective (Alegría, Carson, et al., 2011; De Kock, 2020; De Kock, Toyinbo, et al., 2020; Krieger, 2011). This means that we studied discrepancies and disparities in substance use treatment at three levels: the micro (client, provider), meso (service, ethnic minority) and macro (policy , dominant perspective on 'good treatment') perspective. We depart from the premise that equitable access consists of (i) equal access for equal needs, (ii) equal treatment for equal needs, (iii) equal treatment outcomes for equal needs (Dauvrin et al., 2019; Starfield, 2001).



An ecosocial perspective on problem substance use and treatment among MEM: adaptation from Krieger and colleagues 2013 (Epidemiology and the People's Health) (De Kock, 2020)

You can find more information about the theoretical backdrop as well as the full MATREMI results in the MATREMI report and in the practice oriented '*Wegwijzer voor een toegankelijke en interculturele drughulpverlening / Recueil sur l'accessibilité et l'interculturalité des services pour usagers de drogues'* (online via www.belspo.be and in book format via www.gompel-svacina.eu).

We conclude this summary with concrete recommendations at the Belgian / federal level, at the level of the regions and at the organisational level of substance use treatment. These recommendations are based on our results and previous studies.

9.1 Registration of migration and ethnicity related indicators

Planning substance use treatment in national and local health settings is ideally based on the availability of accurate data on at least treatment need and treatment demand. Modelled analysis of

this type of data allows to identify 'treatment gaps'. Treatment need is defined as the presence of a diagnosis for which treatment is available whereas treatment demand reflects the population that wants treatment (Ritter et al., 2019).

The treatment Demand indicator (TDI) is the largest reliable drug-related data set in Europe (Antoine et al., 2016; Montanari et al., 2019). It informs about met (Ritter et al., 2019) treatment demand[100] (as opposed to unmet treatment demand). Treatment demand, one of the five key epidemiological indicators of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), allows to get insight in the number and profile of people entering SUT (Montanari et al., 2019).

TDI was introduced in Belgium in 2011 (Antoine et al., 2016). TDI registration of treatment episodes within Belgian substance use treatment (SUT) services subsidised by the Federal Institute for Health Insurance (INAMI / RIZIV) are collected and processed by the REITOX national focal point (Sciensano) since 2011.

A survey disseminated to the EU-28 Reitox National Focal Points with a response rate of 68% demonstrated that in national TDI registries across the EU-28 member states one third of the countries registers nationality. The following indicators were also registered in at least four member states: birthplace, EU/non-EU, ethnicity and nationality at birth. (De Kock, 2019b)

If we look at migration and ethnicity related indicators in other European surveys – such as the European Labour force, health and social surveys (ESS) and EU-SILC – they additionally use indicators concerning birthplace of mother. The International PISA questionnaire in turn includes language related questions (mother tongue, home language) besides country of birth (of mother and father). The Generation and Gender survey (GGS) uses a combination of birthplace, mother's birthplace, nationality, nationality at birth, naturalisation as well as religious participation and belief.

The Flemish migration and integration monitor in turn gives an overview of integration trajectories, employment, education, housing, poverty, health and social participation. It is mainly based on data in STATBEL, Eurostat, the Labour market data warehouse of the Crossroads Database for Social Security and other administrative data sources (Noppe et al., 2018) (see below for specificities in the health domain). The additional Flemish study 'living together in diversity' (*Samenleven in Diversiteit*) (Stuyck et al., 2018) reports on employment, housing, education, religion, family, language, integration, social identity, perspectives on diversity, public spaces and health. It uses the following indicators for migration background: birth country, current nationality, birth nationality, nationality father and mother, birth country father and mother, duration of stay in Belgium, reasons for migration.

Concerning registration of migration and ethnicity related indicators in Belgian substance use treatment, an e-mail consultation to all services subsidised by the Federal Institute for Health Insurance (INAMI / RIZIV) with a response rate of 28% identified several other registration systems besides TDI such as the Electronic Patient Files (EPD) used by the centres for mental health (CGG),

[100] The first actor who defined a common protocol for collecting data on people entering substance use treatment was the Pompidou Group (PG), who coordinated studies at city level (in Dublin and London in 1991) and a developmental project in 11 cities and the creation of a European expert group which met several times to discuss and agree the methodological guidelines. (TDI protocol 3.0)

CIS (VVBV *Vlaamse Vereniging van Behandelingscentra Verslaafdenzorg*), MSOC.net, Digipolis, OBASI registration and MPG / RPM (minimal psychiatric data). Important to note is that some of these registers are not (only) used for administrative or epidemiological purposes but that they also serve to store and share client files across or within services.

However, the type of data envisaged by TDI is administrative and epidemiological in nature (as opposed to data used for client evaluation and follow-up) and is not the subject of the recent legislation concerning data sharing across professionals. The above-mentioned registers allow to varying degrees to monitor ethnicity and migration related data (e.g. EPD, CIS, MSOC.net). However, the used indicators are often not sufficiently discriminatory (e.g. 'origin') and are not harmonised across services. Consequently, comparability in and between service or at the health system level is complicated.

Based on our review of indicators we propose to include in the TDI dataset a minimum, medium and / or in-depth indicator.[101]

- Minimum (2 indicators): nationality, country of birth (with ISO 3166 answer options with a repetition of these nationalities for double nationality)
- Medium (4 indicators): country of birth, country of birth mother & father (with the same answer options used in the minimum indicators)
- In-depth (7 indicators): Language spoken at home, language most commonly used, third language (with PISA answer options)

Based on a review of the GDPR application in this domain we conclude that, although this is sensitive data and the patient should be protected at all stages of data gathering, processing and analysis, this type of data processing is not prohibited by law (Farkas, 2017b). We subsequently propose to include reliable indicators in TDI but also in other drug use and treatment related registers and surveys, to broaden and specify purpose specification of the national TDI protocol by including a similar aim as included in the Public Health England data collection protocol: "to protect and improve the nation's health and wellbeing, and reduce health inequalities", besides its current epidemiological goal. Moreover, guidelines for professionals need to include this purpose specification to obtain informed consent.

Additionally, to be in line with GDPR and privacy legislation and to enable disaggregated analysis data should be processed anonymously which implies that the use of a (pseudo)anonymised identifier instead of a national identification number (NIN) needs consideration. Furthermore it will be useful to harmonise these indicators across data registries and surveys with the eye on multi-indicator analysis for tiered substance use treatment policy planning.

9.2 State of health(care), access to health and substance use treatment in Europe

During the last decade, the World Health Organisation has been at the forefront in sensitising governments concerning migrant and ethnic minority health and the need for health system adaptations.

[101] Because in Belgium persons can get a 'double nationality' the proposal for Belgium differs slightly from the European proposal as formulated in (De Kock, 2019b).

At the European level several projects aimed at monitoring and enhancing migrant health (services) (e.g. CARE, AMAC, CLANDESTINO, EQUI-HEALTH, HEALTHQUEST, EUGATE, HOME, MIGHEALTHNET, NOWHERECARE, RESTOR, SRAP). **Unfortunately the results of many of these projects are not fully or publicly available and it remains unclear whether recommendations have been implemented.** Moreover, little to none of these projects (besides SRAP) focussed specifically on substance use treatment for MEM but rather on broader health issues.

We identified two interrelated themes that might lead to service disparities: **lower access to health** for some MEM, higher prevalence of risk **factors and social correlates** for both substance use and treatment disparities. Also, two target groups stand out as particularly vulnerable to problem substance use and low access to treatment: (undocumented) **refugees and Roma populations**.

Concerning access to health care, a comparative study of the right of access to health care for undocumented migrants in the 27 member states (Cuadra, 2012) demonstrated that in 2011, only 5 countries granted undocumented migrants the full right to access care that is more extensive than emergency care. An analysis within the framework of the QUALICOPT project (Hanssens et al., 2016) demonstrated that within 31 European countries, people with a migration background felt disadvantaged during the health care process. A systematic review (Hanssens et al., 2016) demonstrated differential utilization of somatic healthcare services by first generation migrants compared to non-migrants in Europe. Lastly, Detollenaere and colleagues (2017) found that in European countries income inequality, primary care work force development as well as accessibility of primary care are significantly related with **inequity in unmet healthcare needs**. Moreover communication barriers result in a lack of knowledge and trust and contribute to underutilisation, lower care continuity, lower satisfaction and subsequent treatment success rates (e.g. Mangrio & Forss, 2017).

Concerning risk factors, The WHO report on migrant health in Europe (WHO, 2018) sums up the following risk factors that are considered as morbidogenic conditions related to migrant health (Lindert & Schimina, 2011; Puchner et al., 2018; WHO, 2010b): **transit and travel conditions, mode and duration of travel, loss of family and friendship networks,** (Acculturation and / or post-traumatic) **stress**. Migrants and ethnic minorities, especially refugees and asylum applicants but also intra-European migrants and persons with a second, third and fourth generation migration background are for example more exposed to trauma (Karl-Trummer, Novak-Zezula and Metzler 2010; Horyniak, 2016) and social inequality when compared to non-MEM counterparts. Missine and colleagues (2012) in their research of 23 European countries noted that MEM have more depressive symptoms compared to persons without a migration background.

A large scale Dutch study nuances that it may rather be current stress and lack of resources in the host country on top of traumatic stress that leads to PTSD and depression among mental healthcare-seeking refugees (Knipscheer et al., 2015).

Roma – the largest ethnic minority in Europe – in many eastern European countries do not have (sufficient) access to health services due to structural discrimination. The existence of institutional discrimination in for example Romania has recently been corroborated by the European Court of Human Rights (ERRC, 2019). The second European Union Minorities and Discrimination report (FRA, 2017) observed that Roma respondents experience the highest rates of discrimination in access to

health compared to other national and ethnic minorities. The highest rates were recorded in Greece, Romania, Slovakia and Croatia[102].

The SRAP report (2012) identifies three main types of barriers to health services for Roma: **administrative barriers** (lack of entitlement), **barriers related to orientation to the health system** (continuity of care and finding the right services) and **lack of access to information**. The SRAP study concludes that **poverty, segregation, low access to education, employment and health services** are important risk factors that contribute to substance use in the six studied Roma communities in Italy, Bulgaria, Romania, Spain, Slovenia and France.

In the consulted international literature we found little references to state funded research projects specifically aimed at substance use treatment for migrants and ethnic minorities (De Kock, Decorte, Schamp, et al., 2017; Ostergaard et al., in review; Salama et al., 2018; Stoever & Hariga, 2016).

9.3 Substance use among migrants and ethnic minorities in Europe

Our analysis of the Reitox national drug reports (2012, 2014) demonstrates that in the EU-28 countries the following MEM populations were identified as requiring extra attention in substance use treatment:

- Roma in mainly central, Eastern European and Baltic member states,
- Russian-speaking populations in neighbouring and other EU countries,
- non-nationals in mainly Northern and Western EU member states.

Northern and western EU member states did not focus on intra-European migrants including Roma or on (undocumented) refugees. This is surprising because these populations have been growing during the last decade.

Concerning substance use prevalence among refugees little studies have been conducted in Europe (Priebe et al., 2016). Horyniak found that prevalence estimates of hazardous/harmful alcohol use ranged from 17%-36% in camp settings and 4%-7% in community settings and that **male sex, trauma exposure and symptoms of mental illness** were commonly identified correlates of substance use (Horyniak et al., 2016, p. 1).

Bogic et al. (2012) in turn found substantial differences between countries: 11.8% of refugees in Germany had any substance use disorder, compared with 1.7% in England and 0.7% in Italy; 4.7% of refugees in Germany had alcohol dependence, compared with 0.7% in England and 0.3% in Italy. The authors suggest that **substance use patterns may be influenced by social norms in the host country**. Priebe and colleagues (2016) corroborated this hypothesis by concluding that the prevalence rates of substance use (including alcohol-related) disorders among refugees, asylum seekers and irregular migrants tend to become similar to those of host country populations with time, even when they were lower (or higher) immediately after migration. We corrobated this hypothesis elsewhere (De Kock, 2020 in review).

[102] Apart from 10 % of the respondents with Turkish background in the Netherlands and 9 % of the respondents with South Asian background in Greece, no other groups indicated having experiences with discrimination when accessing healthcare services in the 12 months before the survey.

A Swedish study in turn found in a national cohort of 43 403 refugees and their families that the rates of dispensed psychotropic drugs in the newly settled refugee populations were low but that the rates increased with longer duration of residence (Brendler-Lindqvist et al., 2014). This pattern is suggested to reveal barriers to access mental health care, a hypothesis that was corroborated in later studies (Mangrio et al., 2018; Mangrio & Forss, 2017).

A review of research on Roma substance use in Czeque Republic and Slovakia (Kajanová & Hajduchová, 2014) reported that the main substances used include buprenorphine, cannabis, toluene and other inhalants, heroin, and methamphetamine. But more research concerning prevalence is warranted.

In conclusion, little is known, about substance use prevalence rates among specific MEM populations. Also, national health surveys often do not use scientifically sound ethnicity or migration related indicators. Even if they do so, sample sizes are often small and unrepresentative, as is the case in Belgium. **Purposive sampling and / or targeted surveys are warranted to fill this caveat.**

9.4 Substance use among migrants and ethnic minorities in Belgium

In Belgium too, research on the prevalence of substance use among MEM is absent (Dauvrin et al., 2012; De Kock, Decorte, Schamp, et al., 2017; Derluyn et al., 2008). **Lorant and collega's (2016) demonstrated that migrant youth who have more social bounds with non-migrant youth were more prone to using cannabis and alcohol. This appears to confirm the hypothesis that prevalence of substance use among persons with a migration background will become increasingly similar to prevalence in the general population with time (Bogic et al., 2012; Priebe et al., 2016).** Berten (2012) pointed out that independent of migration background of students, growing up in a 'highly educated family' increases the risk for alcohol use both among non-migrant and migrant youth.

One study did venture in analysing alcohol use among those respondents in the Health Survey (2013) that identified as having a migration background (first- or second-generation and a western or non-western migration background) (Van Roy et al., 2018). Although the study sample was relatively small, the most important conclusion here was that non-western first-generation migrants used significantly less alcohol. Moreover, respondents with a western first and second-generation migration background and those with a non-western migration background reported significantly less binge drinking compared to Belgians.

We did not find any other reports or research materials (2009-2019) that inform about the prevalence of substance use among persons with a migration background.

Independent of (hypotheses about) the prevalence of substance use among specific subpopulations, a good understanding of risk mechanisms on the one hand and caveats in the available substance use treatment services on the other hand is indispensable to design targeted substance use treatment policies.

In the qualitative PADUMI study (patterns of substance use among migrant and ethnic minorities, Belspo DR/69) the following reasons for substance use were identified: marital and other family related issues among Turkish and Easter-European respondents. Eastern-European respondents additionally noted that financial problems were part of the reasons for substance use. Undocumented migrants, refugees and asylum applicants in turn mainly reported that insecurity concerning the residence status and the reasons for migration were reasons to use substances (De

Kock, Decorte, Schamp, et al., 2017). Additionally, all Eastern-European and Turkish respondents experienced (inter-)ethnic and other type of discrimination (De Kock & Decorte, 2017). Lastly, we identified in a secondary analysis that Turkish problem users experience more identity related problems compared to recreational users with a Turkish migration background (De Kock, 2020).

Nevertheless, the causal pathways and mechanisms that contribute to substance use and recovery among MEM (sub)populations remain largely understudied and warrant further research.

9.5 Migrants and ethnic minorities in Belgian substance use treatment

Concerning substance use treatment (SUT), Blomme, Colman and De Kock (2017) departed from the hypothesis that presence of MEM in substance use treatment should be equal or approximate their presence in general society (Vanderplasschen et al., 2003, p. 19). In the absence of consistent prevalence rates, this is justified by the European studies that indicate that prevalence will become increasingly similar to prevalence in the general population over time (Bogic et al., 2012; Priebe et al., 2016). Of course, one should also consider individual risk factors and help seeking behaviour.

Although the study is not framed as such, it indirectly also hypothesised that Belgian nationals' presence in varying treatment services should be similar to non-nationals in treatment to account of equitable treatment possibilities. Considering the availability of this data, future studies should keep monitoring these subgroup differences. Comparing populations with and without a migration background is well accepted in MEM health studies, together with the study of populations with similar backgrounds across national contexts (to study policy effects) and subgroup analysis of similar populations that have and have not migrated (to study the role of migration) (Agyemang & van den Born, 2019).

The analysis of the presence of non-Belgians in Flemish treatment revealed major differences between treatment types (Blomme et al., 2017). European non-Belgians are a lot less present in residential settings compared to their share in the population and compared to the number of non-European clients in treatment. Non-nationals are overrepresented in ambulant methadone substitution treatment services.

An additional analysis (De Kock, Blomme, et al., 2020) of this same data found a strong association between nationality on the one hand and type of solicited service, gender and housing situation, on the other hand. Treatment episodes involving non-national clients were more often located in outpatient treatment compared to Belgians that more often solicited and were referred to higher threshold inpatient services. The documented European gender gap (one in four to one in five is female) in SUT was larger among non-national clients and especially among third-country clients compared to Belgians.

A comparison between European and third-country non-national clients consistently suggested lower socio-economic parameters (education, labour, housing) among third-country clients. We found no Belgian studies concerning MEM client satisfaction in treatment or retention in treatment. Regarding **referral**, non-national clients admitted in 2012-2013 were less often referred by general practitioners and hospitals compared to Belgian clients (De Kock, Blomme, et al., 2020). Furthermore, they were more often referred by 'other' actors and self-referred to treatment and these results did not differ across European and non-European nationals. This is consistent with a previous study by Derluyn and colleagues (2008).

The PADUMI study (see above, De Kock, Decorte, Schamp, et al., 2017) found that the types of consulted services differed substantially across MEM subgroups. The Turkish respondents had knowledge of and consulted all specific substance use treatment services whereas the group of undocumented migrants, asylum applicants and refugees mainly consulted ambulant methadone substitution treatment. Eastern-European respondents reported that they mainly asked for help to general practitioners, hospital emergency services, public social welfare offices but also trade unions and mutual health insurance services.

9.6 The perspective of professionals in Flanders

9.6.1 General health and presence of MEM in Flemish substance use treatment

The health status of persons with a migration background is less documented compared to the domains of education, employment and housing in Flanders. Nevertheless, Noppe and colleagues **point out that the amount of persons with very bad self-rated health is larger among non-EU nationals compared to EU-nationals and Belgians in Flanders**. Furthermore, the amount of people postponing health care consultations because of financial reasons is significantly larger in this same group of non-EU nationals in Flanders.

Nevertheless, the national health survey cannot inform policy and research about the prevalence of recreational and harmful substance use in these populations. A study of this data in 2013 reported that the sample of persons with a migration background in Flanders was too small to report on alcohol use in this population (Van Roy et al., 2018).

As is the case at the Belgian level, there was an overrepresentation of non-Belgians in methadone substitution treatment (MSOC) (15% of the population in these services compared to a population of about 7%) in Flemish SUT in 2012 and 2013 (Blomme et al., 2017). This considerable representation in Flemish MSOC contrasts with a low presence in crisis (3.5% and 5.8% in these services) and therapeutic communities[103] (1.8% in 2013 and 2.2% in 2013). Additionally, with the exception of the therapeutic communities, there were twice as many individuals with a non-EU nationality compared to EU-nationals in all treatment types. Contrarily, the vast majority of non-Belgians in the 2012-2013 population statistics had a EU nationality. **This indicates an underrepresentation of European nationalities, compared to their presence in the general population.**

In 2016, the Department of Health, Wellbeing and Family published a policy analysis concerning ethnic diversity in this Flemish policy domain (Demeyer & Vandezande, 2016). The analysis identifies an 'ethnic cleavage' because the social position of persons with a migration background is often worse compared to counterparts without a migration background. This was confirmed in our analysis of socio-economic status in the 2012-2014 TDI data (De Kock, Blomme, Antoine, in review), especially among non-EU nationals in treatment. The answer to the main question – "*what is the policy framework concerning ethnic diversity in healthcare and wellbeing?*" – was that policy documents demonstrate a willingness to work with the concept but that the concrete goals remain vague.

[103] A therapeutic community is – as in the TDI data –any residential programme subsidised by the Federal Institute for Health Insurance (INAMI / RIZIV) in which residential treatment and living in group is predominant (see: *TDI registratie in de RIZIV-revalidatiecentra voor verslaafden – Jaarlijks rapport 2012*).

The specific analysis of the mental health domain identified that the topic is mainly approached on a project basis and that this impedes long term and continuous policy making (Demeyer & Vandezande, 2016, p. 70). This analysis did not include the 'concept note on substance use treatment' (*concept nota verslavingszorg*). We screened this document with the same keywords used by Demeyers & Vandezande[104]. We conclude that the note does not specifically focus on migrants and ethnic minorities in substance use treatment because none of the key words were mentioned in this text.

9.6.2 Understanding disparities in Flemish substance use treatment

In Flanders, research on substance use and treatment among MEM is premature and topical describing issues such as substance use in specific populations (Muys, 2010), supporting MEM family members (Noens et al., 2010), needs assessments (Bekkers, 2019; El Osri et al., 2012), care trajectories (Derluyn et al., 2008) and the nature of substance use and help seeking behaviour (De Kock, Decorte, Schamp, et al., 2017).

Given the fact that there is no data on prevalence, we can only rely on hypothesises for explaining the large underrepresentation of non-nationals in residential treatment services and their overrepresentation in low threshold ambulant treatment services (mainly MSOC).

Subsequently, we conducted semi-structured interviews with 14 professionals in substance use treatment and mental health care. The main goal was to map the needs and challenges to increase the reach and retention of and the accessibility for persons with a migration background in substance use treatment in Flanders. We focused on professionals because of our policy oriented focus in this research project and because we had focussed on user voices in a previous research project (De Kock, Decorte, Schamp, et al., 2017).

We also disseminated an online survey to all services in substance use treatment to identify inspiring practices aimed at increasing the reach and retention of and the accessibility for persons with a migration background in substance use treatment in Flanders.

Overrepresentation in ambulant centres is explained by the fact that they are low-threshold and often do not require that a client has a social security number. Concerning the underrepresentation of (especially) EU-nationalities in residential services, the hypothesis that European problem users would make use of residential services in the home country is unlikely given the fact that many low-income EU countries have a smaller array of SUT services and / or have more restrictive drug policies compared to Flanders.

The reason is more likely to be found in both individual health seeking behaviours as well as the Flemish health system considering that the underrepresentation is less pronounced in Brussels and Wallonia.

Concerning access, we identified four reasons that contribute jointly to the underrepresentation of non-nationals in residential treatment. First, the fact that language is an exclusion criterion in most residential SUT is a valid hypothesis for the underrepresentation of non-nationals in these services. Second, we discerned in the 2012-2014 TDI data that non-nationals were less often referred by GP's

[104] diversiteit' – 'etni*' – 'cultu*' – 'allocht*' – 'minderhe*' – 'buitenland' – 'vreemdeling' – 'migr*' – 'herkomst'- 'afkomst' – 'kleur'.

compared to 'Belgian' clients whereas qualitative studies indicate that these populations will rather resort to a GP with problem substance use related issues.

Third, we pointed out that in Flanders the number of persons postponing treatment due to financial reasons is larger among the group of non-EU nationals compared to Belgians and this could be a contributing reason for underrepresentation in residential treatment. Fourth, Mortier (2017) found that detainees with a Turkish and Moroccan migration background were less often referred to residential treatment compared to Belgians.

Additionally, the specific character of residential SUT should be stressed. It contributes to its selectiveness. The 11 Flemish SUT services subsidised by the Federal Institute for Health Insurance (INAMI / RIZIV) that offer residential (besides outpatient) care are focussed on 'revalidation' and therefor have a clearly delignated target group and offer therapeutic-pedagogical interventions, in collaboration with other sectors and with a recovery oriented perspective (VVBV, 2018). Nevertheless, there is a need to consider how residential service aims and methods can be broadened to also include client who do not speak the language.

Both the interviews and the survey demonstrate that current efforts towards MEM (sub) populations mainly focus on increasing access of services and reaching these populations while retention (service quality and treatment outcomes) are less a focus. Only one survey respondent noted that the implementation of service wide diversity policy had increased retention of clients with a Turkish migration background. Two studies (Derluyn, 2008; Mortier, 2017) did point out that drop-out is larger among specific (sub)populations. **This implies that further research into service quality and reasons for drop out is warranted.** Knowledge about the available services in specific (sub) populations has proven to inevitably also play its role in reaching the right treatment setting.

Based on our current results and previous research (De Kock, Decorte et al., 2016) the hypothesis that there is a mismatch between treatment need and treatment offer merits further inquiry. The 'mismatch' between treatment needs and the available treatment should additionally be evaluated critically. Many participants note that language is an exclusion criterion in most residential services while questions are raised concerning the dominant focus on speech therapy as compared to community-based treatment and systemic treatment approaches. This is not only the case for residential treatment but also in centres for mental health care.

Moreover, about half of the participants in the survey identified as mental health workers which implies that there is large potential for expertise exchange between SUT and mental health workers. Furthermore, services that regularly (want to) use translators and intercultural mediators, experience financial and organisational barriers. These same barriers are identified as reasons for not making use of these service and appear to be a root cause among professionals of resisting or being reluctant to work with translators.

At the micro level of the clients, participants in the interviews noted that the first question for help is often a **context question** (from e.g. family) and / or that the 'core' **question might be covered** up by **another request for help** (e.g. depression) and directed to a service that is not especially substance use treatment related. Moreover, the results of trauma and feelings of exclusion are hypothesised to be contributors to problem substance use by both previous research and the interviewees in the current study.

At the level of the provider, the participants in the interviews note that **trust, client-centred care, openness, authenticity and reflectiveness** are key in successfully supporting (MEM) clients. However, having and practicing these skills is to be preceded by some prerequisites at the organisational and policy level. Previous research (e.g. Noens, 2010, El Osri et al. 2012) and the presented empirical data emphasised to focus on outreach and networking in SUT services. As mentioned by survey respondents and evidenced in international research (e.g. Guerrero et al. 2017) this change in perspective requires leadership that is positive towards these changes.

All respondents stressed the importance of trust. They stressed not only the trust of the client in the professional, but also the professional's trust as well as a broader trust related to the used methods and the health system. Respondents additionally noted that health system failure (e.g. waiting lists, not being admitted) reduce client's 'epistemic' trust which influences the client-provider relation.

At the federal and Flemish policy level, interviewees identified the following initiatives as relevant to SUT for MEM: the right to urgent medical care, the right to psycho-social support for refugees awaiting the decision of their asylum procedure, first line psychologists, the project 'refugees and asylum' and support to the 'Antenna mental health care' and the operationalisation of Article 107 of the Hospital law. Whereas the theoretical backdrop of these measures is applauded, the implementation side often appears to lag behind.

In conclusion (and as referred to in 7.7), combining the ecosocial and intersectional perspectives (De Kock, 2020; Krieger, 2014) allowed us to identify that barriers to treatment are not located at one or the other level (micro-meso-macro) (see i.e.: Scheppers et al., 2006).

Waiting lists for instance, as a result of insufficient funding, result in the fact that services feel unable to focus on or prioritise additional target groups such as MEM. A lack of funding on the governmental level results in a feeling of inability on the organisational level (meso-macro). Similarly, (potential) clients may not speak the language but professionals and services may be reluctant to work with them (micro-meso) because they have insufficient expertise and resources to work with these clients. In this case too, the barrier is not only located at the micro level of the client. Quite contrarily, the language barrier is far more complex because it consists of an intertwinement of micro, meso and macro constraints and choices. The same goes for the 'trust' phenomenon described above. Being excluded in a residential service (meso) based on insufficient knowledge of the language may induce epistemic distrust on the part of the client. In other words, the client can lose trust in the treatment system (macro) because of experiences at the meso organisational level that will reflect back in the therapeutic relation (micro).

Whereas barriers are often attributed to the client (e.g. language, culture), the same barriers can equally be attributed to services and policymaking (De Kock, 2019a). This change in perspectives highlights the accountability of governmental and organisational policy making, besides only focussing on the responsibilities of targeted MEM populations.

9.7 The perspective of professionals in Brussels and Wallonia

There is very little evidence-based research available concerning substance use treatment for MEM in Wallonia and Brussels. Existing research mainly focusses on access to (general) health care and at professionals. Academic literature, however, shows that professionals in Brussels and in Wallonia are increasingly faced with intercultural situations (M. Dauvrin et Lorant 2016). Patient with a

migration background, as suggested by a study on mental health professionals, raise various challenges such as language barriers, different belief systems, cultural experiences and previous traumatic experience systems (Sandhu et al. 2013).

Despite this, it seems that health professionals do not systematically consider they are responsible for cultural adaptation (Dauvrin & Lorant, 2014). The francophone grey literature on MEM drug use and treatment is scarce since this literature mainly emphasizes the precariousness of migrants rather than their migration background or nationality. This is consistent with our interview results: our respondents and the practices they implemented do not target MEM per se because they are included in those groups considered to be vulnerable.

When it comes to substance use treatment for MEM, it appears that MEM drug users are at the same time over- and underrepresented. In Wallonia and Brussel there is an overrepresentation of non-Belgians in the psycho-medical reception centers (MSOC) both in absolute number as in comparison to their share in the general population. **In Wallonia, there are many non-Belgians in the MSOC (21, 8% compared to a population of 9.7% in 2012).** Such overrepresentation contrasts with the representation of MEM in other types of services, except for therapeutic communities: 6,2% in outpatient services, 11,5% in therapeutic communities and 15,1% in crisis services compared to 9,7% in the total population in 2012.

In Brussels, too, there is an overrepresentation of non-Belgians in the MSOC: 72% non-Belgians in 2012 and 68,3% in 2013, compared to a representation of 32,5% (in 2012) and 33% (in 2013) in the Brussels population. This contrasts with their presence in others services: 20,2% (in 2012) and 28,1 % (in 2013) in the therapeutic communities, 20,3 % in 2012 and 20,6% in outpatient services and 18,9% in 2012 and 31,5% in 2013 in crisis services. (Blomme, Colman, et De Kock 2017)

Given the scare literature on substance use treatment, we can only rely on hypothesises for explaining the large overrepresentation of non-nationals in low threshold ambulant treatment (mainly MSOC) in Brussels and underrepresentation in other services. First, existing literature highlight **stigma and taboo** surrounding drug issues in migrant communities (Sacré, Daumas, et Hogge 2010; De Kock et al. 2016). Persons with a migration background might avoid spending time outside of the house and having to explain their stay in a treatment facility to relatives. As a result, they might prefer to find help in day centers, low threshold ambulant treatment or crisis treatment.

Second, the MSOC often adopt **an unconditional access policy** (e.g. do not require that patients have a social security number). This unconditional access policy might be key in explaining the overrepresentation of MEM in MSOC in Brussels since this city gathers a migrant population who struggle to access regular health insurance. According to the grey literature, in 2009, Brussels gathered more than half of the beneficiaries of the procedure that fund healthcare to undocumented migrants (AMU). Brussels hosts 13,426 of the total of 23,360 AMU beneficiaries in Belgium (FAMGB 2013).

In Wallonia, the situation is slightly different compared to Brussels: non-Belgian are underrepresented in day centers (6,2% in 2012) but there is a slight overrepresentation in therapeutic communities (11,5% in 2012) and crisis services (15,1% in 2012). This might be due to geographical reasons: Brussels is a city-region where all service are (relatively) close to each other while Wallonia covers a larger territory (CRESAM asbl 2015). As highlighted by our respondents,

MEM can be deterred to travel long distances to go to day-centers and prefer to go to residential services.

Moreover, both the interviews and the survey demonstrate that current efforts towards MEM populations **mainly focus on increasing access of services and reaching these populations**. This is in line with the perspective of many of our respondents that MEM drug users should not be treated differently compared to other drug users and the stake is to integrate them in mainstream services. Thus attention is on access rather than retention of MEM in treatment.

Interviews also help us to raise the following barriers that MEM drug users face and might explain why MEM drug users are overrepresented in low-threshold services, compared to their presence in the general population in Wallonia and Brussels

At the micro level of the client, participants in the interviews noted that language is a barrier. While many respondents point out that they found solutions to overcome this barrier, it seems that there are different attitudes towards language issues. While low-threshold services seem to find creative solutions to deal with the language barrier, professionals working in the mental health domain rather focus on the quality of the translation and therefor prefer working with live interpreters, which is administratively burdensome and complicates access because of the organisational requirements (making appointment, waiting times etc.).

Additionally, a respondent raised that the langue barrier might be problematic for residential treatment: when drug users do not speak French, it causes tension among residents. **These different approaches concerning language and how to deal with it might explain why MEM who struggle with French tend to be overrepresented in low-threshold services where translation does not require burdensome administrative and organisational procedures.**

Moreover, our respondents stress the level of precariousness of MEM drug users and link it to legal statuses and the required administrative procedures to access health (e.g. struggle to access to health care assistance and AMU). In this respect, the unconditional access policy adopted by low-threshold services (mainly MASS / MSOC) might be a factor explaining the overrepresentation of MEM in these services.

At the level of the provider, the participants in the interviews noted that **trust** is key in successfully supporting (MEM) drug users. The latter suffer from **discrimination, administrative violence and, sometimes, trauma**. Our interviewees suggest that professionals rather develop these skills in their daily practices than by means of organisational support (e.g. training). Consequently, we suggest that frontline workers of low-threshold services (mainly MASS / MSOC) are more prone to develop such skills, since they are mainly in contact with non-Belgian populations (Blomme, Colman, et De Kock 2017). In the same line of thinking, professionals working in other services, facing less MEM drug users, might not or to a lesser extent develop such skills. As a result, MEM could tend to remain in low threshold services.

At the level of SUT and other services, the lack of **funding** to efficiently deal with MEM drug user-specific need was raised by many respondents. This lack of (financial and human) resources covers various dimensions. Some of our respondents considered that the lack of means to implement long-term programs or initiatives jeopardises their work. Other respondents point out that the existing working conditions foster stereotypes among workers in their contact with migrants.

This is in line with what has been described by scholars studying front-line workers in administration: **because of a lack of resources, frontline workers tend to categorize the public and, on this basis, treat the clients they deem to be more worthy to help (Lipsky 2010),** potentially leading to arbitrariness in the provision of accessible health. As described by our respondents, MEM drug users are often victims of various stereotypes and are labelled as "difficult" patients by services. This can potentially explain why MEM drug users are underrepresented in certain services.

At the policy level, interviewees point out the discrepancy between **the federal attempt to enhance access to health care for migrant drug users on the one hand and the restrictiveness of migration policy on the other hand**. Restrictive migration policy prevents certain populations to access their rights, including the right to health care. This is most strikingly the case for transit migrants and undocumented migrants.

Finally, in line with the Flemish Region, the presence of non-Belgians from outside the EU is double compared to non-nationals with a European background. In our interviews too, EU nationals appear to be an especially hidden population because our respondents did not tell us much about these EU nationalities in their services. **Our interviews focussed mainly on asylum applicants, undocumented migrants and drug users with North-African background**. One of our respondents raised that European citizens in Brussels and Wallonia are often temporarily posted workers. Moreover, according to this respondent, it is difficult to reach these populations since they are very mobile. Because of their low integration in day-to-day life, services focus to a lesser extent on implementing projects to reach these or facilitate access for these populations.

9.8 European inspiring practices

There is very little evidence-based research available concerning substance use treatment for MEM. Some argue that drug policies are all too often based *on "a regime focused on educational provision aimed at adolescent prevention; public health information designed for teenagers; and treatment resources focused on predominantly male and non-parenting problem drug users"* (Measham et al., 2011).

Sempertégui and colleagues (2018) for instance found that there is no strong evidence for the effectiveness of existing interventions for Turkish and Moroccan immigrants with depressive symptoms. They subsequently conclude that there is a need for evidence-based, culturally adjusted therapeutic interventions. Priebe in turn notes that in the mental health domain "*no studies into the effectiveness of good practice compared with other interventions or standard care were found. Consequently, the existing data do not yet provide high-quality evidence on the clinical effectiveness and cost–effectiveness of service models in implementing components of good practice*." (p. 20). Similarly a recent review identifies that there is no evidence available concerning the effectiveness of implementing 'cultural competence' in substance use treatment for the reduction of service disparities (De Kock, 2019a).

In 'Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants' –commissioned by the WHO European Region - Priebe and colleagues note that.

In the domain of substance use treatment, Keane and colleagues (2018), in a review commissioned by UNHR, identified **screening and brief interventions** in for example camp settings and other

asylum facilities as cost-effective prevention and treatment instruments among refugees, although evidence on effectiveness appeared to be mixed. However, this review did not find any such evaluated interventions in the European continent. **They concluded that there is a clear caveat in academic and unpublished literature concerning refugee substance use prevention and treatment approaches.**

In April 2019 we conducted a survey to identify substance use treatment (related) practices with the aim of increasing reach and retention of or access for MEM in SUT. The survey had broad inclusion criteria and identified 34 European practices. Seventeen practices were identified in 12 member states, 12 in Portugal and five in Czechia.

Because of the diversity in the responses it was hard to discern trends in the data. Nevertheless, some interesting issues were identified. The practices in the 12 member states and Czechia mainly focus on recognised refugees, asylum applicants and to a lesser extent intra-European and undocumented or irregular migrant, second and third-generation migration backgrounds. Three respondents specified that their practice was aimed at sex workers, Irish travellers, first- and second-generation war victims.

At least 20 out of the 34 practices were in the harm reduction domain and a lot less practices were located in the prevention and treatment domain. Access and reach of populations were the main aims of these practices whereas retention was only an aim in six practices.

Concerning evaluation quality, about half of the respondents state that the practice has not (yet) been evaluated or that they do not know. The other half indicates that it has positive outcomes, specifying that outcomes are the reach of specific populations, increased treatment uptake or behavioural change. None of the respondents make reference to reports or evaluation studies when reporting these outcomes.

We concluded from these European survey results that there seems to be a research and treatment caveat in higher threshold residential treatment. Additionally, health service planners and drug policy makers should reflect on how to serve the needs of those non-nationals that require other than substitution treatment. An interesting path for the future could be to explore knowledge and expertise transfer between lower and higher threshold services (e.g. outreach and language facilities).

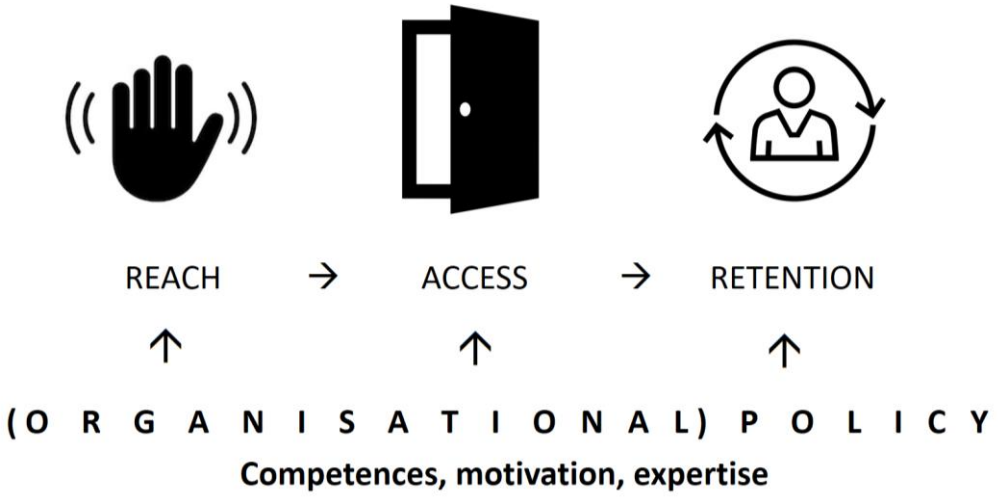
You can find more information about all the identified inspiring practices in '*Wegwijzer voor een toegankelijke en interculturele drughulpverlening / Recueil sur l'accessibilité et l'interculturalité des services pour usagers de drogues'* (online via www.belspo.be and in book format via www.gompel-svacina.eu). Additionally, all European practices are presented in the EMCDDA Background paper *Migrants, refugees and ethnic minorities: an overview of responses to drug-related issues in Europe* (De Kock, 2020 in review).

10. RECOMMENDATIONS

The WHO report on migrant health argues for the need of "*Promoting people-centred, gender-, refugee- and migrant-sensitive health policies and health systems and programme interventions*" (2018, p. 12). Moreover, a European narrative review on substance use and access to substance use treatment services among migrants, asylum seekers and refugees (Lemmens et al., 2017) concluded

that **EU drug policies are not specifically aimed at migrants** and / or asylum seekers and that substance use is not prioritised in delivering health care to newly arrived asylum applicants. Moreover, it is increasingly acknowledged that structurally embedding policy measures is essential for sustained progress and that 'good practices' alone, will be insufficient to overcome treatment disparities (Rechel et al., 2013). Existing caveats in the health system, substance use and mental health services often crystallise among specifically vulnerable populations such as MEM.

The recommendations are aimed at increasing substance use **treatment reach and retention of and accessibility** for migrants and ethnic minorities. Besides the recommendations that resulted directly from our (European) literature search, the surveys and interviews with professionals we will also include recommendations made in previous research projects. These recommendations would ideally be considered in the Interministerial conference against racism and other platforms.



At the Belgian / federal level

As outlined by the Belgian Health Care Knowledge Centre (KCE) (Devos et al., 2019), the performance of a health system is implicitly linked to the attainment of objectives. In the absence of quantifiable objectives, reports (e.g. KCE report and drug reports) are often limited to describing a situation and comparing trends. The KCE report subsequently recommends that:

> *"Policymakers should ensure that health (system) objectives are defined with stakeholder consultation; these objectives must be measurable, set deadlines by which these objectives should be attained, and appoint accountable organisations. Quantified targets should be proposed along proposed along with specific objectives."*

1. Registering and processing migration related indicators in substance use treatment

Relationships of inequality (e.g. under-/overrepresentation in treatment or prevalence of substance use) represented by categories (e.g. migration background) are the *raison d'être* of social epidemiology. For this type of study, the nature of epidemiological data should allow for anti-categorical (population level), inter-categorical (group comparisons) and intra-categorical (in-group) analysis to identify, understand and act upon disparities in health (Wemrell et al., 2016; Wemrell et al., 2017). Additionally, these data should allow to study the impact of policy, migration related factors and individual characteristics (Agyemang & van den Born, 2019).

The registration and availability of several and comparable migration related indicators, conform GDPR, is consequently a key prerequisite to enable this type of analysis and to install positive action (R. S. Bhopal, 2014; Rallu et al., 2004; Van Caeneghem, 2019).

In Belgium subsequent state reforms (regionalising) and paradigm shifts in the health domain (bottom-up and community based care) have resulted in important data limitations that hamper adequate performance measurement (Devos et al., 2019). This is exemplified by the multiplicity of registration systems and migration related indicators that we identified in the SUT domain.

Moreover, European member states are advised to support the monitoring of disparities (2000/43/EG23) and expected to regulate and support this type of data gathering and processing (Makkonen, 2016). Additionally, policy planning in substance use treatment is ideally based on tiered models (Ritter et al., 2019) based on varying data sources including a minimum of harmful substance use prevalence, treatment need and demand data in addition to targeted surveys and other types of data. The issue of monitoring and data analysis in the health domain including substance use treatment should be discussed in the Interministerial conference against racism.

Below, you can find our specific recommendations for achieving these goals in Belgian substance use treatment. More information concerning this topic at the European level can be found in *Migration and ethnicity related indicators in European Treatment Demand (TDI) registries*.

1.1 **Fine-tuning the designation of 'sensitive data' (e.g. race, ethnicity, religion etc.)** and create guidelines in the health domain to enable policy monitoring with an equity focus to the example of e.g. the socio-economic monitoring in the labour domain (UNIA, 2017) (e.g. Data Protection Authority)(Farkas, 2017b; Goldblatt, 2016; Marmot, 2016).

1.2 **Gathering all the actors involved in registration in substance use treatment** such as the responsibles for EPD [CGG], CIS [VVBV], MSOC.net and OBASI (e.g. in Flanders coordinated by *Vlaams Agentschap voor de Samenwerking rond Gegevensdeling tussen de Actoren in de Zorg [VASGAZ*]) with the eye on efficient data homogenisation and reducing registration workload (Zorgnet-Icuro, 2019) (E.g. by KCE).

1.3 **Providing funds** to enable migration and ethnicity related intersectional, multivariate and multi-indicator analysis (Giritli Nygren & Olofsson, 2014; Makonnen, 2016) in treatment demand indicator as well as the national health survey (prevalence of substance use) data (Dauvrin et al., 2012) (e.g. FOD Volksgezondheid, Sciensano).

1.4 **Considering additional purposive sampling in the national health survey** or conducting a purposive survey aimed at persons with a migration background to enable the study of (spectra from harmful to recreational) substance use in a representative sample of subjects with a migration background and subsequent multi-indicator research (Dauvrin et al., 2012) (e.g. by FOD Volksgezondheid).

1.5 **Enhancing (the analytical capacity of) registration of migration background in treatment demand indicator protocol** (minimum: nationality, country of birth, medium: birth place mother and father, in-depth: language related indicators [home language, most common language, third language]) such as the ones used in PISA and the national health survey (De Kock, 2019b). (e.g. Sciensano).

1.5.1 **Incentivising registering services** to remove older registration categories (e.g. binary European / not-European divide, 'origin').

1.5.2 **Integrating in the national TDI protocol purpose specification** to include the purpose of identifying disparities and implementing positive policy action (e.g. to the example of

the 2018 UK "*National Drug Treatment Monitoring System" protocol: "Public Health England exists to protect and improve the nation's health and wellbeing and reduce health inequalities*.") (Rallu, 2004).[105]

1.5.3 Translation of the protocol's purpose specification into **'informed consent' procedures** for the registering by professionals in substance use treatment.

1.5.4 Conducting a **Data Privacy Impact Assessment** (as required by GDPR) (e.g. based on the preparatory work in this report) to ensure the lawfulness of data collection and processing (e.g. Data Protection Officers and / or in collaboration with external expertise such as Infosenstry).

1.5.5 Considering to create a **unique (pseudo)anonymized TDI identifier** to enable explanatory multivariate analysis in the TDI data (as argued for by KCE, 2019 in other health related datasets)[106] without infringing the right to be able to present anonymously to certain SUT services (e.g. MASS / MSOC) (De Kock, 2019b; Devos et al., 2019).

2. Offering accessible (mental) health care for refugees

The respondents in our interviews applauded several federal initiatives such as the use of **intercultural mediators, the right to urgent medical care and the right to mental health care for refugees awaiting their decision**.

They also formulated recommendations to increase formal access to (mental) health care and substance use treatment for refugees at the federal level. Access to urgent medical care for instance is problematic. Similar to the KCE recommendations (Dauvrin et al., 2019), we **found that harmonizing access to urgent medical health care and granting financial support for the application would improve overall health access to treatment for undocumented MEM drug users.**

2.1 **Coordinating federal, regional, community, and municipal levels of governance** by means of for instance an Interministerial Conference on the state of migrant (mental) health including mental health and substance use treatment competencies (Dauvrin et al., 2012). (e.g. as a part of the Interministerial conference against Racism)

2.2 Enhancing the **right to mental health care for refugees** awaiting their asylum decision (e.g. FedAsil):

2.2.1 Offering more leeway for refugees to choose the provider because trusting the provider is key to establish a relationship of trust.

2.2.2 Facilitating faster procedures (follow-up and referral) for requests for psychosocial support by refugees awaiting the decision of their asylum procedure.

2.2.3 Installing substance use prevention and early intervention initiatives in asylum centres (Greene, 2017).

[105] And subsequently broaden at the national level the TDI Protocol 3.0 that stipulates that its aim is to "gain insights into the characteristics, risk behaviours and drug use patterns of people with drug problems in the community, and to help to estimate trends in the extent (prevalence and incidence) and patterns of problem drug use"

[106] The lack of a unique patient identifier does not allow the follow-up of the patient after discharge, and few adequate data are available concerning outpatient care (KCE, 2019) A Unique Patient Identifier (UPI) must be used allowing linkage of RHM – MZG and RPM –-MPG with mortality data from the National register of natural persons with the greatest respect for the confidentiality of the individual data. The UPI allows to follow-up patients after discharge through the entire health system. Linkage with mortality data and follow-up after discharge would allow the computation of a number of international quality indicators, which cannot be computed for the moment.

2.2.4 Meeting the social needs of asylum applicants because two-thirds of migrants state that these needs remain unmet and that this has direct mental health consequences (Abbas et al., 2018).

2.3 **Enhancing asylum conditions** will positively impact the mental health of asylum applicants. (Knipscheer et al., 2015; Kubal, 2014)

2.4 **Disseminating the expertise of and the role of intercultural mediators** to the regions could enhance quality of mental health care and substance use treatment (EUGATE).

2.5 **Sufficient resources should be dedicated to improve access to specific training** as suggested in the ETHEALTH report "requiring better support from the Federal Agency for the Reception of Refugees and Asylum Seekers (FedAsil) for the provision of specific training for these health professionals" might be useful (Dauvrin et al., 2012).

2.6 Concerning the **right to urgent medical care**, that persons without a residence permit, especially those with problem use are very mobile meaning that they often do not have a 'domicile' and cannot register at CPAS / OCMW to use their right to urgent medical care.

2.6.1 *Meddimigrant* urges both **CPAS / OCMW and POD Migration to treat these cases flexibly** and communicate about the allowed flexibility.

2.6.2 Urgent medical care is delivered by CPAS and undocumented migrants are obliged to attend their local CPAS / OCMW. **To avoid arbitrariness, harmonising CPAS / OCMW procedures** would enhance access to health care for highly mobile migrants. (Suijkerbuijk, 2014)

At the Regional level

The Flemish Department of Health, Wellbeing and Family stated (p. 65) in its policy note 2014-2019 that

> "*together with the Department of Integration, it will focus on accessible health care and service provision, especially for persons with a migration background*"

This important and necessary statement was supported by the previous Flemish government. In the more recent context analysis of the policy note of the policy domain Wellbeing, Health, Family and Poverty Reduction (*Beleidsnota ingediend door Wouter Beke, Vlaams minister van Welzijn, Volksgezondheid, Gezin en Armoedebestrijding*, november 2019, p. 14) the following is stated:

> *"The engine of population growth in Flanders is and remains international migration, half of which comes from within European Union (EU) countries. The question "How can care and welfare organizations deal with ethnic-cultural diversity among care users?" is becoming important"*

Based on the MATREMI results we ask the Flemish Department of Health, Wellbeing, Family and Poverty Reduction and its responsible Minister to renew the positive intent of more accessible services, extend it to the mental health and substance use treatment domain, further materialise it (i.e, more accessible mental health services, crisis units, first line psychologists, mobile and crisis teams) and that reducing waiting lists remains a priority.

Moreover, In 2016 the Flemish Department for Wellbeing, Health and Family subsidised a qualitative analysis concerning 'ethnic diversity' in its policy domain (Demeyer & Vandezande, 2016, pp. 72-78). The authors' recommendations are pertinent in the domain of mental health and substance use treatment too, and will be elaborated upon below.

In Wallonia, the "*Walloon health prevention and promotion plan horizon 2030*" (2017) emphasizes that the broad dimensions of and reasons for drug-related problems should be taken into account when making a diagnosis. For example, the plan emphasizes the importance of accessibility of services and criticizes the fragmentation of policy responsibilities and that specific problems among vulnerable populations (young people, migrants, homeless people, etc.) have an impact on problem use (p. 98).

In conclusion, the General Policy statement of the Brussels government 2019-2024 (p. 35) states that:

> *"The Government intends to fully cover the population in its regional territory by means of the development of a perspective of proportional universalism and public health in which the administrative status of excluded persons does not play a role. To this end, the Government will include in the Brussels Welfare and Health Plan an operational section that provides for a "0.5 function", as described in the ordinance regarding primary care policy of 4 April 2019."*

3. Materialising recommendations on diversity

3.1 **Developing a policy domain wide perspective on diversity in (mental)health and wellbeing.**

3.2 **Focussing on structural participation of self-organisations** in the policy domain.

3.3 **Offering room for experimentation and support** to develop and strengthen good and inspiring practices in dealing with diversity in substance user treatment:

3.3.1 Installing a permanent flexible fund aimed at dealing with fast changing trends among vulnerable drug users (VVBV, 2018).

3.3.2 Installing prevention and early intervention efforts in regional asylum centres as a cost-efficient measure to reduce problem substance use (Greene et al., 2019; Kane & Greene, 2018) (see also 2.2.2 on the federal level).

3.3.3 Creating a regional platform of key figures, professionals and peer workers who have expertise concerning refugees, persons with a migration background, mental health and substance use (vb. Pharos) (zie also recommendation 8.8).

3.3.4 Creating a 'good practice' platform for knowledge sharing (e.g. to the example of the wiki-based MIGHEALTHNET that was aimed at stimulating the exchange of knowledge on migrant and minority health through the development of interactive data).

3.3.5 Fund participatory action research, co-creation and the professionalization of peer work in mental health services and substance use treatment to promote client participation and promote these methods in grant applications (Favril et al., 2015; Laudens, 2013; Piérart et al., 2008) (e.g. Cocreate initiative in the Brussels region).

3.4 Focussing on accurate and policy domain wide quality monitoring:

3.4.1 Maintaining and improving in-depth data on health (care use) in the Diversity Barometer (Noppe et al., 2018).

3.4.2 Supporting providers in meeting administrative and monitoring responsibilities by including formally these ICT and administrative tasks to the staff functions and providing training (i.e., TDI, BELRAI, IFIC, VIP, *Kind Reflex, Vlaamse Zorginspectie, Suïcidepreventiebeleid,* GDPR) (VVBV, 2018).

3.5 Collaborating with policy domains responsible for integration.

3.6 Structurally support people who are awaiting an asylum decision to improve their mental health (e.g. Mind Spring, Porte d' Ulysse, Clinique de l'Exil, Santé en Exil, Tabane, Espace 28, Semaphore).

3.7 **Developing active policy to counter stereotyping, racism and discrimination** among professionals in health and wellbeing but also among MEM populations (concerning substance use).

3.7.1 Targeting sensitising campaigns to specific MEM target groups (such as asylum applicants, intra-European migrants but also second and third labour related migration background, and non-EU females) (e.g. *Te Gek!?* In Flanders) and relate mental health related campaign to issues related to substance use and behavioural dependencies.

3.7.2 Reallocating structural funds for training of mental health professionals (e.g. in Flanders formerly organised by '*Steunpunt Cultuur Sensitieve Zorg*').

3.7.3 Foreseeing funds for liaison and referral functions, consulting, intervision, coaching, training and job shadowing to share expertise within and between the sectors of mental health, substance use treatment (VVBV, 2018), wellbeing and integration.

3.7.4 Sensitising and training first line workers (e.g. GP's, asylum centres) about referral to treatment and concerning working with translators (Meddimigrant) as well as supporting clients to avoid unnecessary referral to specialised treatment (VVBV, 2018).

3.7.5 Targeted guidance of clients to avoid unnecessary referral to specific substance use treatment (VVBV, 2018).

3.7.6 Including harmful substance use as an indication to enter ambulant and residential mental health care (VVBV, 2018).

4. Supporting and funding practices that lower thresholds to services

Waiting lists were identified in this study as the main reason not to focus on specifically vulnerable group of MEM. Waiting lists in turn are the biggest barrier to enter substance use treatment.

33% of the FTE's in specific substance use treatment in Flanders (163 of a total of 493 FTE's) are not funded by the Department of Health, Wellbeing and Family but by other sources (VVBV, 2018). A third of the sector is therefore financed by other sources such as projects, municipalities and federal funds (VVBV, 2018). This lack of structural funding results in waiting lists in substance use treatment.

Some Walloon and Brussels interviewees in this study consider that the reduction of hospital beds in the framework of 'article 107' has a dramatic effect on drug users. The effect is that clients who need more time to recover (because of their social situation instead of purely medical problems) can no longer stay in these hospitals. This is problematic for precarious clients who have nowhere to stay outside the hospital and have to return to a 'problem-prone' environment.

Moreover, the stay in sheltered living initiatives is not reimbursed by the PPS Migration (*POD Migratie*) for people without a legal residence. **In other words, it is very difficult for hospitals and other residential providers to offer continuity of care.**

In Flanders, the decision of the Flemish government on the implementation of the Decree of 6 July 2018 as well as the commitment to the 'socialization' of substance use treatment (*vermaatschappelijking van de zorg*) as described in the Flemish policy note 2014-2019 of the Flemish Department of Health, Wellbeing and Family (p. 40) allow to implement these recommendations.

4.1 Specific **projects that have proven to work and additional tasks in the framework of 'article 107' need structural fund allocation** and extra funding by the Department (EUGATE). The VVBV Memorandum argues that the involvement of commercial tendering should be avoided.

4.1.1 There is a structural need estimated at 450 million by Zorgnet-Icuro (2019) to increase ambulant care capacity, psychiatric hospitals as well as protected living services in Flanders.

4.1.2 The mobile and crisis teams have long waiting lists across Flanders and are in need of extra funding. For maximum accessibility, these services need to remain free. (VVBV, 2018)

4.1.3 Methadone substitution treatment services (MSOC) are in need of structural and long terms funding by the regions. (VVBV, 2018)

4.1.4 Working with the family and other context related individuals (e.g. psycho-education) should be funded structurally. (VVBV, 2018)

4.1.5 The project of 'first line psychologists' (2012-2015) outside specified substance use treatment was evaluated positively and needs subsequent structural funding. Moreover first line psychologists (Coppens et al., 2015) competencies should be broadened to include referral of clients with illegal substance dependencies.

4.1.6 Support to network mechanisms to identify context and direct requests for help presented in services outside the SUT domain (e.g. asylum centres, integration centres, CAW, OCMW, e.g. to the example of CAD Limburg) (e.g. Adviespunt Antwerp).

4.1.7 Long term (as opposed to project based) implementation of 'trauma and asylum' support for recognised refugees in the centres for mental health (CGG).

4.1.8 Creating a regional platform for knowledge dissemination across the asylum, mental health and substance use treatment sectors (see also 3.3.3).

4.1.9 Encourage the inclusion of (federations of) local NGO's or 'self-organisations' in the networks on mental health and substance use treatment.

4.2 Remove **restriction of DSM IV code requirements for treatment in specific substance use treatment services** (to also include e.g. alcohol and other legal substances or behavioural dependencies) (VVBV, 2018).

4.3 Meet the needs concerning regional spread of a broad type of service provisions in the regions (VVBV, 2019; Zorgnet-Icuro, 2019) with specific attention for the location of asylum centres and areas that do not offer substitution and crisis treatment.

4.3.1 The equal spread of substance use treatment specific and mental health services needs to be translated in a mapping exercise and subsequent installation of new services (e.g. mapping and needs assessment VVBV, 2018).

4.3.2 The accessibility of substance use treatment and mental health services (including private psychologists hired by asylum centres) should be matched to the needs of local asylum centre needs.

4.3.3 Increase the offer of crisis treatment for persons with complex and severe substance use related problems that do not speak the language (VVBV, 2018) (e.g. ADDIC, Transit).

4.3.4 Residential treatment centres need to be enabled to offer 'protected living' conditions to support clients in need of 'after care' and to subsequently increase treatment outcomes. (VVBV, 2018)

5. Lowering the threshold for the use of translators

An important finding in the current study is that language is a major barrier from the perspective of the client, the caregiver and the service. We conclude from this study that it is indispensable to ask the question whose language we are talking about: does the client not speak the language used in treatment or does the service not speak the language of the client? Or is the answer somewhere in between?

More concretely, there is a need to focus on both the language skills of (potential) clients, but also on the training of providers in dealing with clients who do not speak the language and on supporting

services in dealing with these client populations by means of additional funds for social interpreters in the services as well as by installing innovative, less language oriented methods in (mainly residential) substance use treatment.

5.1 **Lowering the administrative threshold** for the use of translators across all services (e.g. not having to fill out a new form for each new appointment with the client, supporting providers with the administrative load, considering and offering alternative for no-show).
5.2 **Structural collaboration** with the Department of Integration for the use of social translators, e.g. by installing innovative and cost-efficient translation services such as by means of a web-cam, an offer that is currently not available via de Department of Integration.
5.3 **Structurally funding services to use social translators** (e.g. videoconferencing in centres for mental health).
5.4 **Reducing waiting times** for specific languages by hiring more translators.
5.5 **Offer regular standard courses** on the 'Communicatiewaaier' in all (mental) health and wellbeing services, including substance use treatment services.

At the organisational level of substance use treatment

In line with previous recommendations to substance use treatment for MEM (El Osri, 2012) we emphasise the fact that many of the issues MEM problem users are confronted with are the same issues that other types of drug users are confronted with. Waiting lists, but also the need for high motivation for treatment, financial requirements and the length of treatment are only some of these barriers (Tieberghien & Decorte, 2010).

From a client-centred perspective we observe that not all persons with a similar migration background will have the same needs while from a population perspective there is a need for the acknowledgement of (sub) population vulnerabilities and to identify targeted opportunities to enhance their wellbeing in substance use treatment. Nevertheless, it is of utmost importance to approach MEM problem users as problem users with needs that will most likely be similar to those of other drug users (Derluyn et al., 2008).

Finally, it is important to value the specific nature of each specific service from outpatient low threshold to higher threshold residential treatment. The 'socialization of care' (*vermaatschappelijking van de zorg*) cannot be aimed at changing the core identity of these services and their specific goals. Nevertheless, it will be necessary to share practices across services and service types to increase the accessibility of all services.

6. Investing in diversity sensitive and migrant friendly organisational policy

6.1 **Initiating and structurally funding diverse sensitive and migrant friendly organisational policy** to change the service in terms of reach of the population, identity, staff policy and the used methods (Jalhay et al., 2016) by means of in-service 'diversity ambassadors'.
6.1.1 Contact the Flemish or a regional Integration Department (*Agentschap Inburgering & Integratie, Atlas Inburger, In-Gent vzw*) for organisational support.
6.1.2 Incentivise employees to make use of innovative evidence-based methods that have been developed or adapted for MEM. (e.g. 'cultuursensitief addendum bij de multidisciplinaire richtlijn schizofrenie', DSM Cultural formulation interviews, EMDR bij vluchtelingen met PTSD). (See also recommendation 7)
6.1.3 Promote training, coaching and 'intervision' concerned with MEM related questions.

6.1.4 Considering diverse sensitive guidelines and needs when recruiting new staff (considering that a complete reflection of the societal diversity among staff is impossible and that some MEM clients will prefer nog having a 'co-ethnic' care givers) (e.g. by making use of social fund 339).

6.1.5 Translating (parts of) the service website as well as information leaflets.

6.2 **Informing colleagues that represent the service in networks about the specificities of the intake procedure** (requirements and issues that can be dealt with flexibly, e.g. being able to fill out forms beforehand together with other social professionals).

6.3 **The development of divers sensitive intake procedure** by for instance making agreements with external partners about how they can guide a client to the service to reduce the workload of the intake staff in the receiving substance use treatment service and to increase access for MEM.

6.4 **Communicate clearly about the goals and philosophy of the service** and about the full spectrum of available services so that professionals can refer correctly, (potential) clients can make an informed choice and 'unfit' referrals / treatment mismatch can be avoided (VVBV, 2018).

7. Innovating service methods

Client-centred approaches are not new and are well integrated in Belgian substance use treatment and mental health services. However, it is necessary to periodically focus, as a provider on what client-centeredness means to you and to your client (El Osri, 2012).

7.1 It might be more complicated to build a **relationship of trust** because of previous negative experiences with services (in Belgium or other countries), perceived discrimination, not believing in the proposed treatment method and other issues. Open the conversation about such issues with your client and inform them about professional confidentiality. (e.g. Ghent Municipality developed a tips & tricks folder in dealing with Roma)

7.2 **Family inclusion in therapy** (El Osri, Noens) e.g. by implementing multidimensional family therapeutic models (Litle et al. in Alegria et al., 2011), system therapy or by creating therapeutic settings with trialogue. Beware to first analyse the family situation with the client and judge together with the client whether family involvement would be an added value to treatment.

7.3 Have sufficient attention for **other life domains** (e.g. education & work) (El Osri, 2012).

7.4 When (potential) clients are referred to a waiting list, **accompany or refer them during this waiting** time (El Osri, 2012).

7.5 Use methods of **psycho education to induce self-reflection and reflection about the treatment** process and the used methods (Chow et al., 2010) and to subsequently improve retention and adherence.

7.6 **Make full use of your networks and reach out:**

7.6.1 Disseminate information received in networks that bring together ambulant, residential, first, second and third line work in your own service.

7.6.2 Proactively disseminate information about your own services with the goal to reach new client populations with a migration background (Fédito-Wallonne, 2019).

7.6.3 Broadening the new network centred approach (within the framework of article 107) by **including self-organisations, asylum centres, integration services and other services** that have more contact with MEM (sub)populations in existing networks.

7.6.4 Consult your colleagues in other services concerning their opinion about the accessibility (e.g. intake procedures) of your service.

7.6.5 Share expertise in your networks e.g. by exchanging workshops.

7.7 Meeting language related needs will indirectly increase the accessibility of the service as well as the reach and retention of MEM populations.

7.7.1 Reducing the administrative workload when using interpreters and providing information on how to use interpreters can decrease resistance among professionals to make use of interpreters.

7.7.2 The implementation of methods that are less speech oriented in residential care but also in centres for mental health care (El Osri et al., 2012) (vb. Creative therapies, foreseeing time for translation in group session, '*community based psychology'* etc.)

7.7.3 Inviting (potential) clients for an intake talk, even when there is a suspicion that the person speaks the language insufficiently.

7.7.4 Foreseeing sufficient extra time when working with a translator.

8. Identifying, giving voice and reaching out to MEM populations

The following subgroups were identified as specifically vulnerable or as insufficiently reached by substance use treatment:

- **Female substance or alcohol users with a non-European migration background** (underrepresented in SUT services)
- **Asylum applicants, refugees, undocumented migrants** (high prevalence of PTSD, low access to and use of [mental] health services and exposure to risk environments) and especially unaccompanied minors (because of the developmental stage as well as lack of parental and other support networks)
- **Intra-European substance users including Roma** (underrepresented in SUT services)
- **First generation non-European nationals** (low self-rated health and socio-economic status, both inside and outside treatment)

Social stigma and criminalization of problem substance use can be harmful to the recovery process (VVBV, 2018). This stigma often culminates among people with a migration background, and certainly in communities where there are many informal normative rules (De Kock, 2020). Subsequently, the stigma about problem substance use in society, as well as the stigma about problem substance use in certain communities, but also migration related stigma (triple stigma) must be tackled. Finally, it is equally important to tackle the stigma about substance use in services outside substance use treatment such as in health and mental health services.

8.1 Consult regularly with key stakeholders and peer workers in the communities by including them in meetings and networks (e.g. (vb. Migr'En Santé network) (El Osri, 2012; Noens; 2010).

8.2 Proactively disseminate information about substances and dependencies in organisations that reach MEM (e.g. asylum centres, NGO's, OCMW etc.) (e.g. information at DrugLijn).

8.3 Actively lower drug related stigma in specified communities by means of targeted sensitising campaigns that use less stigmatising issues as a point of entrance (e.g. depression and prescribed medication use ('prevention via a detour' to reduce stigma).

8.4 Sensitise and inform subpopulations (mainly European nationalities, refugees, women with a non-EU background) about the available treatment by means of for instance the *Tuppercare* principle, e.g. *Moslim Adviespunt*).

8.5 Identify media and organisations that do reach MEM to reduce drug related stigma (e.g. the work of : l'arbre à palabre, Noire et psy, vzw Hshoema) or to help you reach the population.

8.6 Create a regional platform of key figures, professionals and peer workers who have expertise concerning refugees, persons with a migration background, mental health and substance use (vb. Pharos) (see also recommendation 3.3.3).

ANNEX 1: information leaflet for interview respondents (Dutch)

MATREMI: Mapping & Enhancing Substance Use Treatment for Migrants and Ethnic minorities

WAT

MATREMI (mapping & enhancing substance use treatment for migrants and ethnic minorities) is gericht op het in kaart brengen van migranten en etnische minderheden (MEM) in de drughulpverlening alsook het verbeteren van de hulpverlening voor deze doelgroep. Op basis van een literatuurstudie en een online bevraging van praktijkwerkers (April 2019) worden bestaande praktijken in kaart gebracht die gericht zijn op het verbeteren van de **toegang**, het **bereik** en de **retentie** van deze doelgroep in de Belgische drughulpverlening. Bijkomend willen we **op basis van interviews met experten in kaart brengen hoe de Belgische drughulpverlening verbeterd kan worden voor deze doelgroep.**

Dit onderzoek hoort thuis in een breder onderzoekskader waarin verscheidene onderzoekers aan UGent herstel en toegankelijkheid van de drughulpverlening voor deze doelgroep bestuderen.

WIE

MATREMI wordt gefinancierd door het **Belgisch Wetenschapsbeleid** (Belspo). Het project werd geïnitieerd door Universiteit Gent (Tom Decorte, Charlotte De Kock) in nauwe samenwerking met partners VAD (Fred Laudens, Lyssa Toyinbo), Université Libre de Bruxelles (Dirk Jacobs, Carla Mascia), Fédito BXL (Sebastien Alexandre) en Fédito Wallonne (Pascale Hensgens). De resultaten van het project – een rapport, beleidsaanbevelingen en het *hands-on praktijkboek* voor professionelen – zullen in November 2019 voorgesteld en verspreid worden.

UW INBRENG

Graag nemen we met u een interview af (maximum anderhalf uur) op basis van uw kennis en expertise met MEM (sub)populaties en / of in de geestelijke gezondheidszorg en / of drughulpverlening. Het doel is om een beter inzicht te krijgen in hoe u denkt dat de drughulpverlening voor deze doelgroep(en) verbeterd kan worden. Tijdens dit interview zal de onderzoeker enkele open vragen stellen met betrekking tot uw organisatie en uw eigen mening. Het staat u vrij om op bepaalde vragen niet te antwoorden.

Met uw toestemming, zal het interview opgenomen worden met als enige doel de verwerking ervan voor de onderzoeksdoelen. De interviews zullen letterlijk getranscribeerd worden en toegang tot de transcripten wordt strikt tot de onderzoeker en u zelf beperkt. De interviews zullen anoniem verwerkt worden en u zal bijgevolg niet herkenbaar zijn in de onderzoeksresultaten. U kan uw medewerking in het kader van dit onderzoeksproject op gelijk welk moment stopzetten en u kan het transcript van het interview bij de onderzoeker opvragen. De verwerking van uw gegevens vindt plaats conform GDPR.

MEER INFO

U kan meer informatie over het onderzoek vinden op de website van Belspo:
http://www.belspo.be/belspo/fedra/proj.asp?l=nl&COD=DR/84

Twijfel niet om de onderzoeker te contacteren bij verdere vragen:

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Probleemgebruik, hulpverlening en justitiële doorverwijzing bij personen met een migratieachtergrond en etnische minderheden (MEM) in België

Samenwerking rond hete hangijzers aan UGent

Personen met een migratieachtergrond en etnische minderheden hebben het vaak moeilijker in de samenleving vanwege bijvoorbeeld hun verblijfsstatuut, socio-economische status maar evengoed structurele of gepercipieerde discriminatie. Dit heeft gevolgen voor de mentale gezondheid en kan probleemgebruik in bepaalde doelgroepen beïnvloeden. Vanuit het perspectief van de drughulpverlening is het vaak moeilijk om deze diverse populaties te bereiken en een succesvol hulpverleningstraject te doorlopen. Verkennende studies wijzen erop dat personen met een migratieachtergrond minder aanwezig zijn in hoogdrempelige residentiële hulpverlening; oververtegenwoordigd zijn in laagdrempelige ambulante zorg; en zij later instromen en minder vaak een succesvol hulpverleningstraject doorlopen. Daarenboven suggereren internationale studies dat, wanneer personen met een migratieachtergrond vanwege probleemgebruik en het plegen van strafbare feiten, in contact komen met justitie, zij een ander traject doorlopen in vergelijking met personen zonder migratieachtergrond. Hoewel deze verkennende studies (zoals de Belspo ZEMIV & PADUMI onderzoeken) wijzen op aanzienlijke verschillen tussen personen met en zonder migratieachtergrond, is er in België vooralsnog heel weinig onderzoek naar dit thema én lijkt het erop dat het thema vaak vanuit een weinig sterktegericht perspectief benaderd wordt.

Samenwerking rond hete hangijzers aan UGent

De komende vier jaar (2019-2022) doen twee faculteiten van de Universiteit Gent (Faculteit Rechten & Criminologie, Faculteit Psychologie en Pedagogische Wetenschappen) hierover onderzoek. Het hoofddoel: het maximaal afstemmen van interventies in de drughulpverlening en justitie op de noden binnen deze diverse populaties en handvaten bieden voor toekomstig onderzoek. Dit werk wordt respectievelijk gefinancierd door het federaal wetenschapsbeleid (Belspo), het Fonds Wetenschappelijk Onderzoek (FWO) het Bijzonder Onderzoeksfonds van UGent. Het onderzoek bestaat uit vier onderzoekslijnen rond de volgende vragen:

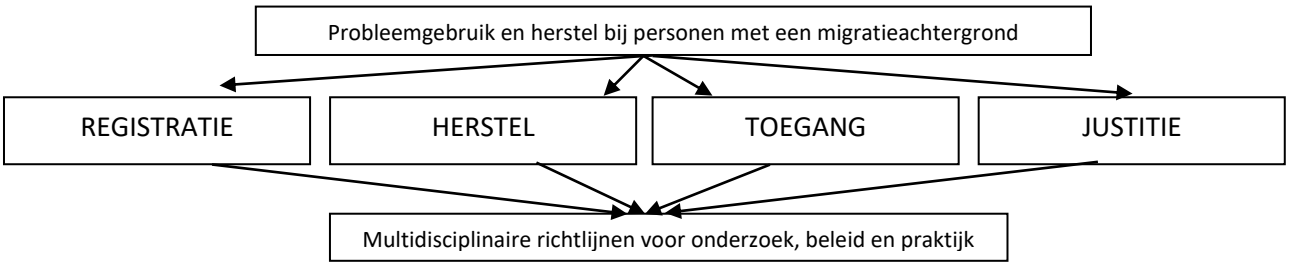
1. **REGISTRATIE & GOEDE PRAKTIJKEN:** Hoe wordt migratieachtergrond gemonitord en wat zijn goede praktijken in de Belgische en Europese drughulpverlening? (Belspo, onderzoeker Charlotte.DeKock@UGent.be, Prof. dr. Tom Decorte, in samenwerking met ULB, VAD, Fédito Wallonne & BXL)

2. **HERSTEL:** Hoe ervaren personen met een migratieachtergrond hun herstel van een middelenproblematiek en welke helpende en hinderende elementen definiëren zij zelf? (Fonds Wetenschappelijk Onderzoek, onderzoeker Aline.Pouille@UGent.be, Prof. dr. Wouter Vanderplasschen, Prof. dr. Freya Vander Laenen)

3. **TOEGANG:** Op welke wijze zet beleid en drughulpverlening in op toegankelijkheid voor, retentie en bereik van (potentiële) probleemgebruikers met een migratieachtergrond? (Bijzonder Onderzoeksfonds UGent, onderzoeker Charlotte.DeKock@UGent.be, Prof. dr. Tom Decorte, Prof. dr. Wouter Vanderplasschen)

4. **JUSTITIE:** Op welke manier speelt migratieachtergrond een rol bij de justitiële doorverwijzing van druggerelateerde criminaliteit naar de hulpverlening? (Onderzoeker Eva.Blomme@UGent.be, Prof. dr. Charlotte Colman)

In de laatste fase van het onderzoek werken we aan de integratie van deze vier onderzoekslijnen. We willen komen tot sterktegerichte, multidisciplinaire richtlijnen, aanbevelingen en **bruikbare strategieën** voor het omgaan met personen met een migratieachtergrond die kampen met probleemgebruik, in herstel zijn en / of strafbare feiten hebben gepleegd.



ANNEX 2: INTERVIEW GUIDE (DUTCH)

DEEL 1 ACHTERGRONDINFORMATIE

1. **Kan u de voornaamste doelen van uw organisatie beschrijven.**
   - Wat is uw functie?

Voor de onderzoeker, verwachte informatie:
- *Werk van de organisatie*
- *Functie van de respondents*

2. **Kan u iets meer vertellen over wat uw organisatie doet met betrekking tot middelengebruikers met een migratieachtergrond?**

- Kan u me iets vertellen over wat u organisatie ontwikkeld heeft of welke actie ondernomen zijn voor deze doelgroep?
- Waarom werden deze acties ondernomen?
- Indien niets significant werd gedaan:
  - Waarom niet?
  - Heeft u zelf reeds iets geprobeerd?
  - Wat zijn de moeilijkheden / barrières?

Voor de onderzoeker, verwachte informatie:
- *Goede praktijken met betrekking tot MEM druggebruikers (breed: beleid, organisatie, client-hulpverlener)*
- *Indien geen praktijken, waarom*
- *Barrières*

DEEL 2 VIGNETTE - GEVALSTUDIE

3. **Kan u denken aan een geval van een specifieke middelengebruiker met een migratieachtergrond in uw beroepspraktijk dat voor u typerend is voor de barrières die zij of waar uw organisatie mee geconfronteerd worden?**[107]

- Wie was deze persoon?
- Hoe beschrijft u het probleemgebruik van deze persoon?
- Hoe werd het probleemgebruik geïdentificeerd?
- Wie heeft hulp opgestart?

Voor de onderzoeker, verwachte informatie:
- *Profiel druggebruiker en doelgroep*
- *Of het middelengebruik anders zowel gelijkaardig omschreven wordt in deze doelgroep*
- *Praktisch geval waarmee de organisatie geconfronteerd wordt*
- *Hoe de organisatie de doelgroep monitort*

[107] case-orientedness of the questions / use of 1 vignette in the beginning of the interviews opens up the conversation and is based on the European PROMO project aimed at identifying promising practices for MEM in mental health (Priebe et al. 2012). Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., . . . 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

4. Waaruit bestaan de behandelingsopties voor deze persoon?

- Wie zou de persoon doorverwijzen?
- Welke diensten / organisaties zouden, een zij zijn geïnformeerd, contact met hem / haar opnemen?
- Hoe zou de hulpverlening die zij aanbieden er uitzien?

5. Wat zijn de barrières voor deze persoon om de juiste hulp te krijgen?

- Op welke wijze kunnen deze barrières volgens u worden weggewerkt?
    - Op welke wijze kan de *cliënt* deze barrières wegwerkten?
    - Op welke wijze kan de *dienst / organisatie* deze barrières wegwerkten?
    - Op welke wijze kan het *beleid* deze barrières wegwerkten?

Voor de onderzoeker, verwachte informatie:
- *Bestaande barrières (micro, meso, macro)*
- *Mogelijkheden om de barrières weg te werken*
- *Identificeren van aanbevelingen (zie ook laatste drie vragen)*

6. Naar uw mening, zou het traject in en naar de zorg gelijkaardig of anders zijn voor personen met dezelfde nationaliteit / migratieachtergrond[108]?
(beschikbare hulp, traject in de zorg, doorverwijzing, barrières, wegwerken van barrières)

7. Naar uw mening, zou het traject in en naar de zorg anders zijn indien het zou gaan om een ander middel?
(beschikbare hulp, traject in de zorg, doorverwijzing, barrières, wegwerken van barrières)

8. Naar uw mening, zou het traject in en naar de zorg anders zijn indien het zou gaan om een vrouw[109]?
(beschikbare hulp, traject in de zorg, doorverwijzing, barrières, wegwerken van barrières)

9. Naar uw mening, zou het traject in en naar de zorg anders zijn indien het zou gaan om een andere nationaliteit?
(beschikbare hulp, traject in de zorg, doorverwijzing, barrières, wegwerken van barrières)

10. Naar uw mening, zou het traject in en naar de zorg anders zijn indien de persoon geen wettige verblijfsdocumenten heeft?
(beschikbare hulp, traject in de zorg, doorverwijzing, barrières, wegwerken van barrières)

Voor de onderzoeker, verwachte informatie:
- *Andere omstandigheden per nationaliteit, gender, verblijfsdocumenten, middel*
- *Mate waarin respondent vindt dat trajecten / barrières dezelfde zijn voor diverse groepen MEM*

DEEL 3: SWOT

11. Hoe wordt drughulpverlening voor MEM gecoördineerd in uw regio (stad, provincie)?

- Hoe wordt de drughulpverlening gecoördineerd op administratief niveau?
    - Is dit gelijkaardig aan andere regio's?
    - Waarom?
    - Kan dit beter
- Hoe wordt dit gecoördineerd op het niveau van individuele patiënten / cliënten?

[108] Complemented, but the idea would also be to see to what degree there are 'intra-group' difference (also in line with not just looking at person with a migration background as 1 group and at the same time identifying vulnerabilities that are also present among 'national' vulnerable populations.
[109] PADUMI demonstrates that female users encounter larger barriers to treatment and TDI analysis TDI 2012-2014 demonstrates absence of female third country nationals in Belgian SUT.

- Is dit gelijkaardig of andere in andere regio's?
- Waarom?
- Hoe zou dit verbeterd kunnen worden?

Voor de onderzoeker, verwachte informatie:
- *Afstemming van verschillende initatiatieven*
- *Niveau van belangrijkste afstemming (stad, provincie, gewest,…)*
- *Structurele coördinatie*
- *Casemanagement op cliëntniveau*
- *Coordination of the various initiatives for MEM drug users*
- *Extra promising practices die we nog niet geïdentificeerd hebben*
- *Invloed van geografische eigenheden.*

12. Naar uw mening, wat zijn de sterktes van de drughulpverlening voor MEM?
- In deze regio
- In uw organisatie
- In het beleid

Voor de onderzoeker, verwachte informatie:
- *Gebaseerd op survey resultaten (toegang, bereik, retentie)*
- *Algemene mening van de respondent*
- *Nagaan of men vooral toegang, bereik dan wel retentie of andere factoren benoemt*
- *Nagaan op welk niveau men sterkte beschrijft (mirco, meso, macro)*

13. Naar uw mening, wat zijn de zwaktes van de drughulpverlening voor MEM?
- In deze regio
- In uw organisatie
- In het beleid

Voor de onderzoeker, verwachte informatie:
- *Probing based on the survey (access, reach, retention)*
- *General opinion of the respondent*
- *Nagaan of men vooral toegang, bereik dan wel retentie of andere factoren benoemt*
- *Nagaan op welk niveau men zwaktes beschrijft (micro, meso, macro)*

14. Kan u benoemen hoe de drughulpverlening voor MEM kan verbeterd worden / welke mogelijkheden er zijn?
- In uw organisatie
- In deze regio

15. Indien u drie zaken zou willen vragen aan het beleid op federaal of op Vlaams niveau, wat zou dit dan zijn?
- Kan u dit verder toelichten
- Hoe zou dit kunnen worden bewerkstelligd?
- Zijn dit realistische ideeën
- Wat zijn de randvoorwaarden voor het verwezenlijken hiervan?

- *Voor de onderzoeker, verwachte informatie:*
- *Gebaseerd op survey resultaten*
- *Algemene mening van de respondent*
- *Nagaan of men vooral toegang, bereik dan wel retentie of andere factoren benoemt*
- *Nagaan op welk niveau men aanbevelingen wil geven (micro, meso, macro)*

- *Aanbevelingen identificeren*

16. Wil u iets toevoegen?

Voor de onderzoeker: alles extra informatie waar we niet aan gedacht hebben.

Priebe and colleagues (2011) in their study on good practices in mental health care for socially marginalised groups identified four components of good practice namely

1. *Establishing **outreach** programmes to identify and engage with individuals with mental disorders;*
2. *facilitating **access** to services that provide different aspects of health care, including mental health care, and thus reducing the need for further referrals;*
3. *strengthening the **collaboration and co-ordination** between different services;*
4. ***disseminating information** on services both to marginalised groups and to practitioners in the area*

*Ledoux and colleagues (2015) in their "Principles of best and good practices in migrant access to health services" additionally identified that **access** to health services, **culturally sensitive healthcare, individual quality care, respect** towards migrants and efficient **communication** are the principles gathering the highest consensus among health professionals.*

Furthermore, specifically for SUT, following priorities were identified:

- *Prevention and early detection*
  - *disseminating **information** on the target groups among the services in an area (Priebe et al. 2014);*
  - *Interventions aimed at **knowledge increase about dependence, risk factors and services** (Priebe et al. 2014);*
  - *Interventions aimed at **migration related coping mechanisms** (e.g. mindspring);*
  - *Prompting (potential) clients to **interact with the formal health care system** or health care providers (Butler et al. 2016) and **referral** to treatment.*
- *Harm reduction and treatment interventions at client level*
- *Service practices (organisation policies and procedures to effectively respond to the service needs of (potential) migrant and ethnic minority clients):*
  - *Establishing **outreach** programmes to identify and engage with individuals with mental disorders (Priebe et al. 2014);*
  - *facilitating access to services that provide **different aspects of health care**, including mental health care, and thus reducing the need for further referrals (Priebe et al. 2014);*
  - *Strengthening the **collaboration and co-ordination** between different services (Priebe et al., 2014);;*
  - *Development of **resources and linkages** to serve specific target groups (access & retention);*
  - *Mainstreaming **interpreter policies** and **support, intercultural work / mediator, diversity policy**, intervention level practices (e.g. cultural formulation interview) (e.g. ondersteuning door Orbit vzw e.d.);*
  - ***Psycho-education**;*
  - *Meeting the needs of specified migrant and ethnic minority needs in treatment;*

- *interventions providing **alteration of an established protocols** in the organisation (Butler et al., 2016).*

- *Personnel practices*
  - *personal **involvement** in specified target groups (reach);*
  - *hiring and retention of **employees with a migration background** and / or specific language knowledge (retention & reach).*
  - ***Provider training & education** (Butler et al. 2016) (e.g. increasing individual staff knowledge and competences about specified target groups (retention) in prevention / harm reduction / treatment / general mental health services.)*

ANNEX 3: POSTER PRESENTED AT LISBON ADDICTION 2019

Migrants & ethnic minorities in EU drug treatment

Practices aimed at increasing reach, access & retention

GHENT UNIVERSITY

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belspo

"some [MEM] may be more vulnerable to substance misuse for reasons such as trauma, unemployment and poverty, loss of family and social support, and the move to a normatively lenient setting" EMCDDA, 2019, p. 9

CAVEATS IN RESEARCH AND POLICY

In Europe and Belgium, research on drug treatment service use among varying migrant and ethnic minority (MEM) populations is scarce. Although indications of service disparities among these populations are emerging, drug policies are not specifically aimed at migrants and ethnic minorities. (Burkhart et al., 2011; Fountain, 2013; Lemmens, 2017).

ACCESS

- Some migrant and ethnic minority (MEM) populations, especially refugees and asylum applicants have limited access to European drug treatment services (Cuadra, 2012)
- Non-nationals are overrepresented in methadone substitution in Belgium compared to their representation in the population (Blomme et al. 2018)
- Non-nationals are underrepresented in residential services (i.e. therapeutic communities in Flanders) and ambulant services (aside from OST) (Blomme et al., 2018)
- Non-national clients are older at first intake and have a lower socio-economic status compared to Belgian clients, especially non-EU nationals (Derluyn et al., 2008; unpublished Belgian Treatment demand indicator analysis 2012-2014)
- Language is an exclusion criterion in some Belgian residential settings (unpublished, De Kock et al., 2019)

RETENTION

- Exploratory studies point out lower retention rates among some MEM populations (Derluyn et al., 2008; Mortier, 2017)
- Growing influence of 'culturally sensitive treatment' (Bombeeck et al. 2019), but little outcome studies on whether 'culturally competent' approaches work to reduce disparities (De Kock, 2019)

REACH

- Knowledge about drug treatment services is limited among some MEM (i.e. Intra-European migrants and refugees) (De Kock et al. 2017)

POLICY ORIENTED RESEARCH QUESTION

Which inspiring practices are used in European drug treatment services to increase access for, reach and retention of MEM populations that can inspire Belgian drug treatment?

- **What are the main goals: reach, access and / or retention?**
- **Which are the targeted populations?**
- **In which domain are these practices located (prevention, treatment, harm reduction)?**
- **(how) Are these practices evaluated?**

→ **Input for a 'Guidebook for accessible and intercultural drug treatment' in Dutch and French**

METHOD: Survey distribution

- 15 core questions: 9 multiple choice and 6 open ended questions
- Dissemination in two waves to 33 European drug treatment related networks (based on an updated list of Fountain [EMCDDA], 2013)
- 84 purposively sampled EU contacts
- Coordinators of 14 EU wide projects on migrant health

Broad Inclusion criteria

- Aimed at increasing access for, reach and retention ofMEM in treatment
- Practices: interventions, projects, (small) service actions, measures, policies

Limitations

- Broad inclusion criteria: hard to discern trends across the practices
- Sampling bias (overrepresentation of Portugal,Czechia)
- Limited time frame of the survey
- Exclusion of Belgium (discussed separately in the MATREMI report)

34 PRACTICES

DOMAIN
- Mainly harm reduction
- Less prevention, early intervention & treatment

GOAL
- Mainly access and reach oriented
- Little to none of the practices aimed at retention
- Besides access, reach and retention, practices also focus on tackling social vulnerability

POPULATIONS
- Varying interpretations of 'MEM' populations
- Little practices aim at (undocumented) **refugees & intra-European migrants**
- Northern and Western states: **'non-nationals' & labour migration related backgrounds**

EVALUATION
- Half had positive outcomes (attendance rates)
- over 80% was not based on previous practices
- Half of the practices had not been evaluated
- Only a small minority has a manual available

CONCLUSION & REFLECTION

Mainly *ad hoc* access and reach oriented practices
Little to no practices aimed at retention in treatment
Little evaluation research and evidence-based practice
Little practices in residential high treshold treatment → what about outreach in a recovery and community based perspective? (cfr. Priebe et al., 2016)
Country representation comparable to the EMCDDA prevention profiles

There is a need for…

- Early (brief) intervention among refugees (Kane & Greene, 2018) & innovating residential treatment to cope with diversity in society
- Targeted prevention aimed at increasing knowledge about treatment (Kohlenberger, 2019; Butler, 2016; Priebe et al., 2011)
- Addressing social needs among varying MEM (WHO, 2018; Priebe et al., 2016)
- Targetted policy support for tackling MEM (mental) health and substance use related issues (WHO, 2018; Burkhart et al., 2011)

We need to think about how we can…

- Share expertise on early intervention in asylum centres and camp settings
- Disseminate and improve existent practices among professionals
- Support professionals in conducting and disseminating (low threshold) evaluation

Some examples of the identified practices

***DMB project , Tovarna ROG (Ljubljana, Slovenia)**: outreach work with migrants that use drugs, support, dissemination of Nalaxone and paraphernalia*

***Opioid Substitution Treatment, ARAS, Romanian Association Against Aids (Bucharest, Romania)**: methadone substitution treatment, testing for HIV and hepatitis, social and psychological counselling, general medical check-ups*

***ADV Rehabilitation und Integration gGmbH Projekt NOKTA (Berlin, Germany)**: intercultural drug treatment: individual therapy plans in residential treatment for men with a migration background*

***Native Videotranslation during treatment, Verein Dialog (Vienna, Austria)**: diagnosis and counselling for drug addicted immigrants*

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Ghent University recently created an informal research network on access to treatment, recovery and judicial referral among migrants and ethnic minorities. This network involves Prof. Dr. Tom Decorte, Prof. Dr. Wouter Vanderplasschen, Prof. Dr. Freya Vander Laenen, Prof. Dr. Colman and researchers Charlotte De Kock, Aline Pauille and Eva Blomme.

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