FEDERAL RESEARCH PROGRAMME ON DRUGS

Short final report

MATREMI

MAPPING & ENHANCING SUBSTANCE USE TREATMENT FOR MIGRANTS AND ETHNIC MINORITIES

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).

Many individuals 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 report. Lies Gremeaux and Jérôme Antoine (Sciensano, Belgian Reitox Focal Point) provided input and comments to the early and advanced versions of chapter 3.5 and 3.6 on migration and ethnicity related indicators in TDI and were key in disseminating the European surveys to National Reitox Focal Points. Hannah Vermaut (UNIA, Belgian Equality Body) provided comments on an early draft of chapter 3.5 and 3.6.

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.

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Conclusions

Migrants and ethnic minorities (MEM)[1], 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 (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 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 therefore 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?

- 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?

[1] 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.

- 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?

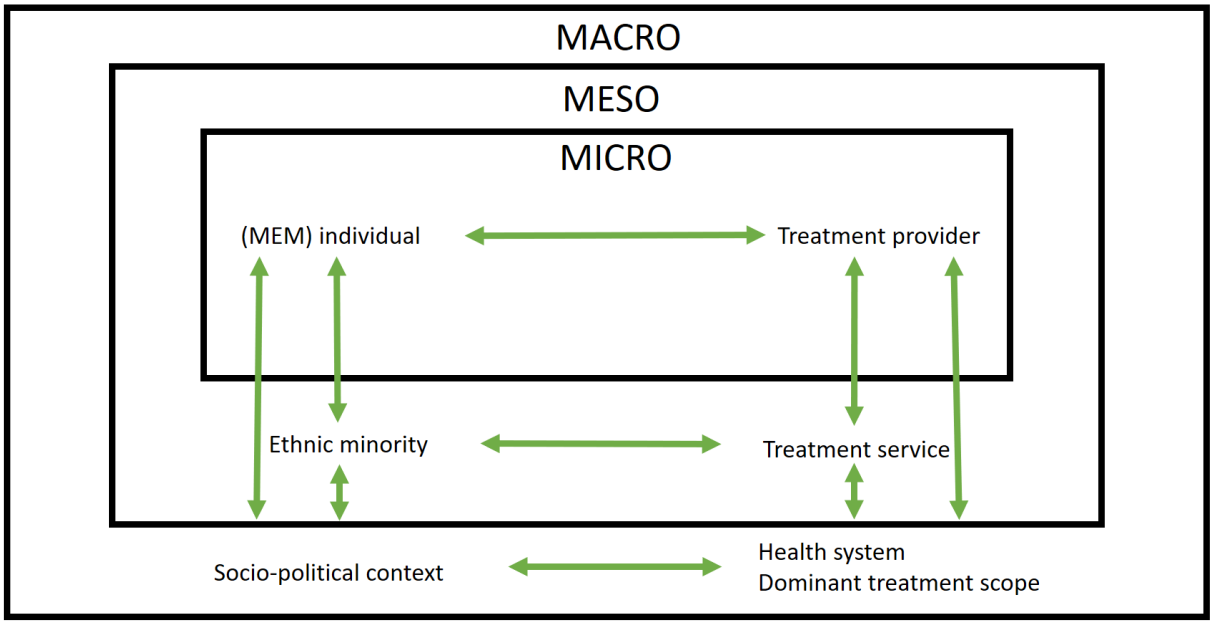
Several methods were used to answer these two main research questions over a period of 8 months:

- **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) (1), followed by an evaluation of the state of (mental) health among MEM in Europe (2). Next, we discuss the knowledge about prevalence of substance use among MEM in Europe (3) and Belgium (4). Then, we move on to discussing substance use an treatment among MEM in Belgium (5). Next, we discuss our empirical findings among professionals in substance use treatment in Flanders (6), Brussels and Wallonia (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 (8).

This study departed from and equal rights and ecosocial perspective (Alegría 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.

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 numbers reflect 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[2] (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' (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 centers for mental health (CGG), 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.

[2] 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)

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 (i.e. EPD, CIS, MSOC.net). However, the used indicators are often not sufficiently discriminatory (i.e. '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.[3]

- 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, 2017). 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.

2. Migrant and ethnic minority state of health(care) and access to health 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.

At the European level several projects aimed at monitoring and enhancing migrant health (services) (i.e. 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

[3] 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).

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 (i.e. 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[4].

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

[4] 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.

contribute to substance use in the six studied Roma communities in Italy, Bulgaria, Romania, Spain, Slovenia and France.

In the consulted international literature we only 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).

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 corroborated this hypothesis elsewhere (De Kock, 2020 in review).

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.**

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 that identified as having a migration background (first- or second-generation and a western or non-western migration background) (2013) (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.

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 & Antoine in review) 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.

6. The perspective of professionals in Flanders

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 substance use treatment 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[5] (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.

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[6]. 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.

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).

[5] 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*).

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

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 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 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 i.e. family) and / or that the 'core' **question might be covered** up by **another request for help** (i.e. 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 (i.e. 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 (i.e. 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 (i.e. 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.

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 MSOCs (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** (i.e. 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 (i.e. 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 (i.e. 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.

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.

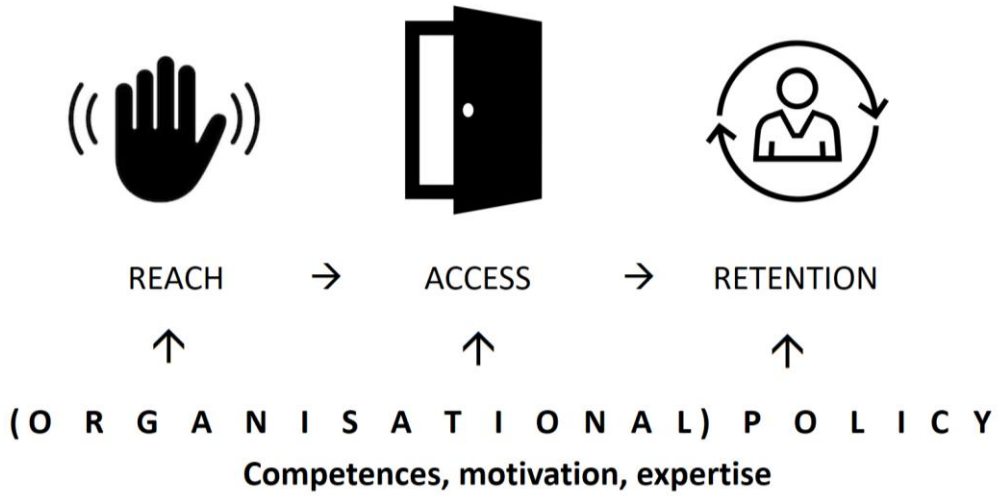
We concluded from these European survey results that there seems to be a research and treatment caveat in higher threshold residential treatment. Additionally, health service planners and drug policy makers should reflect on how to serve the needs of those non-nationals that require other than substitution treatment. An interesting path for the future could be to explore knowledge and expertise transfer between lower and higher threshold services (i.e. outreach and language facilities).

You can find more information about all the identified inspiring practices in the MATREMI report and 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).

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 (i.e. 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 with specific objectives."*

1. Registering and processing migration related indicators in substance use treatment

Relationships of inequality (i.e. under-/overrepresentation in treatment or prevalence of substance use) represented by categories (i.e. 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 background indicators, conform GDPR, is consequently a key prerequisite to enable this type of analysis and to install positive action (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' (i.e. race, ethnicity, religion etc.)** and create guidelines in the health domain to enable policy monitoring with an equity focus to the example of i.e. the socio-economic monitoring in the labour domain (UNIA, 2017) (i.e. Data Protection Authority)(Farkas, 2017; 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 (i.e. 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) (I.e. 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) (i.e. 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) (i.e. 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). (i.e. Sciensano).

1.5.1 **Incentivising registering services** to remove older registration categories (i.e. 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 (i.e. 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).[7]

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) (i.e. based on the preparatory work in this report) to ensure the lawfulness of data collection and processing (i.e. 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)[8] without infringing the right to be able to present anonymously to certain SUT services (i.e. 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**.

[7] 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"

[8] 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.

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 (i.e. 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).

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 (i.e. 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) (i.e. 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 (i.e. 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) (i.e. *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 (i.e. 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 (i.e. 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 (i.e. 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 (i.e. asylum centres, integration centres, CAW, OCMW, i.e. to the example of CAD Limburg) (i.e. 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 i.e. 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 (i.e. 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) (i.e. 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 (i.e. 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, i.e. 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** (i.e. 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, in the future 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. (i.e. '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) (i.e. 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, i.e. 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. (i.e. Ghent Municipality developed a tips & tricks folder in dealing with Roma)

7.2 **Family inclusion in therapy** (El Osri, Noens) i.e. 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** (i.e. 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 (i.e. intake procedures) of your service.
7.6.5 Share expertise in your networks i.e. 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-EU 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-EU 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 (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 (i.e. (vb. Migr'En Santé network) (El Osri, 2012; Noens; 2010).
8.2 Proactively disseminate information about substances and dependencies in organisations that reach MEM (i.e. asylum centres, NGO's, OCMW etc.) (i.e. 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 (i.e. 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 (i.e. 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).

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