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Responding to drug-related problems among migrants, refugees and ethnic minorities in Europe

Background paper commissioned by the EMCDDA for
Health and social responses to drug problems: a European guide

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Contents

Introduction

Migration has had an increasing impact on European policymaking over the past decade, in the wake of what has been called the 'refugee migration peak' (Hampshire, 2016). In addition to an influx of refugees, European countries have experienced relatively new intra-European migration flows, while health and social disparities persist among populations with longer-established migration patterns (Agyemang and van den Born, 2019; Blom et al., 2016; Cook et al., 2013; IOM, 2016).

Definitional issues

A refugee is a person who has been forced to flee his or her home country due to a well-founded fear of persecution, war or violence (UN General Assembly, 1951). The percentage of recognised refugees relative to the population in EU Member States in 2018 ranged from 0.1 % in Lithuania to 2.4 % in Sweden (Migration data portal, 2019). The three most common nationalities of asylum applicants in the EU in 2018 were Syrian, Afghan and Iraqi (Eurostat, 2019).

An international migrant is any person who has changed his or her country of usual residence (United Nations Statistical Office, 1980). In 2019, a total of 11 % of the European population were international migrants (IOM, 2019, p. 24), comprising 7 % who were born outside the EU and 4 % born inside the EU (IOM, 2019; O'Donnell, 2018). The most popular destinations for international migrants among the EU Member States in 2019 were, in descending order, Germany, the United Kingdom, France, Italy and Spain (IOM, 2019, p. 26).

Undocumented migrants. Some refugees do not apply for asylum in the receiving country or are denied refugee status. These persons are often called undocumented migrants, migrants in irregular situations or irregular migrants. This population is estimated to be between 1.9 and 3.8 million (PICUM in O'Donnell, 2018, p. 7). Many of these individuals are in transit (e.g. because they intend to end their journey in another Member State or, for instance, the UK), which makes them particularly hard to reach and vulnerable, especially in the case of unaccompanied minors.

This threefold, though overlapping, distinction — international migrant, refugee, migrant in an irregular situation — is important because it influences the individual's de facto right and access to health care. Whereas the European Union Agency for Fundamental Rights (FRA, 2015) states that everyone has the right to emergency medical and antenatal care, the WHO (2010a, 2010b, 2018) adds that persons should also be entitled to proactive care, including health promotion and disease prevention. The UN Convention on the Rights of the Child (ratified by all EU Member States) also includes the right to health care for children, and antenatal, perinatal and postnatal care for mothers.

Nevertheless, Dauvrin and colleagues point out that access to health care varies across the Member States, from 'no right to health care', or 'a minimum of rights', to the right to primary and secondary care (Dauvrin et al., 2012). However, even when care is received, it is often inadequate or insufficient. Many migrants in irregular situations are unfamiliar with their entitlements and face barriers in accessing health care services (Winters et al., 2018). For a full list of European countries' regimes of entitlements see O'Donnell's overview (2018).

Intra-European migrants and Roma ([1]). In 2017, about one-third (29.5 %) of international migrants in the Member States were nationals of a different EU Member State (Eurostat, 2019; FRA 2018). Emigration from Eastern European countries to Western Europe has been a growing trend, particularly since the expansion of the EU in 2004 and 2007 (IOM, 2019, p. 93). Romanian, Polish, Italian, Portuguese and British citizens were the five biggest populations of EU citizens living abroad

([1]) The Council of Europe uses 'Roma' as an umbrella term. It refers to Roma, Sinti, Kale and related populations in Europe, including Travellers and the Eastern populations (Dom and Lom), and covers the wide diversity of the populations concerned, including persons who identify themselves as Gypsies (FRA, 2018).

in EU Member States in 2018 (Eurostat, 2019; FRA 2018). There are no estimates of the percentage of Roma among these migration flows. Nevertheless, Roma are the largest ethnic minority – estimated at 10 million – in Europe and are at particular risk of experiencing prejudice, intolerance, discrimination and social exclusion in their daily lives, as well as facing barriers to accessing health care (European Commission, 2011; Sándor et al., 2017).

Migrants and ethnic minorities (MEM): The combined terminology 'migrants and ethnic minorities' is used by the European Regional Office of the World Health Organization (WHO, 2010b), the European ETHEALTH report on equality in health and health care (Derluyn et al., 2011) and the European Public Health Association (2018). Health researchers increasingly recognise that migrants and ethnic minorities (MEM) may face comparable societal and health challenges (Razum and Stronks, 2014), experiencing similar disadvantages across the range of host societies (Bhopal, 2019; Filler et al., 2020; Razum and Stronks, 2014). The benefits of using this combined terminology include that it allows researchers to consider: (1) the individual history of migration; (2) the feeling of belonging to an ethnic group; and (3) societal denomination, categorisation and its consequences (De Kock et al., 2017b). The combined terminology encompasses residence status, generation, nationality, gender, socio-economic class, etc., while allowing researchers to distinguish between these factors. When studying high-risk substance use and responses in these populations, this approach facilitates a layered understanding of the aetiology of problem use and help-seeking behaviour.

Nevertheless, this combined terminology has limitations and in some cases the differences in experiences between these populations may be greater than the similarities. By the same token, incomplete citizenship rights, discrimination, social exclusion and health inequities might be experienced differently (WHO, 2010a) by different groups. Moreover, MEM should be studied intersectionally, with a focus on self-definition as well as inter- and intra-categorical diversity and heterogeneity (De Kock et al., 2017b; Razum and Stronks, 2014; Wemrell, et al., 2017). It should also be noted that definitions, concepts and categories of migrants and migration are necessarily informed by geographic, legal, political, methodological, temporal and other factors (IOM, 2019). In addition, it is important to recognise that countries define or categorise first-, second- and third-generation migrants in different ways, which reduces the comparability of prevalence estimates.

Report structure

In the following section we present the available prevalence studies of illicit substance use among MEM and discuss their limitations (1.1), as well as looking at prevalence and risk factors for substance use among refugees (1.2). Two subsections focus on specific issues among non-refugee third-country nationals (1.3) and Roma (1.4). Section 2 of this paper summarises risk and protective factor mechanisms in an ecosocial framework, while sections 3 and 4 are the core of this paper, and focus on social responses targeting migrant and ethnic populations in prevention, treatment and harm reduction, as well as highlighting broader responses which support these interventions. Finally, sections 5 and 6 conclude the report with a discussion of major challenges in addressing drug-related problems among these populations and examine some possible implications for policy and practice.

1. Prevalence of substance use among MEM: key issues and data gaps

There are few studies that report on the prevalence of substance use among MEM populations in Europe. Priebe and colleagues (2016) point out that evidence for the prevalence of any mental health disorder among irregular migrants is particularly limited. Cross-sectional prevalence studies that are representative at the general population level are only available for Finland (Salama et al., 2018), Norway (Abebe et al., 2015), Spain (Sarasa-Renedo et al., 2015) and Sweden (Harris et al., 2019) ([2]) (see Table 1).

Increasing the availability of data on the prevalence of substance use among MEM in the Member States would provide a basis for this emerging research domain. However, data about prevalence alone, as stated by Ritter and colleagues (2019, p. 22), 'is limited in its usefulness unless it is matched with consideration of different treatment types and their relative intensity, and/or explored as a function of geography and subpopulation'.

Moreover, where data exist, cross-sectional studies that compare MEM and non-MEM populations reveal differential rates of prevalence which cannot fully be explained because they can only investigate individual aetiology by including individual-level moderator and mediator analysis (De Kock et al., 2017b). Consequently, and in line with recent migrant health research practice, studies that compare MEM to their home populations as well as making MEM cross-country comparisons are indispensable in developing a deeper understanding of the influence of, respectively, context (e.g. health systems) and the role of migration (Agyemang and van den Born, 2019).

Understanding these varying root causes (individual, context, migration) is vital to the development of logical intervention models and for adapting existing treatments that target key contributors to substance use. Consequently, and because studies of substance use prevalence among MEM are scarce in Europe, this paper will discuss prevalence rates in the light of these root causes (see sections 1.2-1.4 and 2). Exploring prevalence rates against this background clearly reveals and exemplifies the strengths and limitations of substance use prevalence studies for understanding this topic

([2]) Studies were primarily identified in the MATREMI study (De Kock, 2020c). Additional inclusion criteria were: studies published during the past decade (thus excluding studies such as Hjern, 2004); population- or survey-based cross-sectional studies that approach representativeness at national level in an EU Member State (excluding studies of specific treatment contexts such as register-based hospitalisation or primary care and studies focused on the regional level such as Qureshi et al., 2014; Svensson and Hagquist, 2010); those published in English in an academic blind peer-reviewed journal and studying illicit substance use as a main outcome (excluding studies such as Rolland et al., 2017 which only examined alcohol use). All study bibliographies have been screened and citations followed up on. The authors were contacted to identify additional studies.

Table 1: Cross-sectional population and survey-based studies on the prevalence of substance use among migrants and ethnic minority populations in the EU			
Member State	**Reference**	**Design, sample, outcome measured (from abstract)**	**Substance-use-related results (from abstract)**
Finland	**Salama et al. 2018**	• **Sample:** Survey participants were of Russian (n = 702), Somali (n = 512) and Kurdish (n = 632) origin. • **Method:** Cross-sectional data from the Finnish Migrant Health and Wellbeing Study (Maamu) and comparison group data of the general Finnish population (n = 1 165) from the Health 2011 Survey. • **Outcome:** Substance use included self-reported alcohol use within the previous 12 months (AUDIT-C questionnaire), current and lifetime daily smoking and lifetime use of cannabis and intravenous drugs.	• The prevalence of lifetime cannabis use was 21 % in men and 14 % in women of Russian origin, and lower among Kurdish origin participants (6 % in men, 1 % in women). Somali participants did not report cannabis use. Somali migrants and Kurdish women were excluded from the further analyses. Cannabis use during the previous 12 months was reported by 9 % of Russian men and 2 % of Russian women. **The prevalence of lifetime cannabis use was low among migrants of Kurdish and Somali origin. The reported prevalence rates of lifetime cannabis use among Russian migrants were lower than those of the general population** reported elsewhere. • Among Russian migrants, lifetime cannabis use was associated with younger age, underage migration to Finland and a longer residence in Finland. • Lifetime intravenous drug use was very rarely reported in all the migrant groups. • Several migration-related factors, such as age at migration and language proficiency, were associated with substance use.
Norway	**Abebe et al. 2015**	• **Sample:** 10 934 adolescents aged 14-17 years, just over half of which were females. The sample comprised 73.2 % ethnic Norwegian adolescents, and 9.8 % first-generation and 17 % second-generation immigrants from Europe, the US, the Middle East, Asia and Africa. • **Method:** School-based cross-sectional survey of adolescents in junior and senior high schools in Oslo, Norway. • **Outcome:** Prevalence and factors associated with binge drinking, cannabis use and tobacco use.	• Past year prevalence for cannabis use ranged from 10.6 % among second-generation Europeans and those from the US to 3.7 % among second-generation Asians. • After adjusting for age and gender, the **risk of cannabis use was significantly lower among second- generation adolescents from the Middle East, Asia and Africa and first-generation Middle Eastern and Asian adolescents, compared to ethnic Norwegian adolescents**. • Being older, male and belonging to non-Christian/non-Muslim groups, as well as having more severe symptoms of depression, were significantly associated with a higher risk of cannabis use.
Spain	**Sarasa-Renedo et al. 2015**	• **Sample:** 12 432 adolescents with recent immigrant background (ARIBs, ≥ 1 foreign-born parent) and 75 511 autochthonous adolescents (ARIBs were classified by the adolescents' birthplace (Spain/abroad), whether they had mixed parentage (one Spanish-born and one foreign-born) and country-of-origin characteristics). • **Method:** Pooled from 2006-2010 school surveys. • **Outcome:** Use of alcohol, tobacco, cannabis, stimulants and sedative-hypnotics.	• Compared to autochthonous adolescents, **foreign-born adolescents with recent immigrant backgrounds and without mixed parentage showed significantly lower adjusted prevalence ratios**, i.e. < 1 for all substances, which generally approached 1 in Spanish-born ARIBs with mixed parentage. • The main factors mediating ARIBs' lower risk were relatively infrequent socialisation in leisure environments and less association with peers who use such substances. ARIBs' lower risk depended more on country-of-origin characteristics and not having mixed parentage than on being foreign-born. • Tobacco, cannabis and stimulant use in ARIBs grew with increasing population use of these substances in the country of origin. ARIBs from non-Muslim regions had a lower risk of using alcohol and a higher risk of using sedative-hypnotics than those from Muslim regions.

Sweden	**Harris et al. 2019**	• **Sample:** 1.2 million people. Refugee and non-refugee migrants (restricted to those from regions with at least 1 000 refugees in the Swedish registers) compared to Swedish-born individuals. • **Method:** Nationwide cohort study; a cohort born between 1984 and 1997 from their 14th birthday or arrival in Sweden, if later, until an International Classification of Diseases (10th revision (ICD-10)) diagnosis of substance use disorder (codes F10.X-19.X), emigration, death or end of follow-up (31 December 2016). • **Outcome:** Substance use disorders (F10.X-19.X), alcohol use disorders (F10.X), cannabis use disorders (F12.X), and polydrug use disorders (F19.X).	• Refugees compared to non-refugee migrants were more economically disadvantaged at cohort entry ($p < 0.001$) than the Swedish-born population. • **Refugee (aHR: 0.52; 95 % CI 0.46-0.60) and non-refugee (aHR: 0.46; 95 % CI 0.43-0.49) migrants had similarly lower rates of all substance use disorders, compared with Swedish-born individuals** (crude incidence: 290.2 cases per 100 000 person-years; 95 % CI 287.3-293.1). • **Rates of substance use disorders in migrants converged to the Swedish-born rate over time**, indicated by both earlier age at migration and longer time spent in Sweden. • Findings did not differ substantially by migrants' region of origin. • While post-traumatic stress disorder **(PTSD) diagnosis was over five times more common in refugees than in the Swedish-born population, it was more strongly associated with increased rates of substance use disorders in the Swedish-born population** (aHR: 7.36; 95 % CI 6.79-7.96) **compared to non-refugee migrants** (HR: 4.88; 95 % CI 3.71-6.41; likelihood ratio test [LRT]: $p = 0.01$) and refugees.

1.1 Refugees

Becoming a refugee influences risks for substance use disorders due to high levels of distress and mental health problems, disruption of protective community networks, transformation of social roles, changes in access to substances, and weakened enforcement of substance control policies

(Weisbecker et al. in Greene et al., 2019, p. 246)

In line with the 'healthy migrant effect' ([3]) (Constant et al., 2018) as well as the 'migrant paradox' ([4]), prevalence studies demonstrate that — in a range of mental health disorders and mainly in the first years of resettlement — only post-traumatic stress disorder (PTSD) rates are higher in refugees compared to the general populations of their host countries (Giacco et al., 2018). The prevalence of PTSD in refugees is estimated at an average of 9 % in Western countries (Giacco et al., 2018), with higher rates in some Member States such as the Netherlands (ranging from 13 % to 25 %, Speth et al., 2018), but less is known about the prevalence of substance use.

There is evidence to demonstrate that not only do pre-migration circumstances (e.g. trauma or substance use in the individual's home country) contribute to PTSD, depression (Knipscheer et al., 2015; Lindert and Schimina, 2011) and substance use after migration (Bogic et al., 2012; Brendler-Lindqvist et al., 2014; Horyniak et al., 2016), but post-migration circumstances and experiences (e.g. stress, lack of social integration, lack of resources or poor access to mental health services) also have an impact.

In addition to these pre- and post-migration circumstances, substance use in the host country also influences substance use among refugees — especially among those who have been settled for a longer time (Bogic et al., 2012). At the individual level, being a younger male and not living with a partner were associated with substance use disorders in Bogic et al.'s (2012) study among longer-settled refugees.

Similarly to their adult counterparts, unaccompanied minor refugees are more susceptible to PTSD, depression and anxiety (Derluyn and Broekaert, 2008). A review of the prevalence of mental health disorders in Europe found no studies on the prevalence of substance use ([5]) among unaccompanied minor refugees (Kien et al., 2018). However, Ivert and Magnusson (2020) found that untreated mental health problems, stressful living conditions and a lack of support and control might put these children at greater risk of substance use. Worrying trends concerning the use of, for instance, alcohol, toluene and Rivotril (clonazepam) among young refugees have indeed been signalled in the media in Sweden, Germany, the Netherlands and Belgium. Nevertheless, these trends appear to be rapidly changing and remain largely under-studied in academic literature.

Besides the above-mentioned potential causes, individuals may differ in their propensity and vulnerability to substance use and in the degree of their exposure to 'criminogenic' settings (Wikström and Sampson, 2003), or in terms of the simple availably of substances. These factors may all contribute to (the initiation or progression of) substance use. Nevertheless, the association between mental health problems and substance use, particularly in the context of self-medication, is well documented (Jané-Llopis and Matytsina, 2006). By contrast, a high-quality study linking Swedish

([3]) The 'healthy migrant' effect is a phenomenon that occurs when the health of immigrants is better than their native-born counterparts upon arrival. Studies suggest that this advantage deteriorates over time (Aglipay et al., 2013, p. 851). In the European context, the influence of this effect on substance use has only been confirmed in the first generation (Rolland et al., 2017).
([4]) The migrant paradox holds that recent immigrants often out-perform more established immigrants and non-immigrants on a number of health, education and conduct or crime-related outcomes, despite the numerous barriers they face to successful social integration.
([5]) Termed as 'use of illicit substances and alcohol' in the referenced study.

register data found that while a PTSD diagnosis was over five times more common in refugees than in the Swedish-born population, it was more strongly associated with increased rates of substance use disorders in the Swedish-born population compared to refugee as well as non-refugee migrant populations. As this finding has not been corroborated in other contexts, more research is warranted.

There is consensus among researchers that substance use prevalence rates among refugees are generally lower compared to non-MEM populations, and this may reflect prevalent behaviours with respect to substance use in the countries of origin (Harris et al., 2019). However, the prevalence of substance use becomes increasingly similar to that of the general population over time (Horyniak et al., 2016; Hurcombe et al., 2010; Priebe et al., 2016; WHO, 2018). Additionally, studies point out that adverse socio-economic living conditions (Hjern, 2004), particularly pre- and post-migration, may contribute to a higher risk of substance use.

The findings of Lorant and colleagues (2016) and Van Royen (2018) appear to corroborate this hypothesis among non-refugee MEM populations ([6]), but further research is needed. Moreover, prevalence could well be lower or higher among specified MEM subpopulations — due to, for instance, intersecting risk factors — and among those individuals endorsing substance-use-related coping (Alamilla et al., 2019; Gibbons et al., 2016).

1.2 Non-refugee third-country migrants

There is a lack of data on the prevalence of substance use and treatment demand among the wider population of third-country migrants (De Kock, 2019b). Nevertheless, national data reported to the EMCDDA do reveal some tendencies that warrant further research. For instance, the figures show high proportions of third-country nationals in outpatient opioid agonist treatment in Greece and Cyprus. Third-country nationals in Belgium have also been reported as over-represented in opioid agonist treatment and under-represented in high-threshold residential treatment (Blomme et al., 2017; De Kock et al., 2020).

Russian-speaking populations and former USSR nationals have been identified as a significant client group in harm reduction services in some Member States, such as Belgium (De Kock, 2020d; Mascia, 2020), Germany, and France (Jauffret-Roustide et al., 2017). This could be partly due to restrictive drug policies in the home countries (see Golichenko and Chu, 2018; Rhodes et al., 2006), but may well result from the impact of living in areas of protracted conflict, for instance eastern Ukraine (see IOM, 2019, p. 93). Additionally, both Estonia and Latvia reported Russian-speaking clients in treatment (Reitox drug report, 2014), but it remains unclear whether they are members of these countries' Russian ethnic minorities or Russian citizens crossing the border to seek treatment. Overall, Russian-speaking populations identified in European substance use treatment services are very diverse (i.e. national minorities versus first-generation migrants) and remain largely under-studied.

More recently, a growing number of vulnerable substance users from south-east Asia were reported in Cyprus (national data reported to EMCDDA) and Portugal (Fuertes et al., 2017). However, although people of certain nationalities, or distinguished by particular migration patterns or ethnic backgrounds may appear to be either over- or under-represented in substance use services, it is vital to explore these trends in context, which may include issues such as disadvantaged social positions or barriers to social integration and health services (Razum and Stronks, 2014).

([6]) Among adolescents, factors linked to higher prevalence rates included higher proportions of social ties with non-migrants (Lorant et al., 2016) and speaking the host country's language at home (Delforterie et al., 2014).

1.3 Roma

The second EU minorities and discrimination report (EU-MIDIS, 2017) observed that Roma respondents — particularly in Greece, Romania, Slovakia and Croatia — experienced the highest rates of discrimination in accessing health services compared to other national and ethnic minorities ([7]). Additionally, large proportions of Roma are not covered by health insurance (ERRC, 2016; FRA, 2018), inhibiting their formal access to treatment (SRAP, 2012).

Several studies reported trends of concern, such as exposure to infectious diseases associated with drug injection and a high prevalence of (injecting) heroin use (Casals et al., 2011; Gyarmathy et al., 2008; Matrix, 2014), as well as the dangers of binge drinking among young people, alcoholism in adults, and individuals underestimating the consequences of substance use and living near open drug scenes (Kajanová and Hajduchová, 2014; Köhnlein, 2018; López et al., 2018; Mravčík et al., 2014; SRAP, 2012).

These phenomena, in addition to limited access to health and social services, have been documented with widely varying scientific rigour in Bulgaria, Czechia, Greece, France, Germany, Hungary, Lithuania, Romania and Slovakia (SRAP, 2012). A study under the aegis of the European Commission observed that the available evidence on alcohol consumption and illicit substance use amongst Roma reported conflicting findings (Matrix, 2014).

Moreover, the 2012 Roma minority report (in SRAP, 2012) suggested that substance use and gambling are among the phenomena that accompany Roma social exclusion, and this is corroborated in other studies (Casals et al., 2011; Iliescu et al., 2015; López et al., 2018). An analysis of the 2014 Reitox drug reports (De Kock, 2020c) demonstrates that studies from Bulgaria, Croatia, Czechia, Lithuania, Romania, Slovakia, Slovenia and Spain stress the significant representation of Roma in mainly low-threshold harm reduction services. In the 2019 EMCDDA national monitoring data, only Romania and Czechia reported high numbers of Roma clients in mainly outpatient opioid agonist treatment services, and high substance use prevalence rates in the case of Czechia.

Most probably because of different registration practices, Roma are not specifically identified as a vulnerable population in the northern and western Member States in the 2014 reports and the 2019 EMCDDA national monitoring data. Nevertheless, an exploratory study among mobile injecting substance users (AC COMPANY, 2005) identified vulnerable Slovak and Romanian substance users in both southern and western European countries.

([7]) Apart from 10 % of the respondents with a Turkish background in the Netherlands and 9 % of the respondents with South Asian background in Greece, no other populations indicated having experienced discrimination when accessing health care services in the 12 months before the survey.

2. Interrelated risk and protective factors in an ecosocial perspective

Ecosocial theory proponents in social epidemiology (Alegría et al., 2008; Krieger, 2011) argue that biomedical and lifestyle theories of disease distribution should be enriched with contextual elements. Consequently, individual-level solutions will not suffice to reduce population-level health disparities (Krieger, 2011; Spooner, 2005). When studying the initiation of substance use and the progression to problem use among various migrants and ethnic minorities, the risk factors identified above should not be understood simply as causes but rather as working within mechanisms.

Ecosocial theorists additionally argue that societal and policy-based disparities (macro-level factors) are literally embodied at the individual (micro) level, contributing to health inequalities. The presented research on the causes of substance use (see above) and access to health and substance use services among MEM confirms this need to analyse and act upon meso- (services) and macro-level barriers and social determinants, in addition to addressing individual-level propensities to initiate substance use or progress to problem substance use.

This view is in line with Pearce et al.'s (2004) seminal statement that 'ethnic differences in health are due to historical, cultural, and socioeconomic factors, which in turn influence lifestyle and access to health care'. These combined issues, and especially the social determinants of health (Ingleby, 2019), should be considered in prevention, treatment, harm reduction and future research by seeking out mechanistic pathways (Hedström and Swedberg, 1998; Hedström and Ylikoski, 2010) using quantitative and qualitative methods (Tsai et al., 2019). In addition, it is important to distinguish between the determinants of the initiation of (problem) substance use, on the one hand, and the determinants of the progression to problem substance use, on the other.

Table 2: Interrelated risk and protective factors for substance use among MEM

Level	Risk/protective factor
MACRO (national health system, migration and integration policies) (Bhopal, 2012, 2019; Razum and Stronks, 2014; Spooner, 2005)	**Formal access to healthcare** (defined mainly by legal entitlement, but influenced by knowledge of and [perceived] discrimination or bias in healthcare at the meso and micro level) (Blom et al., 2016; Lindert and Schimina, 2011; Madeira et al., 2018)
	(Exposure to) substance use habits in the receiving country (Bogic et al., 2012; Lorant et al., 2016; Saigí et al., 2014)
	Social exclusion/inclusion (Casals et al., 2011; Ivert and Magnusson, 2020)
MESO ([post-migration] social environment) (Bogic et al., 2012; Horyniak et al., 2016)	**Family/social network** (absence/presence of family, friends, partner, social network, social control) (Bogic et al., 2012; Fisher et al., 2019; Ivert and Magnusson, 2020)
	Housing situation (socially deprived areas, circumstances in asylum camp or centre) (Horyniak et al., 2016) and living near open drug scenes (Kajanová and Hajduchová, 2014; Köhnlein, 2018; López et al., 2018; Mravčík et al., 2014; SRAP, 2012)

MICRO (individual characteristics and propensities)	**(Pre- and post-migration) substance use endorsing coping mechanisms and habits** (such as self-medication) (Brendler-Lindqvist et al., 2014; Dupont et al., 2005; Gibbons et al., 2016; Jané-Llopis and Matytsina, 2006)
	Internalised normative frameworks (such as religious frameworks) (Alamilla et al., 2019; De Kock, 2020b; Hurcombe et al., 2010; Schieman et al., 2013)
	Experience of discrimination/stigma (Alamilla et al., 2019; De Kock, 2020b; Wernesjö, 2020)
	Psychological vulnerabilities/resilience (trauma, PTSD, depressive symptoms, migration-related stress) (Giacco et al., 2018; Jané-Llopis and Matytsina, 2006; Knipscheer et al., 2015; Missinne and Bracke, 2012; Salama et al., 2020)
	Boredom and uncertainty (e.g. as a result of unemployment or awaiting an asylum decision) (Dupont et al., 2005)
	Contact and social networks with non-migrant populations (Delforterie et al., 2014; Lorant et al., 2016)
	Socio-economic status (Hjern, 2004; Lindert and Schimina, 2011; Reid et al., 2001)

These factors are presented as intersecting categories: the same category can work as a risk or protective factor and be intertwined with other levels (macro, meso, micro). For instance, being religious may work as a protective factor for the initiation of use (Dupont et al., 2005), but religious conformity pressure and its resultant stress can work as a risk factor for progressing to and sustaining problem use (De Kock, 2020b; Schieman et al., 2013).

None of these issues will in themselves cause substance use initiation or progression to problem substance use, while the prevalence and dominance of one or several of them as risk or protective factors may differ across populations and individuals. Moreover, these issues are additional to the kinds of individual risk and protective factors found in general populations. The identified factors will also have differential influences, dependent on, for instance, individual propensities.

The individual 'embodiment' of macro disparities results in their intertwining with meso- and micro-level factors (Alegría et al., 2011; Krieger, 2012). For instance, structural or institutional health disparities as a result of not having full access to health care because of one's legal status may result in perceived discrimination and related psychological or psychosocial distress. The severity of such effects, in turn, depends on an individual's resilience and psychological vulnerability, and may lead to substance use initiation or progression to problem substance use if, for instance, a person endorses substance-use-related coping mechanisms and/or is exposed to open drug scenes. In the same way, individual- or micro-level barriers can be dependent on or interwoven with obstacles at the meso or macro level.

3. Drug prevention, treatment and harm reduction responses

Very little attention has been paid to MEM in European drug policies, and the availability of targeted evidence-based practices remains limited (Burkhart et al., 2011; Lemmens et al., 2017; Speth et al., 2018). Establishing both an evidence base and subsequent evaluation practices are key, because MEM are often under-represented in research trials (Sue et al., 2009), and the designs of evidence-based practices do not always fit the circumstances of specific MEM populations (Liddell and Burnette, 2017).

When designing and implementing social responses to drug-related phenomena among MEM, it may be important to define the local variations in targeted populations (i.e. refugees, other third-country nationals, Roma, intra-European nationals, etc.), the type of substance use behaviour to be targeted, and the risk and protective factors, including social determinants as well as life-course-related and developmental vulnerabilities at the micro level, and issues related to the meso (organisation, clinician) and macro levels (health system issues).

Because the literature on drug-related responses for these populations is scarce, a multi-faceted strategy was used to identify health and social responses ([8]), targeting MEM ([9]) and based on an online survey of Member States (April 2019), a screening of review studies (EMCDDA, 2013; Greene et al., 2019; Kane and Greene, 2018; Priebe et al., 2016; Stöver et al., 2018; WHO, 2018), the EDDRA database, the 2014 Reitox national drug reports ([10]) (De Kock, 2020a) ([11]) and the 2019 EMCDDA national monitoring data ([12]). A total of 121 practices were identified (see Annex 1). Of these, 55 % (n = 67) were targeted at prevention (n = 30), treatment (n = 11) or harm reduction (n = 23). A large majority of these drug-related responses were — in line with previous research — located in the prevention (EMCDDA, 2013) and harm reduction domains, and the number of targeted treatment responses was very limited.

In addition, a total of 54 (or 45 %) of the practices identified, while not directly focusing on drug prevention, treatment or harm reduction can be seen to contribute to these goals, sometimes indirectly, and to this extent are categorised here as contributory responses (Figure 1).

There is some preliminary evidence of effectiveness for only a minority of the practices, although these are mainly located in the mental health rather than the substance use treatment domain: ASSIST (Doty et al., 2018), the Cultural Formulation Interview (Rohlof et al., 2017), PACCT© (Serneels et al., 2017), brief interventions (Kane and Greene, 2018), cultural mediation in health services (Verrept, 2019) and Mind-Spring© (Reuten, 2018).

Moreover, many of the identified practices apply methods that have been studied extensively in non-MEM populations, such as supporting parental skills for substance use prevention among adolescents

([8]) In this study, the overarching term ‘practice’ includes projects, interventions, methods, programmes, etc.
([9]) Interventions aimed directly or indirectly at increasing the reach and retention of MEM in substance use treatment, increasing the accessibility of such treatment and establishing broader prevention and harm reduction practices.
([10]) The full method is described in the MATREMI (Mapping and Enhancing Substance Use Treatment for Migrants and Ethnic Minorities) report: www.Belspo.be DR/84. In this study, both the 2014 and 2017 Reitox national drug reports submitted by the EU-28 Member States to the EMCDDA were screened using the following queries: ethn*, minorit*, migra*, nationali*, foreign, roma, asylum, refugee. The publicly available versions of the 2017 reports contained little to no information on inspiring practices aimed at MEM, and not all of the 2015 and 2016 reports were available online. The focus was subsequently on the 2014 report for in-depth analysis. Full paragraphs including the search terms were listed and read per country. Lastly, inspiring practices related to SUT for MEM were listed.
([11]) MATREMI: www.Belspo.be DR/84.
([12]) A search was conducted in the Reitox 2019 workbooks received by EMCDDA before 2 December 2019 using the search terms: migra*, minorit*, foreign, asyl*, refug*, nationali*, unac*, undoc*, ethn*, roma

(Brody, 2008), harm reduction among opioid users by means of opioid agonist treatment, and (trauma-informed) cognitive behavioural therapy (Kane and Greene, 2018).

In the next section we describe the goals and main characteristics of the practices identified.

Figure 1: Identified drug-related responses for MEM

- ✓ Intensive peer work for the development of targeted prevention.
- ✓ Brief targeted early intervention among refugees.
- ✓ Translated prevention materials.
- ✓ Language adaptations in substance use treatment services.
- ✓ Adaptation to the cultural or migration background of the client.
- ✓ Adding a social component to treatment.
- ✓ Fulfilling an active liaison and outreach function to facilitate referral.
- ✓ No or low inclusion criteria and low-threshold harm-reduction services.
- ✓ Actively reaching out to vulnerable populations.

Figure 2: Activities supporting drug-related responses for MEM

- ✓ Social (re)integration strategies.
- ✓ Access to health services and screening of refugees.
- ✓ Organisational competency and training.
- ✓ Translation and mediation services.
- ✓ Targeted mental health services and methods.

3.1 Prevention interventions

Drug prevention aims to delay the onset of or reduce (problem) substance use.

The practices that were identified mainly fall into two categories: first, translated information materials (about substance use), such as leaflets and online videos; and second, at least eight practices consisted of intensive peer work for the development of targeted prevention (Tuppercare homeparties, PaSuMi, Rapid assessment with the target groups, MammaMia, Herkunft-Ankunft-Zukunft, Cannabis Intelligence Amsterdam, PeAS). This peer work includes methods to facilitate reaching MEM parents, training MEM to develop and disseminate prevention methods, and defining prevention priorities together with these populations.

Examples of prevention interventions implemented in Germany

Why could **smoking cannabis**/**drinking alcohol**/**using prescribed medication** become dangerous for me? **(Hessische Landesstelle für Suchtfragen e.V.) (Germany):** These explanatory videos on alcohol, cannabis and prescription medication use draw attention to the consequences of using these respective psychoactive substances through easily understandable stories in German, English, Arabic, Dari or Tigrinya. The videos can be used by professionals in asylum centres or by other professionals who work with clients who speak these languages. (Identified in Stöver et al., 2018.)

PaSuMi (Deutsche Aids-Hilfe e.V.) (Germany): This project targets the participatory development, conception, implementation and evaluation of preventive measures in specified ethnic communities or hard-to-reach populations. Community members are trained to identify needs in the community. This participatory method can increase adherence to the intervention among hard-to-reach individuals and target groups. (Identified in Stöver et al., 2018.)

Prevention for Russian-speaking parents (German Association of Russian-Speaking Parents) (Germany): Forty opinion leaders were trained on the topic of substance use and prevention methods (2017-2019). These individuals offer culturally sensitive information and prevention services to Russian-speaking parents and relatives. (Identified in 2019 EMCDDA national monitoring data.)

Guidance app (Notdienst für Suchtmittelgefährdete und -abhängige e.V., DND) (Germany): This service is primarily aimed at referring and supporting substance users with low German-language skills. (Identified in 2019 EMCDDA national monitoring data.)

Brief early interventions may be used to achieve both drug prevention and treatment outcomes. They are intended to prevent the transition from high-risk use to substance use 'disorders' (Greene et al., 2019), or from recreational to high-risk substance use. Kane and Green (2018), in a review commissioned by the UNHCR, identified that brief interventions in migrant camp settings and other asylum facilities have significant potential as cost-effective prevention strategies and as a component of community-based or multi-component approaches.

Examples of early brief interventions implemented in EU Member States

Shurkan (Fixpunkt e.V.) (Germany): This project is primarily aimed at refugees in Berlin who have already come into contact with substances in their country of origin and/or are at particular risk. Risk characteristics are identified and acted upon by, for instance, supporting a drug-/alcohol-free daily structure and employment, and transfer to or mediation with specialist services. Shurkan acts as a liaison service but also offers early intervention. (Identified in Stöver et al., 2018.)

ASSIST screening and brief intervention: The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is available in Dutch, Arabic, Chinese, French, German, Hindi, Persian, Portuguese, Spanish and Vietnamese. It is an evidence-based instrument that can be used by a broad array of professionals to identify the various types of substance use, raise awareness about substance use, initiate self-support or refer clients to specialist services. ASSIST also contains brief intervention methods that can be easily implemented. (Identified in the MATREMI survey, De Kock, 2020a.)

REFRAME (Kethea/IOM) (Greece): This intervention responds to emergency needs and fosters the empowerment of refugees and migrants. It consists of systematic needs assessment and awareness-raising with respect to legal and illegal substances. Prevention and early intervention groups for families, parents, children and young people are also offered. In addition, REFRAME provides counselling for people with substance use problems and referral to Kethea services if necessary. The practice also aims to raise awareness among and train professionals and volunteers working in accommodation sites and shelters in order to build a network of collaboration and referrals. (Identified in 2019 EMCDDA national monitoring data.)

3.2 Substance use treatment

Substance use treatment is defined as an activity (or activities) that directly targets people who have problems with their substance use and that aims to achieve defined objectives with regard to the alleviation and/or elimination of these problems. It is provided by experienced or accredited professionals, within the framework of recognised medical, psychological or social assistance practice (EMCDDA, Statistical Bulletin 2018).

Opioid agonist treatment is the most frequently used and robustly evidence-based intervention for opioid problems in Europe, taking in approximately 50 % of high-risk opioid users. In terms of treatment objectives there is some overlap between opioid agonist programmes and harm-reduction-oriented interventions, and while not aligned with the EMCDDA categorisation, for the purpose of this analysis, this treatment category only includes outpatient and inpatient treatment not providing opioid agonist treatment. Centres providing opioid agonist treatment are categorised alongside low-threshold harm reduction interventions (3.3 Harm reduction) and analysed below.

We identified 11 practices in this treatment domain. They are mainly services that specialise in serving specific MEM populations, such as migrants and refugees (Kethea Mosaic), men with varying cultural backgrounds (ADV Nokta), foreign language speakers (Transit, ADIC, Verein Dialog) and Irish travellers (Pavee Point, TVG Traveller Support, Voice of New Communities Drugs and Alcohol Network).

Key elements of these programmes include:

- the adaptation of regular services to the language of the client through translation, or not using language as an exclusion criterion;
- adjustment to the cultural or migration backgrounds of the client;
- adding a social component to treatment;
- employing an active liaison, referral or outreach function to facilitate referral.

Examples of treatment implemented in EU Member States

Kethea Mosaic (Greece): Kethea Mosaic offers a non-residential programme that seeks to facilitate social integration and relapse prevention among migrants and refugees who use substances. It is mainly characterised by intercultural counselling services and psychosocial mobilisation for treatment and training. This intervention also emphasises self-help, mutual help and self-management. Knowledge of Greek and documents proving a person's residence status are not required to attend Kethea Mosaic's services (identified in Reitox national drug report, 2014,)

ADV rehabilitation and integration, NOKTA (Germany): This is a Berlin-based residential substance use treatment programme that provides intercultural individual therapy, group therapy, help with migration and social issues and mediation with relatives and family members. It is the only residential programme in the sample that targets men with diverse cultural backgrounds. (Identified in the MATREMI survey, De Kock, 2020a.)

Treatment with native video translation (Verein Dialog) (Austria): This service offers diagnostic and counselling services to non-German-speaking clients by structurally embedding the use of video translation in the service. (Identified in the MATREMI survey, De Kock, 2020a.)

3.3 Harm reduction

´Harm reduction encompasses interventions, programmes and policies that seek to reduce the health, social and economic harms of substance use for individuals, communities and societies´ (EMCDDA, 2010). We identified 23 such practices in this review, including a range of interventions using opioid agonist treatment, as highlighted above.

Eleven practices specifically target vulnerable MEM populations such as Roma (SANANIM, outreach in Vilnius, HORIZON — Carusel, ARAS), female substance users and sex workers with a migration background (Frauentref Olga, Ruhama, Red Cross DropIn), asylum seekers, refugees and/or irregular migrants (Victoria Hall DropIn, Udruga Terra), and black Caribbean users (Bro-Sis project). These are mainly opioid agonist treatment services with a variable offer in terms of health and social services.

The main characteristics of these services are that they have no or few access criteria, operate on the basis of a low entry threshold and actively reach out to and refer vulnerable populations. Twelve of the services aim to reach a broad group of vulnerable (mainly opioid) users, such as those who do not have access to other services, implicitly including migrants and ethnic minorities.

Examples of harm reduction implemented in EU Member States

Bro-Sis Project (Freshwinds) (UK): This project provides a range of harm reduction interventions to promote the physical, psychological and social well-being of Black Caribbean substance users and helps them access treatment services. (Identified by Fountain in EMCDDA, 2013.)

Frauentreff Olga (Germany): This service works with female (including transgender) substance users and sex workers in creating opportunities to leave prostitution or better cope with its risks and to stop using substances. The service offers needle and syringe exchange, general medical assistance and hospital referrals for a wide range of physical and mental illnesses. (Identified by Fountain, in EMCDDA, 2013.)

Udugra Terra (Hungary): This is a harm reduction service targeting persons who have migrated due to deportation or termination of their visa, as well as ex-inmates. (Identified in the Reitox drug report from 2014.)

4. Other health and social responses

Survey respondents highlighted a range of additional interventions, which, while not substance use specific, were considered to be relevant for the target group of MEM.

4.1 Social (re-)integration

Sumnall and Brotherhood (2012) define social re-integration ([13]) following substance use treatment as 'any social intervention with the aim of integrating former or current problem drug users into the community'. It is understood to include housing, education and employment. Similarly, Priebe and colleagues (2016), in their review of mental health care for refugees, asylum seekers and irregular migrants, describe social integration as a key strategy in reducing the prevalence of mental health disorders and lowering the barriers to accessing treatment, and as a facilitator of effective treatment. The rationale here is that the poor post-migratory socio-economic conditions experienced by refugees are associated with a higher likelihood of depression (Priebe et al., 2016, p. 6). This is also stressed by the WHO in its report on migrant health (2018).

A review of the 2019 EMCDDA national workbooks, together with examples provided by De Kock (2020a), identified 16 practices that targeted broader social (re-)integration goals for different MEM populations.

Examples of social integration interventions implemented in EU Member States

Pauke — Life (Pauke Bonn gGmbH) (Germany) This project is committed to the stabilisation and social participation of people with addictions. It provides the participants with basic work skills, equipping them for the job market, and develops a realistic career perspective with them. It is a small project with a partial focus on refugees. (Identified in Stöver et al., 2018.)

LISKO (integration and social co-housing) (Luxembourg): The LISKO service is primarily aimed at vulnerable refugees or families who have few or no resources and are living in asylum centres or in social housing. The LISKO service has a number of missions: refugees are supported through measures designed to increase their autonomy (empowerment) by facilitating intercultural understanding and interpreting where necessary; in addition, LISKO establishes links between social services and various associations. (Identified in the MATREMI survey, De Kock, 2020a.)

Programma Escolhas (Portugal): This government programme aims to promote the social inclusion of children and young people from vulnerable socio-economic contexts, with the goal of creating equal opportunities and strengthening social cohesion. (Identified in 2019 EMCDDA national monitoring data.)

4.2 interventions to increase access to health services

The equitability for MEM of health policies is measured by means of entitlements to care, formal accessibility, responsiveness and measures taken to improve access (IOM, 2016). Many European Member States grant limited access to health care for refugees, especially those in irregular situations (Cuadra, 2011 ([14]). However, 15 Member States and Norway recently reported to the European Migration Network that they have improved access to health care for these populations (EMN, 2019, p. 187). A selection of these practices is listed in Table 4.

([13]) A range of social re-integration practices can be found in the European EDDRA database, which includes over 100 such practices, although none are specifically targeted at MEM.
([14]) Cuadra (2011) demonstrated that in 2011 only five countries granted undocumented migrants full access to care that is more extensive than emergency care.

Table 4: Selected examples of how Member States have improved access to health care for migrants (EMN, 2019, pp. 186–187)	
Cyprus	A co-funded government project covers the medical costs of third-country nationals (including asylum seekers).
Slovak Republic	A project aims to create standard procedures for the prevention of and responses to disease outbreaks among third-country nationals, paying specific attention to vulnerable groups.
Bulgaria	A Bulgarian AMIF project specifically focused on the provision of health care and nursing services to asylum seekers and detainees in reception and detention centres.
Latvia	Latvia has adopted a new law granting stateless persons the right to receive state-funded minimum medical care assistance.
Spain	Spain has re-instituted universal access to the National Health System for everyone in Spain, regardless of their administrative situation. Given that the competences related to health care are decentralised, the autonomous communities must establish the procedures by which foreign persons may obtain the certifying document accrediting their right to health care.

A review of the 2019 EMCDDA national workbooks, alongside examples provided by De Kock (2020a), identified 14 practices that aim to disseminate knowledge about the available health services, including outreach services, and health screening of refugees on their arrival. The screening of refugees is particularly important because of its cost utility (FRA, 2015), which has been documented with regard to mental health issues in Germany (Biddle et al., 2019).

Examples of interventions implemented in EU Member States to increase access to health services

Health screening **(Sweden):** Health screening, including with respect to mental health, must be offered to all applicants for international protection by the county councils/regions in which they reside. (Identified in WHO, 2018, p. 19.)

Smartphone application **(Belgium):** This application gives an overview of welfare, (mental) health and other services and is especially tailored to refugees. The application is available offline and aims to increase access to services. (Identified in the MATREMI survey, De Kock, 2020a.)

Health examination protocol for asylum seekers **(Finland)**: Finland is one of the few European countries that is developing a national health plan for refugees that focuses both on specific vulnerabilities and on professionalising the services that work with refugees. (Identified in WHO, 2018, p. 23.)

4.3 Organisational competency and training

Organisational competency and training to increase professionals' awareness of the different beliefs and expectations of MEM populations enables service providers to take these factors into account in treatment planning at the individual and organisational level (Guerrero et al., 2015; Priebe et al., 2016). Additionally, it is vital that organisations and professionals consider the structural and social factors that influence substance use and access to treatment for MEM (De Kock, 2019a).

Lastly, flexible and transformational organisational leadership have been proven to have an impact on the reach and retention of MEM clients in substance use treatment (Guerrero et al., 2017). A review of

the 2019 EMCDDA national workbooks, together with examples provided in De Kock (2020a), identified 12 practices that focused on training (n = 6) and broader organisational competency (n = 6).

Examples of interventions implemented in EU Member States to improve organisational competency

TransVer Guidebook (Germany): This guidebook is based on the premise that MEM engage with substance use treatment services less frequently and at a later stage, taking into account the fact that barriers are located both in the health system and in the populations. The resource can be used by treatment professionals to increase both organisational competency and transcultural competence (Schu et al., 2013). (Identified in the MATREMI survey, De Kock, 2020a.)

A Roma training programme (Slovenia): This programme targets professionals who work with Roma youth. The programme focuses on learning about Roma history, culture and intercultural communication. It is currently only available in Slovenian. (Identified in the Reitox drug report from 2014)

Alcohol and drug policy in an asylum centre (Flemish expertise centre on alcohol and other drugs, VAD) (Belgium): This is an elaborate guide to setting up an alcohol and drug policy in asylum centres and forging links between services. The guide is currently only available in Dutch. (Identified in the MATREMI survey, De Kock, 2020a.)

Perspective 3D (Berlin Suchpraevention) (Germany): Counselling, coaching and training are provided for professionals who work with refugees, as well as substance use prevention workshops for the refugees themselves. The aim is to recognise threats at an early stage, to act preventively and thus to enable individuals to establish a stable and secure life. (Identified in the 2019 EMCDDA national monitoring data.)

4.5 Translation and social mediation services

Language barriers can be addressed by making trained interpreters available to the relevant services or by using web-based applications. In this way, the experience of foreign-language speakers in health services — and their subsequent retention and adherence to treatment — can be improved (Aelbrecht et al., 2019; Priebe et al., 2016). For instance, Guerrero and colleagues (2012) found that the use of translators can improve substance use treatment adherence among MEM who are at high risk of dropout. However, Kluge and colleagues (2012) found that an estimated 40 % of European health services do not have interpreting services and 54 % reported not having staff with an MEM background.

Seven practices were identified that attempted to overcome language barriers by using interventions including native-language professionals ([15]), translators, (inter)cultural mediators, communication cards and telepsychiatry. In addition to being translated, existing health communication materials also need to be adapted for specific audiences (see Guide on cultural adaptation of health communication materials).

Examples of translation and social mediation services implemented in EU Member States

Intercultural mediation in hospitals (Belgium): Intercultural mediators are employed to resolve linguistic and cultural barriers in a variety of health care contexts. All Belgian hospitals can obtain funding from the federal government to employ an intercultural mediator (Verrept, 2019). (Identified in the MATREMI survey, De Kock, 2020a.)

([15]) Note that ensuring organisational staff's own language variety is representative of the community or locality can add value to a service but also has clear limitations. The main limitation concerns client preference: clients often prefer not to communicate with staff members with similar linguistics or ethnic background, out of fear of confidentiality breaches. Furthermore, staff with seemingly similar backgrounds may in fact not have the same backgrounds (De Kock, 2019a).

National and international telepsychiatry service (Sweden): This service facilitates refugees' access to mental health services. Refugees can call the helpline for psychological support on an anonymous basis between 1 pm and 10 pm. (Identified in WHO, 2018, p. 20.)

4.6 Targeted mental health services and methods

Problem substance use is often comorbid with PTSD in both the general population as well as refugees (Salama et al., 2018), and especially among (young) people with refugee backgrounds (Kozarić-Kovacić et al., 2000; Lancaster et al., 2020; Posselt et al., 2014). So far, limited attention has been given to developing treatments that target comorbid PTSD and problem substance use (Roberts et al., 2015).

Although there are few evidence-based practices in the substance use treatment domain specifically focused on MEM, trials have been conducted in the mental health field concerning trauma-focused targeted methods (Turrini et al., 2019; Wenk-Ansohn et al., 2018) and cognitive behavioural therapy for reducing substance use in non-refugee migrant populations (Kane and Greene, 2018). These and other mental health interventions can contribute to tackling the underlying reasons behind problem substance use.

We identified some practices that primarily aimed to improve the mental health of persons with a migration background by making use of specific expertise on, for instance, trauma (POZAH, ELEA) or healthy relationships (PACCT©), or by including cultural and contextual backgrounds in therapy (Cultural Formulation Interview). One practice served as a liaison between asylum centres and mental health care services (ELEA).

Examples of targeted mental health services implemented in EU Member States

Cultural formulation interview (CFI): The Outline for Cultural Formulation is a tool that helps health professionals gather and organise culturally relevant clinical information. It was included in DSM-IV-TR. DSM-5 refined the outline and introduced a cultural formulation interview (with both patient and informant versions) and 12 supplementary modules (Rohlof et al., 2017). (Identified in the MATREMI survey, De Kock, 2020a.)

Counselling and therapy for all in need (Centre Mokosha NGO) (Slovakia): Centre Mokosha is a non-profit organisation based in the Eastern part of Slovakia, dedicated to providing individual, couple or family counselling and therapy for anyone in need, regardless of age, gender, religion or ethnic background. Services are mainly available in English, Slovak, Dari and Russian. Centre Mokosha specialises in mood and anxiety disorders. (Identified in the MATREMI survey, De Kock, 2020a.)

Guidance and liaison for refugees (ELEA & Cellule lambda [Liaison et Accompagnement MoBile pour Demandeurs d'Asile]) (Belgium): The objective of these mobile teams (formerly subsidised by the federal agency for the reception of asylum seekers, FedAsil) was to create a direct link between asylum centres and mental health care facilities by facilitating access to care for asylum seekers with or without problem substance use and to support teams from the FedAsil reception network in their management of substance-use-related problems. (Identified in the MATREMI survey, De Kock, 2020a.)

5. Challenges in identifying drug-related responses

The practices that we identified vary in terms of goals and scope; for instance, it is not always clear whether they are project-based or structurally embedded in particular services. Moreover, there appears to be some overlap between the categories of prevention, treatment and harm reduction, as, for instance, harm reduction activities can also be interpreted as prevention activities for injecting users, and targeted brief interventions may inevitably be intertwined with screening for substance use severity.

Neither is it always evident what the exact nature of a practice is. For example, Stöver and colleagues' (2018) review denominates many of the examples as 'projects', whereas the current study uses the overarching term 'practice', which also includes 'projects'. Consequently, it is hard to delineate a single practice, because one practice may be the development of a diversity policy regarding treatment that includes many different methods, while one of these methods could well be considered a single 'practice' (see the REFRAME project). The singularity of each practice was therefore outlined based on its primary goals as defined in the reviews and surveys.

The MATREMI survey had a recruitment bias that resulted in an over-representation of practices from Belgium (due to a separate Belgian survey), Portugal (because of a high response rate via one network) and Germany (owing to the inclusion of a German review study, Stöver et al., 2018). Additionally, differential response rates to our online survey (De Kock, 2020a) resulted in response bias. As noted by Fountain in a similar study, the questionnaire was in English and this may have prevented service providers without the relevant language skills from completing it (EMCDDA, 2013), especially considering their heavy workload and other requests for information to be provided voluntarily. However, respondents indicated that they knew about the survey via at least eight of the contacted networks, indicating good coverage through snowball sampling, since at least one-third of those networks disseminated the survey as requested.

A final apparent limitation is that many of the practices that were identified are, strictly speaking, not (only) aimed at substance use treatment, prevention or harm reduction. However, because respondents in both the Belgian and European survey chose to identify these practices in a survey that was clearly aimed at identifying examples of substance use treatment, prevention or harm reduction, the decision was made to include them in this paper.

Moreover, and in accordance with a realist focus (Pawson, 2016), the intention was to understand 'how' practices work by identifying their main goals, instead of investigating 'what' works or whether certain practices work. As noted by Porter (2015), the context in which practices are implemented should equally be a focus in coming to understand how new phenomena are tackled. Part of this context consists of activities (i.e. providing access to [mental] health services, organisational competency, etc.) inherent to particular practices, and practices that are indirectly aimed at or contribute to social responses.

In conclusion, the total number and nature of the practices discussed here is not exhaustive. However, because of the wide range of methods used (survey waves, purposive searches, survey follow-up and reminders, checking up on previous research, national reporting data screening, etc.), this overview gives a reliable time-dependent picture of the nature of existing practices and their main aims. This allows us to analytically describe current drug-related social responses for MEM, and to identify some caveats.

This overview may prove useful in the development of practice examples for professionals working in the field of migration or substance use. In this context we note, however, that only a minority of the practices identified would be characterised as evidence-based interventions. Additional contact with the professionals involved in the practices featured here was not possible within the scope of the

current study, but it would be interesting to create such links in order to share implementation experiences. Also, a specific focus on particularly vulnerable subpopulations such as women and young refugees (who are in a very sensitive developmental phase) is needed.

6. Implications for theory, policy and practice

6.1 Equitable health for all migrant and ethnic minority populations

We outlined in the introduction that, at the population level, the prevalence of substance use among first-generation migrants — especially refugees — appears to be lower or similar to that of the general population, but that this group is more exposed to risk factors for problem substance use. These risk factors (individual and social determinants) in combination with the adaptation to substance use habits in the host country and lack of access to its health system may increase the prevalence of substance use over time. Parts of this dynamic have been documented among ethnic minorities such as Roma populations as well as among people with second- and third-generation migration backgrounds.

The main aim of this paper has been to identify drug-related responses that address the needs of migrants and ethnic minorities in terms of treatment, prevention and harm reduction. Although there is little international consensus about how and if individuals should be categorised in terms of their migrant status (De Kock, 2019b), there is agreement over the fact that many of these diverse populations — which include intra-European migrants, first-generation third-country migrants such as refugees, and persons with a second- or third-generation migration background — face similar challenges in society and in accessing European countries' health systems (Razum and Stronks, 2014; WHO, 2010a, 2010b).

An important symbolic step in departing from this rationale was the European Public Health Association (EUPHA) changing the name of its Migrant Health Section to the Migrant and Ethnic Minority Health Section (Bhopal, 2019). This change acknowledges that although second-generation migrants (who do or do not identify with ethnic minorities) may not have migrated themselves and may be exposed to different risk and protective factors, they may still be perceived as migrants by the receiving society or may self-identify as such and face challenges in the health system (Blom et al., 2016; IOM, 2019, p. 187). This is similarly the case for ethnic minorities such as Roma (Sándor et al., 2017).

Moreover, this inclusive perspective allows us to identify how previous drug-related responses with respect to more established MEM populations (e.g. those formed as a result of labour migration) might inspire responses in dealing with 'new' migration phenomena (e.g. refugees and migrants in irregular situations). Additionally, a focus on ethnic minorities allows us to utilise knowledge about the consequences of societal exclusion (e.g. among Roma) in addressing 'new' issues related to MEM substance use, as well as highlighting questions of access to and quality of social responses.

At the European level, a number of projects aim to improve monitoring and enhance migrant health (services) (for example, CARE, AMAC, CLANDESTINO, EQUI-HEALTH, HEALTHQUEST, EUGATE, MIGHEALTHNET, NOWHERECARE, PALOMA, RESTOR, MIPEX, SRAP). Unfortunately, it often remains unclear whether recommendations have been implemented in the Member States and the results of many of these initiatives are not fully publicly available. Moreover, these projects tend to focus on broad health goals and, except for SRAP, not specifically on addressing issues concerning mental health or substance use among MEM.

As pointed out in the MIPEX study (IOM, 2016), four domains are key to attaining equitable MEM health: entitlement to health care; removing barriers to accessing treatment; supporting responsive health services; and implementing measures to achieve change in migrant health, with special

attention given to social determinants (Ingleby, 2019). Poorly managed, inadequate or discriminatory immigration and health system responses are reported to have negative consequences for the health of migrants and the communities with which they interact (IOM, 2019, p. 209).

6.2 Monitoring treatment need and demand among migrants and ethnic minorities

The need for drug treatment among migrants and ethnic minorities is not currently well monitored in European countries. Where this does happen, there may be possibilities to analyse register data or, in the absence of such data, carry out targeted surveys to assess substance use prevalence among MEM subpopulations and/or examine subsamples of national health surveys. Treatment demand monitoring can in turn be enhanced by optimising Treatment Demand Indicator (TDI) data registration methods and by making a particular effort to identify unmet treatment needs (see De Kock, 2019b).

Combining data on MEM's levels of need and demand and undertaking multi-indicator analysis will allow treatment planners to base drug-related social responses on tiered risk modelling (Ritter et al., 2019). Indeed, investment in the European health surveys is required so that Member States can gather more objective, representative and comparable data with respect to these populations. Policymakers should invest in better monitoring of migration (i.e. country of birth and country of birth mother) and ethnicity-related (i.e. language-related) indicators across policy domains (Farkas, 2017) and especially in health, substance use treatment demand and intervention need data gathering (De Kock, 2019b). This type of data collection will allow the aetiology of substance use among the MEM population to be studied and subsequently inform logical intervention models as well as policymaking. Moreover, there is an urgent need to harmonise existing data collection methods in this domain across the EU Member States to facilitate cross-country comparisons. Population prevalence alone, as stated by Ritter and colleagues (2019, p. 22), 'is limited in its usefulness unless it is matched with consideration of different treatment types and their relative intensity, and/or explored as a function of geography and subpopulation'.

Lastly, researchers should examine, both quantitatively and qualitatively, how real-world patterns of consumption match the narratives and discourse about substance use among MEM, for instance by looking at media analysis of reports concerning drug-related issues among refugees across the EU.

6.3 Enhancing treatment, prevention and harm reduction

A pertinent issue, as outlined by Rechel (2011) and Fountain (2015), is the extent to which generic service providers can demonstrate that their programmes operate effectively and meet the needs of all members of their target population, whatever their migration or ethnic background, through offering equitable access, experience and outcomes (Starfield, 2001). Where this is not the case, additional targeted interventions are warranted within the framework of proportionate universalism (Carey et al., 2015) — a leading policy framework in many EU Member States — as well as ecosocial theory (Krieger, 2012).

Knowledge sharing

Knowledge sharing among professionals in the field and dissemination of the identified practices could be a 'quick win' in designing targeted drug-related responses, especially in the domains of prevention and harm reduction. Practitioners and policymakers can draw on existing practices in the following domains:

- peer-based interventions (Tuppercare homeparties, PaSuMi, Rapid assessment with the target groups, MammaMia, Herkunft-Ankunft-Zukunft, Cannabis Intelligence Amsterdam, PeAS, Pavee Point, TVG Traveller Support, Voice of New Communities Drugs and Alcohol Network);

- adaptations in residential services (Kethea Mosaic, ADV Nokta, Transit, ADIC, Verein Dialog);
- screening for substance use and brief intervention among refugees (FRA, 2015; Greene et al., 2019; Lemmens et al., 2017) (ASSIST screening and brief intervention, REFRAME — Responding to Emergency Needs and Fostering Refugees' and Migrants' Empowerment);
- interventions targeting Roma (SANANIM, Outreach in Vilnius, HORIZON – Carusel, ARAS, SRAP);
- outreach, referral and liaison services (ELEA / Cellule Iambda, Pavee Point, TVG Traveller Support).

A focus on retention and quality of care

The main goal of many of the identified practices was limited to reaching specific MEM populations. Therefore, there are few studies covering retention in treatment or the quality and success of prevention, treatment and harm reduction measures in EU Member States. We identified a surprisingly small number of practices in the domain of targeted treatment interventions for 'new' (i.e. refugees) or 'older' more established (i.e. Roma, second- and third-generation migration backgrounds) migrants and ethnic minorities.

More brief and early intervention provision

Targeted brief and early intervention strategies have significant potential in providing cost-effective indicated prevention (Greene et al., 2019) within the context of expenditure in the health system. Nevertheless, they appear to be used to a very limited extent in Europe. We identified very few brief and early intervention strategies related to recent trends in substance use among (young) refugees, such as the problem use of prescribed medication (e.g. tramadol). The implementation of these kind of practices (brief and early intervention, translated product information leaflets) in, for instance, asylum settings can reduce the costs incurred by problem substance use in the health system.

Social (re-)integration and social determinants are key

Integrating broader (mental) health and social determinants when targeting drug-related issues among MEM is key (Jané-Llopis and Matytsina, 2006). This ties in with a perspective in the substance use treatment domain that is oriented towards social recovery and which moves beyond a clinical recovery focus by including broader life domains such as education, employment, housing and social capital (Best and Laudet, 2010; Granfield and Cloud, 2001; Sumnall and Brotherhood, 2012), as well as seeking to empower actors surrounding the individual such as the substance use treatment services and the health system at large.

Considering that MEM are often faced with discrimination in many domains (education, housing, employment), a greater focus on social determinants, social recovery and integration is especially important. MEM, particularly women and young refugees, are often worse off in terms of socio-economic status. Additionally, women and girls are more prone to experience gender-based violence and discrimination, and often face greater risks and challenges during their migration process. These issues have been documented as influencing the use of, for instance, prescribed medication and other substances (Clark, 2015) and should consequently be considered in the substance use treatment and broader health domains.

A 2017 scoping review of 83 empirically evaluated interventions to improve MEM health globally found that many health promotion initiatives failed to consider the broader framework of how socio-ecological factors and the social determinants of well-being impact people's health (Diaz et al., 2017). The risk of victim blaming, in the sense of placing responsibility for poor health on the inability of the individual to comply with certain strictures or change their behaviour, has been identified by IOM (2018) as detrimental to health promotion among MEM and should equally be a focus of attention in the specific domain of drug-related responses targeting MEM.

Treatment planners should be careful not to focus predominantly on ‘cultural competence’ to overcome drug-related issues among MEM, since over-emphasising culture can obfuscate the deep-rooted social determinants and health disparities that originate at the service and health-system levels. This may lead to downscaling these issues in prevention, harm reduction and treatment (De Kock, 2019a, 2020b; De Kock et al., 2017b; EMCDDA, 2013; Hunt et al., 2018; Nordgren, 2017).

In conclusion, it is important to focus on and fund (voluntary) screening as well as brief and early interventions for incoming (young) refugees. Investments should further be made in migrant and ethnic minority substance use treatment with a focus on mental health, social (re-)integration and trauma-informed methods, while strengthening generic services’ accessibility, organisational competence and language-related facilities. These conclusions

tie in with the MIPEX recommendations (IOM, 2016) to invest equally in ensuring MEM are granted a legal entitlement to health care, reducing access barriers, creating responsive health systems and, importantly, targeting the social determinants of health (Ingleby, 2019).

Annex 1: the number of identified practices per member state

BE	26
DE	26
CZ	7
GR	6
PT	6
UK	5
AU	4
IE	4
LU	4
NL	4
SI	4
MA	3
N/A	3
SE	3
ES	2
FI	2
HR	2
RO	2
SK	2
EE	1
FR	1
LI	1
LT	1
NO	1
PO	1
BG	-
CY	-
DK	-
IT	-

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