

PADUMI

Substance use and service use among people with a migration background

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Summary



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1. Introduction

Professionals in addiction care services have identified a discrepancy between the prevalence of problematic substance use among people with a migration background on the one hand, and the presence of these groups in addiction care services on the other, both in Belgium (Vandeveldt et al., 2003) and across Europe (Derluyn et al., 2008; Fountain et al., 2004). However, little research is available on this topic, and a number of obstacles exist in the detailed study of this discrepancy. Addiction centres do not consistently document the ethnic background of their clients, and studies that focus on this topic often use different variables (e.g. nationality of the client, nationality of the parents, etc.), restricting comparative and longitudinal research. In addition, this target group can be difficult for researchers to reach, and substance use is a taboo subject among both the general population and people with a migration background. Research in this field has had very little impact on addiction care and substance use among the target population.

In an attempt to address these shortcomings we chose to work with an explorative and qualitative community-based participatory research design in four case studies (the Turkish community in Ghent; Eastern European communities in Ghent; the Congolese community in Brussels; and asylum applicants, refugees and undocumented migrants). Community researchers collected the data, and the results have been disseminated in collaboration with the communities and with stakeholders in addiction care.

Research on the nature and patterns of substance use and factors affecting (mis)use is a necessary first step towards more accessible addiction care for these target groups. This research builds on a previous project funded by Belspo, "Treatment trajectories of drug users from ethnic minorities" (ZEMIV, 2006–2007; Derluyn et al., 2008), and was implemented by a multi-disciplinary team covering sociology, criminology, special education needs and social work.

2. Research questions

In this research we wanted to answer two main research questions:

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

We also had two societal objectives:

1. Raising awareness and knowledge of problems related to substance use in the four target groups, and communicating the needs of these groups to practitioners in addiction care.
2. Developing sustainable cooperation on this theme with stakeholders in the communities and in drug treatment.

3. Results

3.1 Nature and patterns of use

A total of 247 interviews were carried out with individuals describing themselves as migrants or belonging to the respective ethnic minorities: 67 drug users primarily identified as asylum applicants, refugees and undocumented migrants; 55 users and seven family members of users with a Turkish migration background; 62 users with an Eastern European migration background; and 56 users with a Congolese migration background. In the Turkish sample as well as the sample of asylum applicants, refugees and undocumented migrants two-third of respondents describe their substance use as problematic. In the Eastern European sample only one in five do so.

Regarding the substances used, the same “top three” substances used by the general population (Plettinckx, 2015) are found in all four target groups: alcohol and cannabis alternate between the top two positions, with cocaine consistently in third place. The use of tobacco was not included in this study.

There are quite a few heroin users (n=25) among our respondents, most of whom have a Turkish migration background or are asylum applicants, refugees and undocumented migrants. The use of sedative (prescribed) medication and antidepressants is quite high in all target groups apart from the Congolese group. The use of “downers” is more prevalent than the use of “uppers” in all target groups.

3.2 Reasons for continued use

The user careers of the respondents are very diverse. Most participants note that their use started in Belgium, since most of them have been living in Belgium for over five years and some were born in Belgium. Some do not describe their use as problematic – these respondents mainly situate their use in recreational settings and are less inclined to give a reason for it.

The reasons given for continued and problem use are quite different but are well defined among the target groups. The two most common reasons for continued use in the respective target groups are specified here. In the Turkish community marital difficulties and other family problems (sometimes caused by arranged marriages), and early life experiences (such as insecurity about possibly returning “home” and discrimination in school) are given as the reasons for use. Among asylum applicants, refugees and undocumented migrants the lack of resident documents and consequent feeling of insecurity, and the migration history and consequences of migration, such as loneliness, are the main reasons for use. In Eastern European communities the main reasons for use are financial and work-related difficulties (caused partly by discrimination in the labour market), and family problems (mostly due to family members living abroad and divorce). Respondents in the Congolese target group provide no specific reasons for problem or intensified use.

3.3 Help-seeking behaviour

Generally speaking, very few respondents report the use of formal treatment support. In the Turkish and Congolese communities many of the users consider their use to be “their own problem” and they feel they “have to” deal with this problem themselves. Among the Turkish respondents and the group of asylum applicants, refugees and undocumented migrants, one-third of the problem users report that they have received formal treatment services. Less than one in seven of the Eastern European respondents report that they have received formal and informal treatment support. The aforementioned “treatment gap” might in reality be wider, taking into account that many of the participants in our research do not

consider themselves to be problem users. Significantly, most participants from Eastern European communities who asked for help from the community researchers requested psychological help.

3.4 Social mechanisms affecting substance and addiction care

Taboo, shame and (ethnic) conformity pressure (Van Kerckem et al., 2014) affect respondents' perceptions of addiction and interfere with their use of addiction care services in the Congolese and Turkish communities in this study. Social pressure within the communities ensures that substance use carries a stigma that impedes help-seeking behaviour in some cases. In the other two case studies (Eastern European communities, and asylum applicants, refugees and undocumented migrants) social pressure fulfils a less important role.

The lack of information about addiction care is quite high in the Eastern European communities and among asylum applicants, refugees and undocumented migrants. This is primarily due to poor language skills and limited social connections and networks. Also in the Turkish community language is a barrier to accessing (psychiatric) services, even when participants have a good knowledge of the Dutch language because they feel

Ethnic identity, acculturative stress and discrimination are factors influencing the use of substance and addiction care services. All the participants in this study report that they have experienced racism and/or discrimination. Furthermore, participants who describe themselves as problem users appear to have less mental resilience and fewer coping mechanisms to deal with this experience. In some cases this is associated with the development of a reactive ethnic identity, which enhances isolation and is a risk factor for problem use. The majority of the respondents do not feel Belgian, and find it hard to define their ethnic identity. Hence, we cautiously suggest that the formation of a well-balanced identity is key to psychological stability, and that psychological instability can influence patterns of substance (mis)use.

Finally, it should be noted that the social network of most participants consists primarily of individuals with the same migration background or people with similar use patterns as their own. Moreover, a lot of these respondents live rather isolated lives, because they want to avoid a user environment, do not feel welcome anymore in their family or community, or do not have any family ties in Belgium. This means that their recovery capital is relatively low.

3.5 Specific barriers to treatment

In our literature review we found that cultural or religious views on addiction have an impact on the use of addiction care services, and whether treatment is successful. Our study expounds on this point of view. Although the Turkish target group describes addiction as problematic only when it concerns physical dependency, these respondents are very critical of treatment, especially when it is based on medication. Participants from the Eastern European communities requested more psychological help. The use of alternative treatment methods (consulting hodjas, scientology) is only observed in isolated cases and does not seem to be widespread.

Since this study primarily targets users, we were not able to collect insightful information on barriers in the organisation of treatment. Our respondents do mention that general practitioners failed to answer questions related to addiction. Also, Turkish respondents indicate that psychologists and psychiatrists pay too little attention to the importance of family in the client's life.

Considering the significant link between socio-economic status and (mental) health (Saloner et al., 2013; Marmot & Bell, 2016), it is important to note that people with a migration background often have low socio-economic status and a relatively high risk of depression and chronic stress. In our study the impact

of these socio-economic risk factors seems to be underestimated by users and communities, and by those involved in addiction care and policy. Therefore, a structural approach to dealing with discrimination, improving socio-economic statuses of people with a migration background is required in order to improve their (mental) health status.

4. Recommendations

Based on this research we make recommendations for (1) the federal and confederal governments, (2) local policy, (3) addiction care and (4) communities of and for people with a migration background.

4.1 The federal and confederal governments

1. Creating binding obligations for mental health care and substance abuse treatment centres to pay attention to diversity.
2. Encouraging local networking between services within the framework of PSY 107 projects and reforms of mental health care:
 - link local heroin substitution centres to one another;
 - enable referral from out-patient heroin substitution centres to in-patient treatment;
 - provide funding for outreach workers in in-patient addiction services;
 - link the reduction of in-patient psychiatry to an extension of frontline services (e.g. community health) to cater for mental health needs.
3. Introducing courses that promote cultural competences as a mandatory part of the education of practitioners in mental health care.
4. Encouraging research into migrant and ethnic minority health status and health care.
5. Combating labour market discrimination and ensuring existing anti-discriminatory legislation in companies is applied.
6. Taking into account the specific educational needs of migrants and ethnic minorities, especially first-generation migrants, but preventing the creation of “education ghettos” and discouraging the systematic orientation of migrants and ethnic minorities in specialised schools.
7. Identifying migrants and ethnic minorities in a systematic health care register to enable better monitoring, for example by consistently linking data from the social security database *kruispunt databank sociale zekerheid* to the e-health platform.
8. Encouraging public health authorities to join (inter)national networks to promote intercultural health care.
9. Increasing the representativeness of the national health survey in the health care sector by involving and defining people with a migration background.
10. Limiting the impact of austerity measures on the funding of health interventions and specifically drug-related initiatives, drug-related research and prevention activities and on professionals working with vulnerable groups (Suijckerbuyck, 2014: 237) by:
 - eliminating waiting list problems in the Flemish general welfare centres (CAWs) and mental health centres (CGGs);

- stimulating research on and use of heroin “user spaces”;
 - restarting the Central Registration Points (CAPs).
11. Considering the specific topic of substance and treatment use in migrants and ethnic minorities in the (community) safety contracts and in metropolitan policy.
 12. Allocating a more proactive and transversal role for Unia, the Interfederal Centre for Equal Opportunities, so that it can combat discrimination in all layers of society even more effectively.

Tackling specific problems in asylum applicants, refugees and undocumented migrants:

13. Ensuring decent (pre-) reception conditions that respect human dignity (including the need for privacy and mental well-being) for all asylum applicants, to avoid situations where their temporary place of residence may increase mental problems.
14. Clarifying the application of the legislation on Urgent Medical Aid and ensuring a clear framework of reimbursement for health care for migrants with a precarious legal status, for example by implementing the recommendations made by RIZIV/INAMI (RIZIV, 2014: 5) for simplifying Public Centre for Social Welfare procedures concerning MediPrima.
15. Delivering to all irregular migrants a voucher entitling them to request assistance from different social and medical institutions.
16. Extending the use of the medical card to irregular migrants, entitling them to urgent health care.
17. Diversifying the health professionals and health services available to treat migrants with a precarious legal status or who have an irregular status, to prevent the formation of “health ghettos”.
18. Ensuring access to all health care services for all asylum applicants, regardless of their place of residence.
19. Providing multilingual information regarding substances, substance use and (addiction) care in shelters for asylum applicants (Fedasil, Rode Kruis, local care initiatives, etc.).
20. Enabling better support for the Federal Agency for the Reception of Refugees and Asylum Seekers (Fedasil) for the provision of specific training (for what concerns mental health and addiction treatment possibilities) for health professionals (e.g. general practitioners).
21. Enabling better contact between Fedasil and local partners in order to fine-tune efforts and consequently improve working efficiency.

4.2 Local policy

22. Creating flexible, proactive, low-threshold, locally embedded intermediary primary health care services.
23. Encouraging each health professional, health service and socio-cultural service to develop action plans to meet the specific needs of people with a migration background.

24. Sensitising and training general practitioners about substance (mis)use in people with a migrant background, drug treatment services and referral systems, for example by using the “me-assist” tool, working with the expertise of Fedasil and/or the example of CAD-Limburg.
25. Providing an intercultural worker for support in the development of a diversity policy in substance abuse treatment centres to make them more accessible to people with a migration background, for example based in the independent municipal integration agencies in Flanders (*Externe Verzelfstandigde Agentschappen*).
26. Developing and providing culturally competent mental health services, especially in urban centres in all the regions of Belgium.
27. Providing adequate information to people with a migration background about substance abuse treatment centres and distributing it via locations where the target groups will find the information (e.g. Public Centre for Social Welfare, Public Employment Service, health insurance funds, local shelter initiatives, etc.).
28. Improving collaborative links and referral between mental health services, street-based social work and socio-cultural organisations.
 - Collaboration between mental health services and social outreach services (e.g. mobile teams and Dienst Outreach Stad Gent, mental health centres, heroin substitution centres).
 - Collaboration between integration (e.g. IN-Gent), social (Buurtwerk & Dienst Outreach werk) and mental health care services (mobile teams, crisis teams and also, e.g., *Villa Voortman*).
29. Stimulating the implementation of a dedicated, harm reduction oriented drug strategy with specific attention to people with a migration background.
30. Considering mental health as a main activity and priority of the primary health care services (e.g. *Medikuregem*).
31. The creation of a platform for transcultural/culturally sensitive mental health care for knowledge sharing and dissemination, which can also possibly function as a contact point for family members and users.
32. Entrusting the Public Centres for Social Welfare (OCMWs) with the social support of clients to decrease the burden on social services in hospitals, for example by means of training employees concerning substance (mis)use related problems and substance abuse treatment services (cf. the expertise in the mental health centre Eklips).
33. Stimulating regular contact with the general practitioner in the target group.
34. More intensive follow-up of users during and after incarceration and treatment (Tieberghien & Decorte, 2008) via staff of CAPs, judicial assistants, Public Centres for Social Welfare and/or other judicial and medical services.

4.3 Addiction care

35. Structural integration of preventive activities into the existing mental health care services by means of diversity policies.

36. Adopting proactive initiatives to provide comprehensible and adapted information on the health care system for people with a migration background, strengthening especially the role played by the health insurance funds, public welfare centres and trade unions (for Eastern European populations).
37. Increasing the accessibility of, and encouraging collaboration with, interpreters and intercultural mediators.
38. Increasing knowledge and awareness of culturally specific components in health care delivery, in an attempt to improve the accessibility of mental health care and substance abuse treatment services to people with a migration background (e.g. based in Trimbos Institute's "Cultuursensitief addendum bij de multidisciplinaire richtlijn schizofrenie").
39. Taking into account, as much as possible, the context of the client in the delivery of health care facilities, especially in specialised psychiatric departments in hospitals.
40. Psycho-education to increase self-reflection as an important instrument in the treatment process (Chow et al., 2010) (e.g. the Mind-Spring project).
41. Fostering contact and networking with community members and socio-cultural organisations by means of stimulating outreach work on the different levels of substance abuse treatment services, but also in prevention and harm reduction services.
42. Involving close family members in treatment, for example by means of multidimensional family therapy (Little et al. in Alegria et al., 2011), multisystem therapy or triadogue therapeutic settings, which could result in higher treatment completion rates.
43. Implementing targeted information and prevention initiatives for reaching hard-to-reach target groups as well as dealing with problems that affect specific groups (e.g. the Mind-Spring project for and by asylum applicants, refugees and undocumented migrants¹).
44. Taking into account the medical perspective on addiction that some people with a migration background have (Broers & Eland, 2000) may open pathways to more durable treatment solutions for particular users.
45. Eliminating distrust of treatment centres while building a relationship of trust with the client (especially among stigmatised target groups, e.g. Roma).
46. The implementation of participative engagement and research methods in future projects and research calls and in local government and social and health care service practice (such as local health care centres) (Favril et al., 2015; Laudens, 2013; Piérart et al., 2008).

4.4 Communities of and for people with a migration background

The recommendations below are based on the target groups in our research study. Consequently they are not necessarily applicable to all migrant communities, nor exhaustive.

47. Prioritising information initiatives about the risk factors for substance misuse (such as marital problems, economic problems, a taboo on addiction, insecurity caused by the asylum procedure

¹ Mind-Spring offers psychological support, empowers the target group by including them in the actions and reduces social isolation among these individuals.

or not having documents at all, coping with discrimination, etc.) rather than about substance misuse per se. Mosque associations could contribute to this, for example the successful Tupperware formula (Laudens, 2013).

48. Extending the tasks of the existing emergency telephone helpline of the Muslim Executive in terms of addressing questions about mental health care and substance misuse issues.
49. Opening the discussion in mosque associations and Islamic education as to the interpretation and use of the dynamic concept of *haram* in Muslims' lives with the aim of eliminating or at least reducing the taboo on substance use.
50. Inserting social consultants in cultural and/or religious organisations such as mosque associations.

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