Intercultural Responses to drug-related challenges for refugees, migrants and IDPS

Handbook for professionals working in the field of addictions with refugees, migrants, and internally displaced persons

Pompidou Group
Groupe Pompidou

COUNCIL OF EUROPE
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Executive summary

In 1971, former French President Georges Pompidou formed the Pompidou Group (PG), an intergovernmental body of the Council of Europe, whose mission is to provide knowledge, support and solutions for effective, evidence-based drug policies through a human rights perspective. It was created in response to a substantial increase in drug addiction throughout Europe. In 2021, the PG celebrated 50 years of in the same year the PG extended its mandate to take a more inclusive and holistic approach, which now covers addictive behaviours linked to licit substances (such as alcohol and tobacco) and new forms of addiction (such as internet gambling and betting). The PG's motto, "Human rights at the heart of drug policies", is manifested through its humane approach to tackling drug addiction as a health issue rather than a crime issue. In fact, many PG member states have implemented low-risk drug consumption rooms, placing individuals' dignity at the forefront of addressing substance use disorders.

As addictions are not confined to European borders, the PG established the Mediterranean network for co-operation on drugs and addictions (MedNET) programme in 2006, which includes non-Council of Europe member states, namely: Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine[1] and Tunisia. Many European countries, especially those in the Mediterranean region, were and continue to be impacted by the migration crisis that has been ongoing since 2015. Refugees, migrants, and internally displaced persons (IDPs) can be especially vulnerable to substance use disorders and thus require a great deal of interdisciplinary professional support to manage and overcome the many risks they face as people on the move.

In 2017 and 2018 the PG EXASS Net and MedNET networks co-organised two meetings, with the support of the National Drug Co-ordinator of Greece, on "Refugees and Drugs: Estimating needs, support practice, preventing risks", where practitioners working with migrants, refugees and IDPs expressed concern about their ability to adequately respond to and meet the needs of this target population. To address these concerns, the PG included the activity "Correspond to New Challenges for Refugees, Migrants and IDPs" in the 2019-2022 PG Work Programme and established a support network of professionals (SNP) to work on drug-related challenges for refugees, migrants and IDPs. This network aims to identify and collect common and experimental practices in responding to the needs of the target groups, provide training for professionals working with the target groups, support capacity building, and promote the outcome and conclusions of the project at the European and international level through partner institutions.

This handbook takes a multidisciplinary approach to addressing these risks, as legal, psychological, and socio-cultural understandings are all vital to aiding the target population in a way that preserves their basic right to dignity. It was written by professionals for professionals and functions as a basic guide to understanding the various factors related to working with refugees, migrants and IDPs and how these factors contribute to the development of substance use disorders among the target population. It emphasises an individualistic approach to aiding those of the target population in that while they are all migrants, they are also individuals with unique backgrounds and experiences and should be aided based on their personal needs. The recommendations provided within the handbook are evidence-based and derived from existing literature, best practices, legal cases and documents, and the expert legitimacy of professionals working in the field. It is the PG's hope that this handbook provides practitioners with the insight and resources they need to adequately treat and respond to the needs of refugees, migrants and IDPs in the context of substance use disorders.

1. This designation shall not be construed as a designation of a state of Palestine and is without prejudice to the individual positions of Council of Europe member states on this issue.

AIM OF THE HANDBOOK

This handbook aims to provide practitioners with a comprehensive guide to understanding the needs of migrants, refugees and IDPs in the context of substance use disorder, and how to meet and respond to their needs in a culturally appropriate manner. It is intended to be a valuable resource for various professionals and policy makers working with the target population, as it offers advice and recommendations to consider when implementing actions and policies, as well as working alongside the target population in general. This handbook also takes a human rights centred approach and thus emphasises the necessity of equal access to treatment and intercultural competence to appropriately address the individual needs of the target population and preserve their dignity.

METHODOLOGY AND PROCESS

The project of developing this handbook began in December 2019 with the establishment of a working group of 12 professionals working with migrants, refugees and IDPs in the context of substance use disorder. The group was named "Support Network of Professionals" (SNP) working with migrants, refugees and IDPs and for more than two years exchanged valuable knowledge, experience, and support to achieve the final result. The Handbook is also an activity foreseen in Council of Europe Action Plan on Protecting Vulnerable Persons in the Context of Migration and Asylum in Europe (2021-2025), coordinated by the Special Representative of the Secretary General on Migration and Refugees of the Council of Europe.

Despite the Covid-19 outbreak, which occurred shortly after the beginning of this project, the working group was meeting (online) on a regular basis to decide on and draft the various chapters of the handbook.

With their personal insight in mind and their experience from the field, they then conducted an extensive literature review on their respective topics to support their points. Following the literature review, the experts began to put together a first draft of the handbook, which took place in the early months of 2020, just prior to the Covid-19 outbreak. The writing of the handbook concluded in May 2022 following the final working group meeting, which took place on 9 May in Strasbourg.

STRUCTURE OF THE HANDBOOK

Chapter 1 – Introduction to migration

Chapter 1 defines the various groups of people on the move, explores different reasons for why they might be on the move, and how having, or not having, certain legal protected statuses impact their access to different health and social services.

Chapter 2 – People on the move and drug-related challenges

Chapter 2 describes risk factors that might be experienced by people on the move, the different phases of migration, socio-cultural competency to be adopted by professionals, and specific risks related to the Covid-19 pandemic.

Chapter 3 – Screening and first assessment

Chapter 3 deals with screening and first assessment of migrants upon arrival in their host countries. It emphasises screening for identification of vulnerabilities, e.g., mental disorders, physical health problems, etc.

Chapter 4 – Prevention

Chapter 4 discusses the development and implementation of prevention interventions for the target population including housing, community-based preventions, household/family level, women and children, and concludes with recommendations to policy makers on how to effectively achieve various prevention efforts.

Chapter 5 – Harm reduction

Chapter 5 introduces the harm reduction model and harm reduction challenges and closes with recommendations for professionals and policy makers on harm reduction interventions.

Chapter 6 – Treatment and social inclusion

Chapter 6 speaks to the treatment of substance use disorder and how it relates to social inclusion challenges and ends with recommendations for professionals in regard to treatment, followed by recommendations to policy makers on how to design treatment services.

Chapter 7 – Law-enforcement aspects

Chapter 7 focuses on various aspects of law enforcement, characteristics of the drug market in Europe, drug-related crime prevention and co-operation, recommendations and advice for law-enforcement professionals, and recommendations for policy makers surrounding law-enforcement interventions.

Chapter 1

Introduction to migration

Migration can be defined as the movement of people away from their place of usual residence, either across an international border or within a state. Over the last few decades, several studies have been conducted that investigate the migration phenomenon and provide different definitions, motives and circumstances linked with it. However, when it comes to the definition of "migrant", the debate is still ongoing since there remains no clear-cut definition. Some of the reasons for the lack of a precise definition are often associated with the existence of many binary approaches to migration studies. Binary approaches usually stand for the migration status (legal vs irregular migrants), or they are sketching the reasons or motives of people on the move by dividing migration into two categories: forced and voluntary migration. There is considerable scepticism regarding the distinction between forced migration and voluntary migration, since it is often not possible to clearly distinguish between volition and coercion. In practice, most migration cases have elements of both coercion and volition behind the choice to leave the place of usual residence.

The scope of this chapter is not to analyse or classify migration cases. There is a plethora of material that has instigated the legal, political, or socioeconomic framework of migration. This chapter provides brief descriptions and characteristics of people on the move that fall under the interest of this handbook – namely, those who are forced to migrate internally (internal migration), and those that cross international borders (international migration).

1.1. Internal migration

Internal migration refers to the movement of people within the same state and involves the establishment of a new temporary or permanent residence.[2] Those people who are forced to leave, and move internally, are universally defined as internally displaced persons (IDPs). The Guiding Principles on Internal Displacement of 1998 explain that IDPs are "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised state border".[3] According to the Parliamentary Assembly of the Council of Europe (PACE),[4] we can trace IDPs in 11 out of 46 Council of Europe member states, namely Armenia, Azerbaijan, Bosnia and Herzegovina, Croatia, Cyprus, Georgia, Moldova, North Macedonia, Serbia, Turkey and Ukraine. Most of these people (approximately 4 million in 2017[5]) are in Ukraine,[6] Turkey, Azerbaijan, Cyprus, Serbia, and Bosnia and Herzegovina. While the current patterns of internal displacement in Europe have mainly resulted from conflicts – some of which date back to the 1970s or 1990s – and instability, some cases of displacement have resulted from the impact of climate change or natural disasters, for example in Croatia following the earthquakes in 2020 and 2021, in Italy following the earthquakes in 2016, and in Bosnia and Herzegovina following the floods in 2014.[7] The most recent data of the Internal Displacement Monitoring Centre (IDMC) show that at the European level, the majority of new IDP flows were found in Albania and were mainly generated by natural cataclysms (approximatively 33 000 people) and in Spain, caused by fire crises (around 23 000 people).[8] On some occasions, IDPs subsequently became ethnic minorities.[9] For instance, in the Soviet Union, there was a practice of displacing people from their republic of origin to other Soviet republics. Furthermore, after the fall of the USSR, IDPs became ethnic minorities in different countries. Ethnic minorities may encounter obstacles like those of migrants. People who use drugs and come from foreign or diverse cultural and ethnic backgrounds may be subjected to cultural specificities; therefore, treatment and social inclusion services need to consider their differences.[10]

2. International Organization for Migration (2022b).
3. UN (1998), Guiding Principles on Internal Displacement.
4. Paraskeva (2017), p. 8.
5. Council of Europe Commissioner for Human Rights (2018), "Europe's duty to internally displaced persons", available at www.coe.int/en/web/commissioner/-/europe-s-duty-to-internally-displaced-.
6. From February to April the numbers of IDPs in Ukraine have massively increased. It is estimated that over 7.1 million people have been internally displaced since the beginning of the invasion: www.iom.int/news/71-million-people-displaced-war-ukraine-iom-survey.
7. Council of Europe High Commissioner of Human Rights (2018), "Europe's duty to internally displaced persons", available at www.coe.int/en/web/kyiv/-/internally-displaced-persons-idps-integration-participation-and-non-discrimination.
8. www.internal-displacement.org/global-report/grid2020/.
9. An ethnic minority is a group of people of a particular race or nationality living in a country or area where most people are from a different race or nationality.
10. Fedorova O. (2012), p. 10.

1.2. International migration

Looking at one of the most authoritative definitions, an international migrant is considered a person who moves away from his or her place of usual residence, across an international border to a country of which (s)he is not a national, temporarily, or permanently, and for a variety of reasons.[11] There are two main approaches to the definition of the term "migrant": (1) the inclusivist view, followed among others by the International Organization for Migration (IOM), holds that migrants are people who have moved from their usual place of residence, regardless of their legal status and their motivations for moving; and (2) the residualist view, which sees migrants as people who have moved from their usual place of residence for any reason other than fleeing war or persecution.

From the inclusivist view, migrants include refugees, foreign workers, trafficking victims, and those whose status or means of movement are not specifically defined under international law, such as international students, trailing spouses, and many other categories of individuals.

In addition, there is a growing consensus to introduce and include environmental migrants as a category. Climate change and disasters have always been major drivers of migration. However, climate change predictions for the 21st century indicate that an increasing number of people are expected to be on the move due to extreme weather-related events.[12] No legal definition for persons on the move due to environmental drivers exists to date, nor an internationally accepted one. In 2007, the IOM put forward a broad working definition for environmental migration, which seeks to capture the complexity of the issues at stake: "Environmental migrants are persons or groups of persons who, predominantly for reasons of sudden or progressive change in the environment that adversely affects their lives or living conditions, are obliged to leave their habitual homes, or choose to do so, either temporarily or permanently, and who move either within their country or abroad."[13]

1.3. Common features and legal framework of the target groups

We will now try to identify common features of the above-mentioned categories, setting as a starting point the fact that they are all people who were forced to move, or had to move in an irregular way. This can lead to unauthorised stay in a country, in addition to facing all the associated challenges that such a relocation brings. In practice, both international and internal migrants face challenges related to movement and adaptation to a different place. Adaptation to the cultural and societal norms of the host country (or region) implies significant effort on the part of the person and is often accompanied by a great deal of stress.

According to the international legal framework, IDPs are entitled to specific rights as stated in the UN Guiding Principles on Internal Displacement (E/CN.4/1998/53/Add.2), namely the right to basic humanitarian assistance, to protection, and to safe return. The governments of the states where IDPs are found are responsible for their assistance and protection.[14] However, even if at first glance it is assumed that IDPs have more privileges or have had to overcome fewer challenges in comparison with international migrants, in practice they face similar challenges such as experience of trauma, long processes of resettlement and long duration of stay in temporary settlements. In the context of international migration, the legal perspective becomes more complicated. On the one hand, the 1951 Geneva Convention imposes upon state parties the responsibility of providing rights and protection to both asylum seekers and refugees. One of the guiding rules in the matter of refugees is the *non-refoulement* principle, which forbids a country to return asylum seekers to a country in which they would be in danger of persecution. Once granted protected status, refugees are given the right to work, study, health care, freedom of movement, and the benefits established by law for the citizens of the host country. While refugee status is universally recognised by the state parties to the Geneva Convention, other forms of protection such as humanitarian and subsidiary ones, rely on national and international laws, hence the rights they protect vary between countries.

Refugees are internationally recognised as persons that move due to fleeing wars or persecution. Refugees' rights are officially stated in the Convention Relating to the Status of Refugees of 1951 and the New York Declaration for Refugees and Migrants. According to the 1951 Convention, a refugee is a person who leaves the country of his nationality due to well-founded fears of persecution for reasons of race, nationality, religion, sexual orientation, membership of a particular social group or political opinion and for the reason of fear does not want to return in the country of origin. During the process of evaluation for the request of asylum, potential refugees are called asylum seekers. This official status places them under international protection and allows them to enjoy rights in a country other than that of their origin.

On the other hand, if an international migrant's asylum application has been rejected yet they remain on the

11. International Organization for Migration (2022b).
12. The Synthesis Report (SYR) of the IPCC Fifth Assessment Report (AR5) (2014), available at www.ipcc.ch/report/ar5/syr/.
13. International Organization for Migration (2017).
14. United Nations Office of the High Commissioner for Human Rights, www.ohchr.org/EN/Issues/IDPersons/Pages/Issues.aspx.

territory beyond the deadline assigned to voluntary return to their country of origin, they are referred to as an "irregular or undocumented migrant". Irregular or unauthorised stay in many states is considered a criminal offence. Therefore, irregular migrants often face criminalisation or are subject to forced return (repatriation)[15] to their country of origin, even after several years. Thus, there is no guarantee of support or provision of services for undocumented migrants, and they usually face several legal and social barriers during their settlement and adaptation phase. Consequently, international migrants are subject to a potential risk of discrimination because of their nationality, ethnicity or race, which will further influence the exercise of their rights (access to education, health, labour or justice). For example, in the case of *Gaygusuz v. Austria*, the applicant could not benefit from social services in his time of need, despite having worked in Austria for years and contributing to its economy, because he was not a national of the country he migrated to. Similarly, in the case of *Paposhvili v. Belgium*, the applicant fell seriously ill during his prison detention, and was not prescribed any treatment, which further aggravated his health status.[16] How to provide international migrants with access to different services in a timely manner is a question of serious concern.

1.4. Conclusions

People on the move have different reasons for leaving their country and show different characteristics, and often national and international legal instruments do not properly frame this multifaceted target group. The recognition of a status is a complex procedure, and gaining this recognition is especially difficult for migrants who lack legal counselling and support. Migrants without a clear legal status are subjected to a grey zone where the enjoyment of basic rights and the access to public services is complicated and uncertain. This unfortunate reality is of grave concern because it increases the vulnerability of an already disadvantaged population, thus creating an ever-pressing need for social and health support.

15. United Nations Basic Principles and Guidelines on the Right of Anyone Deprived of their Liberty to Bring Proceedings Before a Court (A/HRC/30/37, para.13; WGAD, Deliberation No. 5).
16. European Court of Human Rights, *Paposhvili v. Belgium*, No. 41738/10, 13 December 2016.

Chapter 2

People on the move and drug-related challenges

Key aspects

1. People on the move often face additional risks along various phases of the migration route that can affect mental and/or physical health, and the likelihood of developing substance use disorder (SUD).
2. Experience of trauma is a high-risk factor for the initiation or continuation of substance use.
3. Social exclusion and stigmatisation in host communities are additional complex risks.
4. The migration crisis and the Covid-19 pandemic created new challenges and revealed the need to review and adapt existing migration policies in Europe. Each country's vaccine distribution plan must incorporate migrant populations.

2.1. Risk factors

Chapter 2 focuses on risk factors for people on the move including trauma, poor mental health, and risk factors faced at various stages of migration. Chapter 3 will then discuss prevention, treatment, and harm reduction options available for implementation for practitioners and other relevant key stakeholders. At present, there is not sufficient evidence or enough studies indicating that migrants (independently from their legal status or classification) are more prone to develop addictive behaviours, or alternatively that they have higher rates of use in comparison with the general population.

The migration crisis that has taken place in the last decade in Europe is considered the largest mass movement of people since the end of the Second World War.[17] The massive flows of 2015 led to unmanageable situations predominantly for the frontline countries in Southern Europe and Turkey and to the creation of camps, host facilities and detention centres (after temporary settlements) across Europe. In addition, lack of human resources staff across all industries within member states, in conjunction with high volumes of asylum seekers, created a landscape of a prolonged status-less stage for thousands of vulnerable people. Most refugees and migrants arrived via the Western Balkans route and the Mediterranean route through North Africa and Turkey, and on average, half of the arrivals were typically men, closely followed by children and women. To better address risks faced by the target group in discussion, current European drug policies – related to the conflation of people and drug-trafficking routes, supply, and usage – must be reviewed in light of this mass movement of people from non-European countries. The pre-existing and ongoing situation has been burdened since February 2022 following the Russian Federation's invasion of Ukraine. Russia's invasion of Ukraine has resulted in worsening humanitarian conditions, which have affected millions of people inside Ukraine. Since March 2022, an estimated 6.48 million people in Ukraine have become IDPs, and as of 18 March, UNHCR reported that over 3.2 million refugees, half of whom were children, had fled Ukraine and were seeking shelter in other countries, notably Poland, which has taken in more than 1.9 million refugees from Ukraine. Hungary, Romania, Slovakia and Moldova are the other frontline countries receiving large numbers of refugees.

Several circumstances could be considered risk factors increasing the vulnerability of people on the move to develop substance use disorders. These include poor living conditions, deprivation of liberty, long-term detention, social instability and long-standing legal processes, family separation, exposure to violence, social exclusion, unemployment, stigma, lack of social and educational inclusion and past traumatic experiences in the country of origin or during the migration journey. Furthermore, how the Covid-19 pandemic impacted and continues to impact migration to and within Europe remains to be seen, as well as the negative consequences faced by migrants such as mental health and drug use.

While dealing with people on the move, professionals should consider the 14 indicators of geographical mobility of people elaborated by F. Düvell.[18] Some of the most important factors are duration of stay, place, push factors, legal status and cultural distance. Drawing on these attributes, certain typologies have been developed (see Table 1) to aid professionals in dealing with drug users with a migrant background.

17. Van Hout M. C., Hearne E. and Wells J. (2016).

18. Zhanny Zayonchkovskoy, Iriny Molodikovoy, Vladimira Mukomelya (2007), Методология и методы изучения миграционных процессов. Междисциплинарное учебное Пособие [Metodologiya i metody izucheniya migratsionnykh protsessov. Mezhdistsiplinarnoye uchebnoye posobiye] (Methodology and methods of studying migration processes. Interdisciplinary curriculum Allowance), Moscow, pp. 71-96, available at www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Moscow/pdf/Manual_on_Migration.pdf.

Table 1

Characteristics of migrants	Typologies
Duration of stay	Migration can be permanent, temporary, seasonal, pendular. Migrants' behaviour can differ dramatically as there are significant differences among these types of migration. Consequently, it is important to consider the duration of stay of a person with a migratory background in one or more host countries.
Place	Migration can imply a change in the context of the settlement from country of origin to hosting country, such as: rural-urban, rural-rural, urban-urban, and urban-rural. Professionals should bear in mind the type(s) of settlement the migrant goes through. Migration should also be framed in relation to administrative borders (internal or international) and to the journey of the person (whether they are in a transit country or the final destination).
Push factors	Often, there are multiple push factors behind a migrant's choice to leave. However, it is useful for professionals to identify the most common ones, and to understand how they are perceived by the migrant. Examples: ▶ labour migration ▶ career migration ▶ family reunification ▶ education migration ▶ forced migration because of war or prosecution ▶ migration due to natural disasters.
Legal status	Migrants' status plays a significant role when organising work with them. Legal status affects access to social and health services as well as migrants' willingness to connect with officials and public services.
Cultural distance	The degree of similarity or difference of cultural specificities of migrants with the hosting population is an important factor when making contact and further dealing with the client. "It is considered that the degree of difference of values between the country of origin and the hosting country is directly proportional to the number of difficulties that individuals live through in the process of adaptation."[19]

Source: Fedorova O., "Transcultural drug work", Pompidou Group of the Council of Europe[20]

It is essential that professionals do not perceive migrants as a homogeneous group and as a universal concept. When working with a person with a migrant background, the above-mentioned characteristics and all the specificities they imply must be taken into consideration. This will enable specialists to adopt an individual and tailored attitude and strategy towards the person with a migrant background.

19. Psychological and sociocultural adaptation, available at www.balticregion.fi/, p. 4.
20. Fedorova O. (2012), p. 25.

2.2. The pre-migration phase

The pre-migration period typically occurs in the individual's country of origin. In many cases, it is where individuals prepare for the move. Factors which compel an individual to begin the migration process – interstate or intrastate conflicts, human rights violations or interpersonal violence, persecution, threats, seeking better job opportunities, or loss of stability – are often sources of trauma themselves, which have the potential to increase the likelihood of developing SUD.[21] The means of migration, whether voluntary, irregular, for economic or educational purposes, or due to displacement, each have individualised stressors and risks. Both policy and patient care must take these complex migratory risks into account.

2.3. The migration phase

The second stage is the process of migration itself: the physical transition from one place to another, often involving psychological, social, and economic steps.[22] This process can be relatively straightforward, especially if the individual is migrating for educational or economic reasons and has migration documents. However, in the event of displacement or for persons seeking asylum, the migration phase can be arduous, life-threatening, or long and unpredictable. In the migration phase, mode of travel and travel conditions, especially for irregular migrants or asylum seekers, can cause trauma or compound pre-existing trauma.[23] In addition to the negative health impact of the often-perilous journeys to Europe, many arriving migrants have complex health and social needs from pre-existing health problems, their exposure to violence, conflict, displacement, inhumane smuggling, and trafficking schemes.[24] For migrants who experienced pre-migration trauma, negative experiences during the migration process can have long-lasting impacts on their mental well-being.[25]

2.4. The post-migration phase

The third stage is the post-migration period, when individuals experience the social and cultural contexts of their receiving country.[26] In the arrival and integration phase, additional risks can lead to or increase trauma experiences felt by migrants. These can be environmental or political exposures at the destination, including a migrant's legal status in the receiving country (such as refugee or asylum seeker). The latter can determine access to safe working conditions as well as the quality and affordability of health care.

Seeking asylum is an often lengthy, costly, stressful, and unpredictable legal admission process. This legal process essentially places vulnerable asylum seekers in a status-less state for an undetermined amount of time while they wait for a decision on their claim. The length of time spent in this state of uncertainty, where denial of a claim can lead to deportation, is directly correlated with poor mental health: compared with recent arrivals, asylum seekers who remained in a host country in a status-less state for longer periods are more likely to suffer from mental health problems, including post-traumatic stress disorder (PTSD), depression and anxiety.[27] In Switzerland, specifically, asylum seekers have been shown to have high levels of psychiatric disorders while living in this state of uncertainty.[28] The length of time that refugees wait in legal and social limbo for a decision on their asylum claim, and therefore experience *de facto* unemployment, also impacts upon their economic integration. Reducing the asylum waiting period can not only benefit asylum seekers' health, but also unlock their economic potential by increasing their chances of successful employment.[29]

Trauma factors at this phase can also include "othering", xenophobia, racism, stigmatisation, social exclusion, discrimination, sexual or labour exploitation, limited or no access to the health care system, fear of deportation, and poor living conditions in temporary settlements.[30] Family or partner separation can also compound stress. The attitudes and behaviours of members of the host society towards migrants, particularly resistance and hostility, provide additional factors that can determine negative mental health outcomes in the post-migration phase.[31]

Gender, education, age, social class, and access to housing and employment can affect migrants' adjustment to their new community as well as how they care for their health. Other vulnerable migrant groups, such as the elderly, those with an intellectual disability, and lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals have specific concerns that clinicians and policy makers must consider. Feelings of persecution may further add to a sense of vulnerability.[32] For example, a 2017 study in North America found that rates of PTSD among LGBTI migrants were as high as 70% to 100%, while alcohol and substance misuse were 2% to 36% higher for LGBTI migrants compared to non-LGBTI migrants.[33]

21. International Organization for Migration (2019), Ch. 7.
22. Schouler-Ocak M. (2015) p. 62.
23. International Organization for Migration (2019), Ch. 7.
24. World Health Organization (2018).
25. Schouler-Ocak M. (2015), p. 4.
26. Schouler-Ocak M. (2015). p. 62.
27. Priebe S., Giacco D. and El-Nagib R. (2016).
28. Heeren M., Mueller J., Ehlert U., Schnyder U., Copiery N. and Maier T. (2012).
29. Hainmueller J., Hangartner D. and Lawrence D. (2016).
30. International Organization for Migration (2019), Ch. 7.
31. Schouler-Ocak (2015), p. 62.
32. Schouler-Ocak (2015), p. 71.
33. White, Cooper and Lawrence (2019).

Finally, due to their status and problems with health literacy, irregular migrants may have difficulty engaging with and trusting health services and psychological therapies in their host community. Often, they fear that practitioners might report them to the authorities should they access needed health services, even in countries where this may be regarded as breaching confidentiality.[34]

2.5. Socio-cultural competence

The development of multiple conflicts, economic crises and natural disasters in the country of origin have contributed to a large influx of migrants. These migrants belong to different cultures, speaking diverse languages, sharing values, adopting various lifestyles and behaviours. It is for these reasons that it is important to develop a strategy for interacting with people from different cultural and social backgrounds. A person's culture significantly influences how they perceive the world around them, the attitudes of others and their actions, and the way they conduct themselves.[35] Migrants are used to certain models of interactions and behaviours in everyday life. Nevertheless, during the migration period they often face distinct forms of intercommunication, conduct and values, have different reactions to these conditions and specific needs. Professionals need to be conscious of these challenges faced by migrants and adopt an individually based attitude toward them depending on their specific culture.

In order to differentiate migrant types and assess cultural differences effectively, professionals need to have certain socio-cultural competences. Such cross-cultural competences are described as "the ability to observe and understand **individual life-worlds** in a specific situation and in different contexts and to deduce from these appropriate ways of action".[36] Although migrants may come from a particular culture or religious background, this does not necessarily mean that they always follow their cultural rules, for example eating a certain type of food even if it is forbidden by religious restrictions. Professionals need to take the time to listen carefully to the individual's personal experience to notice important differences and determine the right treatment strategy.[37] Furthermore, the **individual life world** reflects the specificity of the actual practice of the subject. Thus, the key to the successful integration of migrants into society and the existing health and social care systems lies in the cross-cultural competence of social institutions and the professionals working and interacting with them.

A study conducted by the psychologist J. Berry on cross-cultural psychology indicated the "important links between cultural context and individual behavioural development". He mainly argues that migrants face two tasks in the host country.[38] First, they must decide what to do with their cultural identity within the new cultural system (keep it or abandon it). Second, they should understand their position towards the new culture they face.

These tasks are resolved in the process of acculturation. Table 2 lists the four acculturation strategies.

Table 2

Separation strategy	Marginalisation strategy	Assimilation strategy	Inclusion strategy
Migrants prefer to preserve the cultural traditions and lifestyle of their country of origin. Consequently, they interact minimally with representatives of other cultures and often aggregate in communication with people of similar origin.	This strategy involves giving up certain cultural roots, while being unable to root oneself in another culture and accept new norms, values and contexts.	This strategy implies a willingness to overcome cultural distance, giving up part or all of one's previous cultural identity. For example, migrants try to learn the language quickly, change their appearance, eating habits or behaviour, actively communicating with the local population.	This strategy includes the ability to preserve the old cultural identity and at the same time accept the new culture. Such migrants are comfortable in both cultural environments.

Fedorova O., "Transcultural drug work", Pompidou Group, Council of Europe

34. Priebe, Giacco and El-Nagib (2016).
35. Krylov A. A. (1998), Психология: Учебник [Psikhologiya: Uchebnik] (Psychology: Textbook), p. 11.
36. Domenig (2007), p. 29.
37. See Kleinman and Benson (2006).
38. See Berry, J. W., Poortinga, Y. H., and Dasen, P.R. (2002), *Cross-Cultural Psychology: Research and Application*, Cambridge university Press, Cambridge.

Understanding the migrant's attitude can contribute to a more personalised management of the migrant's case and to trust-building between the professional and the person with a migrant background.

2.6. Trauma and mental health risks

Existing literature and studies have shown a correlation between exposure to trauma and the development of SUD. This correlation can put vulnerable populations such as migrants, refugees and IDPs at higher risk of developing SUD. The challenges that they face before, during and after their journey to a receiving country or their forced internal displacement can cause or contribute to their trauma. The term "trauma" was traditionally applied to physical injuries. Since the late 1800s, however, "trauma" refers to a range of psychological symptoms caused by experiencing the threat of violence, injury or loss. Events that cause trauma include a range of intentional and non-intentional acts of violence, such as personal assault, physical or sexual abuse, kidnapping, war, conflict, or seclusion.

Trauma, whether from a singular event or repeating events, affects every individual differently. Some may clearly display symptoms associated with PTSD, while others can "exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive." How an individual is impacted by an event depends on various factors, including "characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors"[39].

Trauma exposure is often linked to psychological consequences. These consequences include reactive distress, dissociation, depressive and anxiety disorders, panic disorders, and PTSD. The most frequently reported condition, especially among refugees, IDPs and recently arrived asylum seekers, is PTSD. PTSD was once considered an anxiety disorder and is now categorised as a trauma and stress-related disorder.[40] Symptoms can include flashbacks, severe anxiety, increased arousal, nightmares, negative changes in thinking and mood, avoidant behaviours, and changes in physical reactions (such as trouble sleeping or concentrating, angry outbursts, or self-destructive behaviour such as use of substances).[41] Delayed onset of PTSD can appear months or years after the traumatic event occurred, and repeated exposure to traumatic events can make a person more vulnerable to developing PTSD.[42]

Trauma is commonly associated with consumption of alcohol and other psychoactive substances, to numb and self-regulate painful emotions. The Adverse Childhood Experiences (ACE) Study in Serbia (2019), which analysed the incidence of different painful circumstances (including death of a parent, physical and sexual abuse) in more than 2 500 people, concluded that for each ACE, the risk of the early development of substance use increased two to four times.[43]

Migrants who followed an irregular migration path in the World Health Organization European Region in 2018 were shown to be at greater risk of poor mental health compared to migrants who moved for economic reasons. The World Health Organization reported that, in 2018, refugees exposed to stressful and threatening experiences showed a 9-36% prevalence of PTSD compared to 1-2% in host populations. Among Syrian migrants in Turkey and Sweden in 2018, the PTSD prevalence rate was 30% and 83% respectively, with higher rates among women. The report also documented that mental health problems, such as PTSD, may contribute to an increase in substance use and abuse. A study in Sweden reported SUD among male refugees, who connected substance abuse with psychological stress to cope with difficult memories.[44] Unaccompanied minors seem to experience higher rates of depression and symptoms of PTSD compared to other refugees and migrant groups. They also face additional risks such as death or disability, detention by authorities, early or forced marriage, physical and sexual violence, starvation, or limited access to physical and mental health care.[45] Additionally, the United Nations Children's Fund (UNICEF) found that, in 2017, unaccompanied minors who crossed the Mediterranean route to Europe were more at risk of exploitation or trafficking than adults.[46]

Regarding gender, migrant women are more prone to develop depression, anxiety, PTSD, or other relevant mental disorders.[47] Furthermore, women and girls are more exposed to all forms of violence, including physical and sexual violence during the migration route or during their stay at temporary settlements. They face increased exposure to harassment, sexual exploitation and human trafficking compared to men. Women also have a higher probability of engaging in sex work, which has a correlation with substance use and abuse. Family separation, lack of employment, pregnancy,

39 Treatment Improvement Protocol (TIP) Series, No. 57, (2014), Chapter 3, Center for Substance Abuse Treatment (US), Rockville
40. Schouler-Ocak (2015), p. 9.
41. Mayo Clinic (2018).
42. Schouler-Ocak (2015), p. 14; p. 226.
43. Adverse childhood experiences (ace) study, Research on Adverse Childhood Experiences in Serbia, Unicef in Serbia, March 2019.
44. World Health Organization (2018).
45. Ibid.
46. Ibid.
47. Arpa (2017).

childcare responsibilities and social marginalisation increase the likelihood of developing psychological disorders during and following migration.[48] Within the European Union, women who develop PTSD are at an increased risk of developing SUD. Due to social stigmatisation, women are also more likely to hide the state of their mental health, their trauma and their substance abuse, and avoid due treatment.

2.7. Trauma-informed care

Trauma-informed care (TIC) is a critical protective factor for practitioners to use when working with people on the move. TIC requires a broad understanding of traumatic stress reactions and common responses to trauma. A deep understanding of psychological symptoms is imperative. These symptoms may manifest as feeling different, experiencing triggers or flashbacks, disassociating, changes in behaviour, re-enacting the trauma in various ways, avoidance, self-harm, and self-destructive behaviours, among others. Trauma-related symptoms may exhibit themselves right away or arise years following the traumatic event. Co-occurring disorders, such as anxiety and substance use, are common, and it is therefore common for trauma survivors to be underdiagnosed or misdiagnosed.

In addition to psychological symptoms, some people with conditions such as PTSD may first present physical or somatic symptoms. Therefore, primary care may be the first and only setting for individuals to seek assistance for trauma-related symptoms. There is also a significant connection between trauma and chronic health conditions. Common physical disorders and symptoms include sleep disturbances, gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, dermatological disorders, urological problems, and substance use disorders.

Substance use is often initiated or increased after experiencing trauma. Clients in early recovery have a higher relapse risk if they experienced trauma. Substance use and abuse in trauma survivors can be a way to self-medicate and therefore avoid difficult emotions associated with trauma.

Advice to professionals

- Mental health risks should be routinely assessed, and TIC should be implemented at temporary settlements and communities in Europe.
- In early stages of TIC, establish, confirm, or re-establish a support system (such as culturally appropriate activities) as soon as possible.
- Educate your clients by reframing their physical symptoms (sleep disturbances, etc.) as physiological reactions to extreme stress.
- Communicate that treatment and other wellness activities can improve psychological and physiological symptoms.
- If appropriate, explain links between traumatic stress symptoms and substance use disorders.
- Normalise trauma symptoms (e.g. explain that symptoms are not a sign of weakness, being damaged, etc.).
- Support your clients with messages that convey that they are not alone, not at fault, and that recovery is possible.

Resilient responses to trauma can increase bonding with family and the community and heighten sense of purpose and meaning. TIC must be adjusted to the appropriate age group of the client, as each age group expresses unique trauma-related symptoms. TIC must also be culturally relevant and respectful of the client's specific needs. For people on the move, particularly those forcibly displaced, this must be an integrated approach to prevent and address the possible development of SUDs and to increase their ability to adjust to host communities.[49]

2.8. Social exclusion and stigmatisation risks

As a psychosociological process, inclusion is essential to the migration experience. The 2020 World Migration Report defines inclusion as "social cohesion and migrants' incorporation in the various societal areas, such as education, health, employment, housing, and civic and political involvement". Designing and implementing inclusion policies can be challenging; however, the lack of inclusion policies can be costly both for migrants who face discrimination and marginalisation, and for social cohesion in host communities.[50]

Exclusion can have detrimental effects on migrants' mental well-being. It can also negatively impact their contributions to trade, skills, and labour supply, which provide major economic benefits to receiving countries. Addressing migrant exclusion is essential to reducing risks, improving the chances of healing from trauma for migrants, and promoting societal well-being.[51]

48. Clark, M. "The Gender Dimension of non-medical use of prescription drugs in Europe and the Mediterranean region", Pompidou Group, Council of Europe.
49. Trauma-Informed Care in Behavioral Health Services (2014), Ch. 3, Treatment Improvement Protocol (TIP) Series, No. 57, Center for Substance Abuse Treatment (US), available at www.ncbi.nlm.nih.gov/books/NBK207191/.
50. IOM (2019) pp. 169-70.
51. Ibid., Ch. 6. p. 187.

Stigma, or stigmatisation, generally involves negative or discriminatory attitudes about a particular characteristic or attribute.[52] Stigmatisation and discrimination have the potential to convert the experience of migration into a traumatic life event. Stigmatisation and discrimination are often closely and negatively related to the working and living conditions of immigrants in their host society. A 2010 study in Germany discovered that 43.4% of immigrants were often exposed to experiences of discrimination, regardless of their country of origin.[53] Additionally, mental health is highly stigmatised in many parts of the world and concepts of mental health differ culturally. Internalised stigmatisation can be high among migrants, which can reduce their chances of seeking adequate health care even when it is available.[54]

2.9. Covid-19 risks

The coronavirus pandemic is an intersectional risk to both the physical and mental health of migrants. The conditions around the migration process expose migrants, refugees and IDPs to additional health risks, making them some of the most vulnerable populations during the pandemic.

Not only does migration increase the chance of individual exposure to Covid-19, but it also increases the risks faced by migrants upon arrival. These risks include pandemic-related stigmatisation, uncertainty about the future, lost opportunities, economic hardship, loss of loved ones, isolation, and fear. These psychological reactions can worsen or exacerbate pre-existing mental health conditions or vulnerabilities. In immigration detention facilities and refugee camps, the rates of virus transmission are a major health concern, where migrants are not always guaranteed access to safe and sanitary water, personal protective equipment (PPE), disinfectants, or the capacity to maintain social distancing.[55] Additionally, migrants may not have access to reliable information on the pandemic in their native language.

Common Covid-19 government prevention measures, such as restricting border movements, use of quarantine for people arriving across borders, freezing asylum procedures, and imposing extensive or partial lockdowns have all affected migrants' movement, social connections, access to work and well-being. Suspending programmes for resettlement and voluntary returns deepens feelings of anxiety for those dependent on these processes. Migrants with chronic illnesses or mental health disorders may have reduced access to medication and basic health care, which adds further stressors on them and their families. Additionally, IOM found that prolonged periods of quarantine and isolation can lead to increased stress, insomnia, anxiety, and substance abuse.[56]

Access to vaccines for international migrants (asylum seekers, migrants and refugees) has been further complicated during the Covid-19 pandemic. For most of these people who are without legal status and already have little or no access to essential health services and immunisation programmes, to that effect are at a higher risk of contracting and spreading Covid-19, thus increasing their vulnerability amid the pandemic. It is imperative that countries ensure equitable distribution of vaccines and booster shots among migrant populations.

Traditional barriers for migrants to receive adequate mental health care – including language and cultural barriers as well as poor access to health care providers – have been further complicated following the onset of the Covid-19 pandemic. While countries and international organisations such as the World Health Organization organise vaccine distribution and supply chains, additional efforts should be taken to address trauma, social exclusion and stigmatisation among migratory populations to improve overall community health and reduce the potential development of SUD.

52 Mayo Clinic (2018).
53 Schouler-Ocak (2015), p. 4.
54 WHO (2018).
55 International Organization for Migration (2020).
56 Ibid.

Chapter 3

Screening and first assessment

A fundamental principle in working with asylum seekers and refugees is to consider the heterogeneity of the population, regarding their origin, the reason(s) that led people to leave their country and the migratory path they have experienced. Professionals who intervene with this population have the ethical obligation to adopt the necessary and adequate resources for this intervention. Specifically in psychological intervention, it is essential to ensure the use of culturally and linguistically appropriate and validated psychological assessment tools for this population. Whenever necessary and possible, professionals intervening with asylum seekers and refugees should integrate cultural mediators and interpreters as partners and facilitators of communication.

On the grounds of general health needs assessment and public health protection, an initial medical examination or health screening should take place upon arrival. In order to provide emergency health care and to avoid the spreading of highly communicable diseases within a temporary settlement or community, early medical examination or triage usually takes place in times of crisis as well.

For countries of the European Union (EU member states), medical examination and related health care provisions are partially based on and guaranteed by Article 17 of Directive 2013/33/EU of the European Parliament and the European Council. The standards for the reception of applicants for international protection have been established in the Article 18 and Article 24 of Directive 2013/32/EU of the European Parliament and of the Council on common procedures for granting and withdrawing international protection.

Extent of screening may be determined by the public health authority and practitioner (or medical staff) in a facility. It should at least involve subjective problems identification and objective findings. Whenever possible, laboratory tests, chest X-rays, urine tests and rectal examinations are recommended.

Focusing on substance use, the aims are:

- thorough medical examinations detecting substance use signs;
- screenings, assessing the severity of substance abuse or use disorder;
- in relation to the partial examinations, the identification of other pre-existing health problems (e.g., HCV) connected to substance use.

Screening is also aimed at identification of vulnerabilities, e.g., mental disorders, physical health problems, problems resulting from being a victim of physical violence, torture, rape, or human trafficking. Vulnerability identification can be helpful in detecting who is at risk of developing a drug dependence or substance use disorder.

Although there are developed drug use screening tools and screening methods for detecting drug and other substance use, doing so among migrants is a big challenge because special instruments need to be developed for this particularly vulnerable group, which must take into consideration linguistic and cultural barriers.[57]

NIDA drug use screening tool, also known as the NIDA quick screen.

Identification of substance abuse at early stages of reception, together with detection of vulnerability, is crucial for prompt provision of appropriate health care, psychosocial support, and first steps toward recovery. According to the findings, results of screening may be/are shared with other professionals as necessary, e.g., physicians, psychologists or social workers. As it can also draw attention to a person at risk of substance use disorder, screening helps to identify a person or a group that should become the focus of a prevention programme.

For appropriate needs assessment, screening must be performed by trained professionals. It is highly recommended to be provided by practitioners experienced in infectiology or travel medicine, pneumology and addictology. If this is problematic in practice, alternatively, good co-operation on case management by different consultant professionals might be equally successful in screening and proposed intervention. Each professional should have at least basic knowledge of migration aspects, vulnerability and addictions.[58]

57. WHO, The alcohol, smoking and substance involvement screening test (ASSIST): development, reliability and feasibility. Addiction. 2002;97(9):1183–1194.
58. International Organization for Migration (2015).

While deciding whether to include screening into the reception process or not, it is crucial to consider current possibilities of performing a medical examination and proceeding with a tailor-made intervention, if needed. Feasibility of a screening may be influenced by several factors – for example, human capital (lack of medical professionals), administration issues, inflow of migrants, occupancy of a facility (e.g., extremely high inflow), staff training and financial resources.[59]

Apart from the aforementioned aspects, the importance of screening upon arrival depends on the existence of prevention programmes and referral systems and facilities. As prevention programmes are focused on persons without substance use problems or persons prone to develop addictive behaviours and attitudes, they should reduce the probability of new addiction cases. Referral systems and networking of professionals (e.g., those working within the facility and those at specialised hospitals) are then important to guarantee access to services when needed. Without such access, even the most accurate screening will not be as beneficial as it could be. It is worth mentioning that screening tools, protocols and extent may differ from country to country. Examples of screening management are presented in Appendix I and II.

59. European Centre for Disease Prevention and Control (2018).

Chapter 4

Prevention

4.1. Overview

Designing and implementing prevention interventions for migrants, refugees and IDPs might be considered a complex process with a plethora of obstacles and challenges for policy makers as well as the different professionals working in supply and demand reduction. The landscape in each EU country and beyond is heterogeneous and each country must adapt its interventions according to the domestic situation and its national drug policy. For instance, is it a frontline country? Do camps and hosting facilities exist? How do they receive new flows of refugees, asylum seekers, migrants? Are there pre-existing migrant communities in the society? Who are the people who migrate in terms of gender, age, reasons for migration? These are all factors that define the steps each professional must undertake to implement adequate prevention programmes.

Existing studies and literature thus far cannot provide consistent evidence that migrants, refugees and IDPs show a higher prevalence of substance use disorders and other addictions in comparison to the general population[60]. However, it is noted that people who experienced forced or involuntary migration are subject to a higher risk of substance use for reasons including coping with traumatic experiences before and during the migration process, co-morbid mental health disorders, acculturation challenges and social and economic inequality.[61] In addition, the high levels of distress and mental health problems that migrants and refugees suffer from increase the risks for substance use disorders, due to disruption of protective community networks, transformation of social roles, changes in access to substances, and weakened enforcement of substance control policies.[62] Therefore, prevention programmes focusing on early interventions are crucial.[63]

The scope of this chapter is to provide recommendations for practitioners on different levels of prevention deriving from literature, existing practices and the experiences of professionals working in the field with these target groups. The recommendations cover prevention interventions at the camps/hosting facilities and the community. Because women comprise half of the migrant population in Europe and often an important share of refugees and asylum seekers, they also follow a gender-sensitive approach. Finally, a special focus is placed on children and youth.

4.2. Early detection upon arrival and preventive reception system

When working with migrants, refugees and IDPs, it is important to account not only for pre-migration exposure to violence and distress factors but also to consider ongoing stressors related to the experience of displacement itself. The proposed ecological model of refugee distress draws on research and underlines that "mental health among refugees and asylum seekers stems not only from prior traumatic experiences related to migration (experience of war or conflict, experience of violence – including gender-based violence and/or domestic violence, prosecution, economic distress etc.),[64] but also from a host of ongoing stressors in their social ecology, or displacement-related stressors".[65] Therefore, it is crucial that transit, receiving or hosting countries develop mechanisms and synergies to increase protective factors and minimise risk factors while addressing displacement-related stressors such as exposure to risk of violence and exploitation, poverty, housing, unemployment and social isolation.

It is essential to implement reception systems that:

1. facilitate the identification of groups of migrants and refugees in vulnerable situations and assess their needs, including taking into account the specific situation, vulnerabilities and needs of women and girls;

60. Horyniak et al. (2016).
61. Lemmens et al. (2017).
62. Weissbecker et al. (2018).
63. Miller and Rasmussen (2017).
64. Report on the Focus Group Analysis (2021) "Drug Abuse and other Addiction within Migrants".
65. "Listen First" UN initiative, available at www.unodc.org/res/listen-first/parenting resources_html/science_of_involvement.pdf.

2. guarantee safe and humane living conditions: duration of stay in temporary settlements should be short and the use of administrative detention centres should be used as a measure of last resort under immigration legislation and unaccompanied children should not be detained. In addition, camps or similar shelters should be eliminated. Alternatives to migration detention should be preferred when possible and access to decent housing should be prioritised;
3. guarantee simple gender-sensitive and efficient legal procedures and shorten the asylum-seeking procedure, to avoid long-term uncertainty and insecurity. As has been observed, long-standing legal procedures and excessive periods without legal status are considered major negative stressors that could increase pre-existing vulnerability since they are related to increasing stress and anxiety for the future, instability and uncertainty. Long-standing procedures could postpone social inclusion since access to labour, education or health is not always possible in that stage;
4. guarantee access to health care by providing health services for both physical and mental health problems;
5. facilitate the integration of refugees and migrants by:
    i. providing trained case managers with transcultural competences to support them with administrative, cultural, and social matters;
    ii. training relevant professionals on gender equality issues and ensuring as much as possible the presence of women among them;
    iii. ensuring access to available information regarding relevant public services and access to justice;
    iv. ensuring access to protection measures in cases of rights violations, including gender-based violence and trafficking in human beings;
    v. ensuring participation in language and digital literacy courses;
    vi. ensuring access to education for children;
    vii. organising trainings for national bureaucratic procedures (insurance number, tax system, health care system);
    viii. fostering new social support networks in the community;
    ix. promoting legal and decent employment;
6. raise awareness by organising preventive and early interventions in sites dealing with addictions in diverse groups of the refugee population like parents, women and youth;
7. provide informative brochures in different languages about health and social services, drugs and alcohol use disorders and other non-substance use addictions.

4.3. Prevention related to housing

Prevention interventions at the different types of accommodation facilities (reception centres, shelters, hosting facilities, detention centres etc.) should be focused on:

- identification of persons with particular vulnerabilities, including experience of gender-based violence;
- improving living conditions and minimising the duration of stay at the temporary accommodation facilities;
- promoting access to individual houses, scattered around the community;
- providing accommodation sites with small numbers of residents close to cities, so the refugees have easy access to public protection, social, health and educational services and, in this way, their integration into the local society is facilitated;
- organising the functioning of the accommodation sites in a way that promotes the undertaking of responsibilities, giving roles to the residents, and promotes educational and leisure-time activities, as the main problem in the sites is the lack of activities;
- regardless of the type of accommodation, full access to services should be guaranteed, as well as the support of a multidisciplinary team, including key role members of the community, that can recognise and address the person's or family's vulnerabilities.

4.4. Prevention at community level

Community prevention of addictions is part of the community health framework based on the "health assets" model. Health assets could mobilise an individual to engage in deliberation, decision making and change. Consequences of health assets are positive health behaviours that could lead to mastery, self-actualisation and improved health outcomes.

The premise for a community intervention is the involvement and participation of the community itself to facilitate the process of change. Therefore, involvement and inclusion of all the different key actors such as public and private organisations, practitioners, cultural mediators, religious leaders, national communities, NGOs, and the target groups are considered essential to promote their empowerment in the prevention of addictions. The participation of women and vulnerable groups should be ensured through targeted outreach measures. Different actions should take place at various levels of intervention to ensure

participation that will lead to the achievement of the desired objectives:

- ocollaboration with health facilities related to addictions that are consolidated in the community (e.g., public administration, governmental agencies, civil society organisations and social groups) to promote shared social responsibility;
- oactive participation in spaces that guarantee organisation and commitment (e.g., forums, round tables, neighbourhood co-ordinators' meetings, etc.) to ensure that institutional representatives, social agents, and the community itself plan joint actions and action programmes, with common structure and goals;
- ofacilitation of the development of community initiatives aimed at the adolescent/youth migrant population sub-group, with a gender perspective in relation to the prevention of substance use or the prevention of non-substance addictive behaviours;
- oco-ordination to ensure the participation of both public administrations, at a political and technical level, as well as the participation of the community members, both women and men in the management of prevention actions.

When the community-based actions are targeting migrants/refugees who do not reside in camps, detention facilities or hosting facilities, it is essential to draw a health inequality map of the territory and proportional universalism should be the basic strategy to guide preventive actions. In addition, preferential attention should be given to groups and neighbourhoods with the greatest health needs or the most vulnerable populations, without neglecting the rest.

It should be noted that it is a frequent phenomenon that migrant and refugee social groups are not included or partially included in the national educational systems and therefore tend to present difficulties in developing a healthy lifestyle. This phenomenon is even more common for children and young people who reside in camps or other hosting/detention facilities. In addition, on many occasions even if they are part of the educational system, they might face social stigmatisation because of their migration/refugee background. Therefore, the interventions targeting these groups have the potential to reduce the risk gap in respect of adolescents and young people who have a better level of social integration, while simultaneously allowing the target groups to acquire access to a health network which otherwise they would not have.

The involvement and participation of all the different practitioners in the prevention of addictions requires the acquisition of cultural knowledge and transcultural skills that must be acquired through specific training. The role of mediation aims to (i) increase protective factors, and (ii) identify motivation enhancement and treatment of cases at risk of use of drugs or developing substance use disorders or other behavioural addictions such as gambling and gaming.

Professionals should consider the following three pillars when they design or implement community-based programmes or interventions.

1. **Health promotion and risk reduction:** Increase competences of health professionals or social workers by organising workshops on healthy lifestyle and risk reduction. Prepare and distribute materials and brochures on health risks associated with substance use disorder and other addictions. Organise workshops related to health promotion: eating habits, hygiene, sleep habits and risky/harmful sexual behaviour. The following topics could be used as examples of modules for health promotion and risk reduction training programmes:
   i. the interrelation between consumption behaviours and the development of risky sexual behaviours;
   ii. the interrelation between consumption behaviours and gender-based violence;
   iii. awareness raising on the risks of psychoactive substances;
   iv. awareness raising on the risks of new psychoactive substances (NPS);
   v. awareness raising on the importance of testing for sexually transmitted diseases (STDs);
   vi. awareness raising on the importance of infectious diseases screening (HIV, HCV, HBV).
2. **Personal development:** Work on the reinforcement of personal abilities and competences, as well as relationship skills. Promote cultural interests as part of personal growth and maturation. Assess the needs of identified vulnerable people who may need more specific interventions and treatment resources, including looking at the needs and situation of women and girls.
3. **Leisure:** Community-based programmes inside or outside governmental facilities should include activities that promote and ease proper leisure habits and healthy lifestyles. The activities should be implemented during leisure hours, in proper spaces and they should have as a primary aim the development of compatible activities as alternatives to drug use.

Finally, migrants and refugees who use drugs might be subject to compounded stigma and hence the importance of the development of access points in the community where they can receive guidance on the above-mentioned topic without having the fear of further stigmatisation. As aforementioned, it is also essential that personnel of these access points possess the transcultural competences needed when offering psychological and social support. If not, the presence of a cultural mediator is necessary.

4.5. Prevention at household/family level

Family is the primary place where prevention strategies should take place as it can be a powerful protective factor in the lives of children and youth.[66] Whole and connected families, who have a strong sense of their values, can go a long way in prevention, and therefore the strengthening of families is of the utmost importance.[67] Prevention programmes should work with vulnerable families of migrants, refugees and IDPs to develop competences that will allow them to:

- increase parental involvement to improve children's emotional well-being and to act as a protective factor;[68]
- identify and prevent domestic and sexual violence and ensure the protection of victims, primarily women and children;
- develop family activities to foster open communication since "children who spend more active time with their parents are less likely to get involved in risky behaviour and substance use";[69]
- develop dialogue competences that allow parents to listen to children and youth as a fundamental step to help them grow healthy and safe.[70]

4.6. Targeted prevention for vulnerable groups

The vulnerability of a migrant or refugee can be evaluated in multiple ways. It is mainly associated with the reasons for leaving the country of origin, with situations that the person encountered during the migration journey and at destination and with a person's gender, age, identity, condition or personal circumstances.[71] Vulnerability associated with reasons for leaving the country as well as the situations encountered during the migration journey and upon arrival was illustrated in Chapter 2. This section focuses on vulnerability associated with identity, condition and/or personal circumstances that could increase the risks of substance abuse and other addictions (gambling, gaming etc.)

66. Ibid., available at www.unodc.org/unodc/en/listen-first/about.html.
67. Focus group Analysis from Croatia.
68. Ibid., available at www.unodc.org/res/listen-first/parenting resources_html/science_of_involvement.pdf.
69. Ibid., available at www.unodc.org/res/listen-first/the-science-of-family activities_html/science_of_family_activities_04_27_October.pdf.
70. Ibid., available at www.unodc.org/unodc/en/listen-first/parenting-resources.html.
71. United Nations Office of the High Commissioner for Human Rights (2018).

In principle, vulnerability is determined by:[72]

1. age:
   - minors (accompanied or unaccompanied)
   - elderly persons
2. gender:
   - women, pregnant women, women with disabilities, and girls
3. family status:
   - single parents or mothers with children
4. sexual orientation, gender identity and sexual characteristics:
   - lesbian, gay, bisexual, transgender, and intersex persons
5. health condition:
   - persons with one or more disabilities
   - persons with serious physical illness
   - persons with mental health disorders
6. exposure to different forms of violence and/or coercion:
   - victims of torture
   - persons who have been subjected to any form of gender-based violence or violence against women including domestic violence, rape, sexual violence, or sexual exploitation
   - victims of human trafficking
   - persons who have been subjected to other forms of psychological or physical trauma or violence.

There are many reported cases illustrating that persons often possess more than one vulnerability factor, notably based on gender and other factors.

4.6.1. Prevention activities for children

Children, accompanied or unaccompanied, are considered the most vulnerable group among the target population. States should guarantee that migration policies take the best interests of children and minors into consideration and take into account the particular needs and vulnerabilities of girls. States should ensure that refugee and migrant children can benefit from the protection measures set out in international conventions and the European legal instruments and enjoy the full realisation of their rights in compliance with the UN Convention on the Rights of the Child and the European Convention on Human Rights. Children and youth should also enjoy special protection and be subject to early prevention interventions while they are guaranteed a safe environment that minimises exposure to risk factors related to drug use.

72. Vulnerability in the context of applications for international protection (2021), EASO Professional Development Series, https://easo.europa.eu/new-chapter-easo-professional-development-series-published-vulnerability-context-applications.

Therefore, it is essential that the following conditions are guaranteed for all migrant and refugee children to create a safe and protective environment.

- **Ensure safe and humane living conditions:** Facilities with a small number of minors which provide safety and stability should be preferred for unaccompanied minors and be adapted to their sex and age, instead of overcrowded safe zones in big sites with adults. In addition, in the case of accompanied children, long-term stay in temporary settlements should be avoided and priority to access housing should be given to families with children.
- **Provide access to the education system:** It should be guaranteed for all migrant and refugee children, bearing in mind the fact that girls may have been prevented from accessing education in their country of origin. Special educational support is also recommended for the facilitation of the language learning process.
- **Ensure provision of independent adequately trained guardians** from the national guardianship authorities for unaccompanied minors.
- **Ensure communication** of children to caregivers or family who remained or live abroad with their family members.
- **Develop leisure activities** within the temporary settlements for the first period and later referrals to local centres for children and youth, where they can develop their social skills and enjoy themselves in a safe and healthy way.
- **Implement tailor-made prevention projects** that account for children's needs including in relation to age and gender, raise awareness about addictions (experimental use of marijuana, alcohol, problematic use of internet and gambling), identify and promote emotion processing and increase self-esteem.
- **Ensure preparation for adulthood** and provide continued support even after they reach the age of 18, maturity and independence.

4.6.2. Prevention activities for women

Women worldwide present lower rates of substance abuse in comparison to men. However, they usually have more complex profiles, mainly because of the exposure to gender-based violence and the higher rates of comorbidity with other mental health disorders (anxiety, depression, PTSD, somatic symptoms, eating disorders).[73] It is estimated that globally, one in three women will be exposed to physical or sexual violence at least once in their lifetime.[74] Evidence shows that 40-70% of women receiving drug treatment have experienced and suffered from physical or sexual violence. Women are more exposed to every form of gender-based violence, at least once in their lifetime.[75] Women who use drugs are more exposed to violence than women who do not use drugs. Rates of violence were found to be even higher among women who use drugs, if they were pregnant or engaged in sex work.[76] Studies and reports of different international organisations and NGOs have shown that migrant, refugee and asylum-seeking women and girls are particularly vulnerable to the exposure of every form of gender-based violence[77], both during their migration journey, in transit and at their destination.[78] Women also face more challenges in revealing substance abuse and are subject to higher social stigmatisation, since many societies are still male dominated, with traditional gender roles and stereotypes and where motherhood is still considered the primary role of women. Apart from the higher stigmatisation, women also face more barriers in accessing health or treatment services for cultural reasons and because of economic dependency and family responsibilities.[79] Finally, women tend to follow different patterns of use. For instance, women are more prone to abuse prescribed medication and alcohol rather than illicit drugs.[80] This specificity constitutes one of the reasons why women's substance use disorder might be undiagnosed and/or untreated.

Professionals working with migrant, refugee and asylum-seeking women should consider gender specificities of substance use while implementing prevention interventions by taking the following steps:

- Ensure access of women who are victims of gender-based violence to protection, health, and social services.
- Ensure collaboration across the different services: health system, law enforcement, social services and support services for refugee/migrant/asylum-seeker women against violence.

73. 2016 Report of the International Narcotics Control Board (INCB), Chapter I: Women and Drugs, p. 4.
74. UN Women website: Facts and Figures, available at www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures.
75. 2016 Report of the International Narcotics Control Board (INCB), Chapter I: Women and Drugs, p. 5.
76. Benoit and Jauffret-Roustide (2016).
77. Protecting the rights of migrant, refugee and asylum-seeking women and girls is a new strategic objective for the Council of Europe's work to promote gender equality and women's rights under the Gender Equality Strategy 2018-2023, see www.coe.int/en/web/genderequality/migrant-and-refugee-women-and-girls#{%2263602265%22:[1]}.
78. The traumas endured by refugee women and their consequences for integration and participation in the EU host country, Study, European Parliament Committee on Women's Rights and Gender Equality, 2021.
79. 2016 Report of the International Narcotics Control Board (INCB), Chapter I: Women and Drugs, pp. 3, 7.
80. Clark (2015).

- Ensure the presence of women among professionals dealing with migrant, refugee and asylum-seeking women and girls.
- Ensure unconditional access for refugee/migrant/asylum-seeking women who use drugs to protection arrangements when they are victims of violence including trafficking in human beings.
- Organise training and awareness-raising seminars for health professionals in regard to the risk of abuse of prescribed medication and develop gender-sensitive guidelines for prescription practices which, while securing the supply of pain relief medication for those in need, do not result in unnecessary or excessive prescription and potential diversion of controlled substances.
- Organise training and awareness-raising seminars for professionals working in women shelters, and in services supporting women, victims of gender-based violence, in regard to gender specificities of substance use.
- Organise information sessions for refugee/migrant/asylum-seeker women on issues related to addiction.

4.7. Recommendations for policy makers

Effective prevention can only be achieved through evidence-based public policies that promote the inclusion of women and vulnerable groups. Advocacy for evidence-based public policies should be among the priorities of social, health and educational workers, as well as the target groups. Public policies should:

- combat social exclusion
- fight poverty
- promote gender equality and gender mainstreaming and aim at preventing all forms of discrimination
- advocate for respect of refugees', asylum seekers', migrants' and IDPs' human rights
- improve refugees', asylum seekers', migrants' and IDPs' living conditions
- increase refugees', asylum seekers', migrants' and IDPs' sense of belonging to community
- guarantee full access to health and social care under the same conditions as other-country residents
- ensure participation and consultation of refugees, migrants and IDPs and their representative NGOs when designing policies that target them
- develop tailor-made prevention activities according to the duration of stay
- promote sharing of best practices and exchange of knowledge and develop synergies that facilitate interstate co-operation.

Chapter 5

Harm reduction

5.1. Overview

The harm reduction model was born in Europe as an alternative, from a public health perspective to the moral and criminal models that traditionally responded to the problem of substance abuse and based their interventions on the abstinence model.

According to Harm Reduction International, harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights – it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support.[81] It is based on the premise that many of the harms related to drug abuse can be mitigated without eliminating consumption, and to this end it will be necessary to promote the competence and responsibility of people who use drugs themselves in order to improve their quality of life.

The Council of the European Union (2004), the World Health Organization (2009) and UNAIDS (2010) have all recommended comprehensive harm reduction packages affecting policy, prevention, intervention, community-based education and advocacy efforts. The effectiveness and cost-effectiveness of harm reduction interventions has been proved through research that indicates that the costs of harm reduction interventions are relatively low and harm reduction is good value for money (at $100-$1 000 per HIV infection averted)[82]. These outcomes could be used to form the policy and plan the actions.

Around the world, there is growing recognition that SUDs need to be approached as preventable, treatable, chronic relapsing and recoverable brain diseases. SUDs have been compared to diabetes, a chronic physical disease approached following the illness management and recovery model suggested for SUDs as well. This kind of approach was approved by NIDA and the UN Convention on Drug Policy in 2016. This clearly contributes to the value of the harm reduction approach. Nevertheless, attitudes towards the practice and the level and manner of implementation vary from country to country. Despite differences of opinion and practice, most countries believe that abstinence and recovery should be complemented by measures that can demonstrably reduce the harms and risks associated with psychoactive substance use.[83]

The policy of reducing the harms and risks associated with the use of addictive substances advocates for the implementation of various interventions that seek to prevent, reduce and mitigate health, social and economic damage to individuals, communities and society resulting from the use of addictive substances. Harm reduction measures should be complementary to measures in the areas of prevention, treatment, rehabilitation, and recovery. Harm reduction improves not only the health of people who use drugs, but also that of their families, their immediate environment, and society in general and is based on a strong commitment to human rights.

The main axes of harm reduction are (1) pragmatism; (2) humanism; and (3) no abstinence imposition.

The main objectives of harm reduction interventions should focus on:

- elimination or reduction of injecting drug use and, if injecting drug use persists, reduction of risk behaviours related to injecting pattern of drug use;
- reduction of the risk of overdose;
- reduction of the prevalence of infectious diseases such as HIV, hepatitis B, hepatitis C, tuberculosis, STDs, and other infections;
- decrease of morbidity and mortality associated with drug use;
- reduction of criminal activities;
- improvement of the family and social situation.

Abstinence is not rejected as a treatment goal for the person who wants to achieve it, but it is not the major goal to be achieved in the short term. The starting point of harm reduction work is where the person stands, respecting the individuals' choice, whether they wish to continue using drugs, to access treatment, or to achieve abstinence. This intervention should not focus on the behaviour, but rather on the person who perpetrates it, and on facilitating the achievement of their goals and needs.

81. Harm Reduction International, see www.hri.global/what-is-harm-reduction.
82 Wilson et al. (2015), p. 9
83 Pompidou Group of the Council of Europe, Policy paper on preventing risks and reducing harm linked to the use of psychoactive substances, P-PG (2013) 20, https://rm.coe.int/2013-pg-20-harm-reduction-eng/16807865f4.

To support each person in this process, the participation of different professionals such as therapeutic and nursing staff together with intercultural mediators that make up the technical team is required, as well as implementing different measures, strategies, activities, and resources. All of this is based on individual-based needs and the continuous re-evaluation of the process. The intervention project should be defined together with the person and accordingly to their own objectives.

In these interventions, professionals must bear in mind the main principles of harm reduction:[84]

- **High-risk behaviours are a social construction**

High-risk behaviours, as many other concepts, are defined under each society's beliefs and values.

- **High-risk behaviours are here to stay**

Historical evidence shows that attempts to eradicate high-risk behaviours, including those associated with substance use, have not only failed, but sometimes have had the opposite effect. In addition, they have been associated with higher levels of crime and large public expenditures. Harm Reduction claims that it would be more effective to focus on working with the affected population and trying to find ways to reduce associated harms.

- **High-risk behaviors may be both adaptive and maladaptive**

Whereas Harm Reduction acknowledges harms associated with high-risk behaviours, advocates for a non-judgmental assessment of each situation and person, promotion of understanding of high-risk behaviours, their interconnection with other lifestyle factors, meanings, and contexts.

- **Harm Reduction does not seek to pathologize high-risk behaviors**

Harm Reduction acknowledges that prolonged substance use can result in dependence and addiction, but this is not an obligatory cause-effect relationship. Harm Reduction aims to achieve a more pragmatic and holistic resolution of problems.

- **Harm and Harm Reduction exist on a spectrum**

Harm Reduction recognizes that when implementing Harm Reduction responses, levels of risk must be considered across multiple spectrums. Harm Reduction practitioners seek to educate, support, and empower individuals and communities to explore and understand various options for reducing harm, valuing all changes toward improved quality of life.

- **Individual behavior is embedded in the larger social context**

Harm Reduction approaches take various factors into account such as socioeconomic disparities as influencing the deterioration of health systems and social networks. In addition to treating the individual, it is important to promote social, economic, and political change.

- **Harm Reduction is fundamentally pragmatic, not theory-driven**

Harm Reduction advocates looking for acceptable, achievable, and effective solutions that are applicable to specific situations.

- **Harm Reduction is an ethical practice**

The experience from the field indicates the necessity of harm reduction services.

5.2. Harm reduction challenges

Professionals working in the field of addictive behaviours with migrants and refugees face more obstacles and challenges in comparison to the general population when they implement harm reduction interventions or when they follow a harm reduction perspective. According to the field experience of the experts of the Support Network for Professionals (SNP),[85] the most common obstacles and challenges that they face are:

1. **Communication and language barriers:** Professionals visiting temporary settlements report that they frequently have the support of a trained interpreter or a cultural mediator and usually work in multidisciplinary teams. On the contrary, professionals of outreach street work programmes state that it is uncommon to have a cultural mediator or an interpreter to facilitate communication if needed.
2. **Connection with personal characteristics (culture, values, religion and social status):** Professionals report that they experience more difficulties in connecting to specific characteristics or refugees/asylum seekers when they approach them to implement harm reduction interventions. The cultural differences, as such, are creating additional barriers. Therefore, professionals need more time to find a way to approach them, to understand the persons' needs, to build a trust relationship and to establish a starting point for support. Additionally, lack of knowledge in regard to the concept and the legal aspects of harm reduction and psychoeducation adds on the existing challenges since the professionals have first to introduce those concepts

84. Marlatt (2011).

85. Field professionals working in the field of addictions as medical or psychosocial staff with refugees and migrants in Croatia, Cyprus, Greece, Spain and Portugal.

and only later start their interventions. This lack of knowledge is often linked to the fact that in many of the countries of origin, harm reduction policies do not exist or are limited to ad hoc projects and interventions implemented by civil society organisations.

3. **Mistrust towards services:** Refugees and migrants appear more sceptical when they are approached by professionals working for governmental services, even if they are health or social services professionals. In addition, it appears that they have more difficulty in revealing their use. Professionals report that most of the time and for long periods, refugees and migrants deny their addiction because of the fear that revealing it might bring legal or other consequences that could affect their asylum application or their legal/residence status.
4. **Challenges related to national laws:** National laws vary between countries, and this creates diverse circumstances and challenges to professionals. There is a wide range of harm reduction services allowed and provided, with diverse entry criteria and possible barriers.

5.3. Recommendations for professionals

Professionals are expected to overcome the above-mentioned challenges daily to offer high-quality services requiring extra effort to approach the target group and to build trust. Harm reduction interventions are considered a bridge with health, legal or social services and hence could facilitate the development of a trusting relationship.

- Enhanced communication skills and intercultural competences are essential. The approach should be based on respect, understanding, and a high degree of sensitivity.
  - Services should be easily accessible and therefore provided close to the main sites of use or need. Multidisciplinary teams should include peer specialists from the same cultural background as the target group as well as intercultural mediators, to provide information for all treatment programmes, social and legal services available.
  - Low-threshold interventions for legal and illegal substances should be available such as supervised consumption services, drop-in centres, overdose prevention training and medication to reverse the effects of opioids, such as naloxone;[86] syringe distribution or exchange programmes including provision of safe material for smoking and injecting, condom distribution, and alcohol harm reduction interventions.
  - Easy access to rapid tests for HIV and hepatitis B and C.
  - Provision of information material in different languages relating to:
    (i) legislation
    (ii) effects and harms of psychoactive substances
    (iii) safe drug use
    (iv) STDs and safe-sex practices
    (v) treatment options for substance use, mental health, and physical health problems.

5.4. Harm reduction recommendations for policy makers

- Facilitate strategies aimed at improving living conditions through access to housing, health and employment. There are several models that can be considered, namely: housing first; supported employment; TIC, etc.
- Encourage the development of an integrative approach including social interventions such as provision of food, clothing, and hygienic facilities alongside low-threshold psychosocial interventions.
- Involve the target group in designing and planning harm reduction programmes and other solutions to their needs.
- Promote advocacy against stigmatisation of psychoactive substance use within both target and host communities.
- Promote co-operation between governmental and non-governmental organisations. Promote targeted harm reduction programmes for vulnerable sub-groups such as women and children including provision for the safe dispensing and collection of drug use materials as well as provision of aseptic material.
- Promote the creation of opioid agonist therapy/heroin assisted programmes.
- Promote the implementation of health care programmes targeting addictive behaviours in national policies and national health systems.
- Promote the implementation of communitarian programmes for the distribution of naloxone.

86. European Monitoring Centre for Drugs and Addictions (2019), "Take-home Naloxone", see www.emcdda.europa.eu/publications/topic-overviews/take-home-naloxone.

Chapter 6

Treatment and social inclusion

6.1. Overview

Treatment of SUD should include all evidence-based pharmacological and/or psychosocial interventions which aim to improve the physical, psychological and social state of people who use drugs. Provision of community treatment interventions as well as residential treatment options are appropriate according to the needs of the person. Access to treatment should be free of charge and guaranteed for everyone who needs it.

Social inclusion used to be viewed as the period after treatment completion, when the person had to apply all the knowledge and the newly acquired skills within the safety of the therapeutic procedure, in the wider society. Finally, social integration in the broadest sense means any form of social inclusion and affirmation through various activities in the field of sports, culture, work and other social activities.

According to the recommendation from the United Nations Office on Drugs and Crime publication "Drug dependence treatment: sustained recovery management" (2008, p. 17), resocialisation can be viewed in the broader context of recovery capital which covers:

1. physical and mental health
2. family and social support and leisure activities
3. safe housing and a healthy environment
4. peer support
5. recruitment and resolution of legal issues
6. community integration and cultural support
7. rediscovering the purpose and meaning of life.

Nowadays, and within the spirit of the above document, social inclusion is considered to start at the same time as treatment entry, and the relationship between treatment and social inclusion is dynamic and reciprocal as progress on one can promote progress on the other.

6.2. Treatment and social inclusion challenges

Treatment of SUD for migrants and refugees is often associated with more challenges and obstacles for both professionals and people receiving services compared to the general population. Aspects of those challenges have been discussed already.

People who use drugs are subjected to various forms of stigma and social exclusion, and this stigma is reinforced by the fact that they might come from another country with different socio-cultural characteristics, meaning they are often exposed to double stigmatisation. It should also be mentioned that the main relapse challenges are mostly linked with social integration issues, which are considered as major stress factors. Often, the persons are not patient enough and do not possess the willingness to achieve really high goals in a short period of time. As it is not possible for almost everyone, it is a reason for relapse. In addition, lack of employment is also one of the most difficult challenges especially for refugees and migrants who are members of the rehabilitation phase.

Field experience suggests that the main obstacles are those regarding the limitations or difficulties of accessing health care and social services, and cultural and language barriers. Furthermore, entering treatment might not be considered a priority, given challenging living conditions and unemployment. In addition, legal status is often an obstacle that limits access to drug treatment, especially opioid agonist treatment (OAT). It has also been observed that there is a delay in accessing psychosocial treatment programmes. Therefore, motivational enhancement approaches are even more necessary for refugees and migrants.

Similarly, professionals face more challenges involving people who reside in temporary facilities or accommodation centres and need treatment for substance use and other addictions. Some of the challenges relate to the temporary nature of residence or to the fact that refugees and migrants tend to believe that they are still in transit, even if they have remained in the host country for a long period of time. As a result, they might refuse to dedicate time to therapeutic procedures in the host country. An important contributing factor is the location of the accommodation centres, which are usually far away from urban areas and service and treatment facilities. As a result, the population feels marginalised, reserved and guarded towards professionals, which creates additional barriers in the development of therapeutic alliance. This social isolation may become a protective factor against substance use due to limited access to the illicit drug market but may also contribute to the observed increased incidence of problematic alcohol and prescribed medication use.

Increased prevalence of mental health comorbidity including PTSD, anxiety and depression, either associated with experience of conflict or war in the country of origin, the experience of violence during the migration route and in many cases within the camps/hosting facilities, in combination with poor living conditions, prolonged administrative process leading to social uncertainty and social exclusion complicate and can compromise the effectiveness of treatment interventions.

6.3. Recommendations for professionals

All interventions should be trauma informed, as being trauma informed can potentially improve patients' engagement, treatment adherence and health outcomes, as well as provider and staff wellness.[87]

Professionals should follow ethical principles in delivering treatment including respect for privacy, dignity and worth of each person regardless of their nationality, religion, race, or any other characteristic, and regardless of their current social position and legal status.

Professionals should aim to support every person with an individualised therapeutic plan, according to their special needs and life plan and within existing time boundaries (short- or long-term accommodation centres, relocation etc.).

Communication between team members and across teams should be systematic and frequent so as to adopt a common approach and to reduce risk of splitting among the staff.

Provision of individualised support such as language and mediation efforts and provision of transport and escort to various services, health, social and legal, depending on needs, support for basic social needs such as accommodation and provision of food.

Support provided by peers, who can draw from their experience, is also recommended.

6.4. Recommendations for policy makers

Collaboration between different stakeholders is vital when services are designed. Involvement of people receiving services should be facilitated through a series of actions in various fields (legal, health, accommodation, mediation with other professionals, etc.) to reduce barriers and increase people's motivation and capability to enter treatment.

Services should be available to address the needs of both those living in the community and those living in temporary settlements.

It is highly recommended that health care teams at reception facilities and hosting centres be multi- and interdisciplinary and include professionals with training in mental health and addictions including psychiatrists, psychologists, counsellors, and nurses.

Measures should be taken for staff safety, provision of support and promoting working in teams (avoid working in isolation). To that effect, supervision in groups is good practice to promote mutual understanding and support and reduce risk of staff burnout.

Initial and ongoing training on ethical standards and guiding principles is essential to safeguard treatment standards.

Interventions should be designed to function as "bridges" with existing treatment facilities and to facilitate access to them.

87. Trauma Informed Care – Implementation Resource Center, see www.traumainformedcare.chcs.org/what-is-trauma-informed-care/.

Chapter 7

Law-enforcement aspects

7.1. Overview

Law-enforcement agencies may differ from one country to another since the agencies that could be included under the umbrella term "law enforcement" depend on the organisational system of their state. Law enforcement is the activity of some members of government acting in an organised manner to enforce the law by discovering, deterring, rehabilitating or punishing people who violate the rules and norms governing that society. Usually when using the term "law enforcement", we are referring to the police, the border authorities, the customs authorities and the immigration office. In addition, the roles and responsibilities of law-enforcement agencies are determined by the national law of each state.

In principle, part of the role and responsibilities of law-enforcement bodies in Europe includes prevention of crime, discovery of crime, criminal investigation, protection of citizens, and co-operation with other organisations, communities, and individuals. Consequently, law-enforcement agencies are indispensable partners in managing and settling the situation of vulnerable groups such as migrants and refugees in Europe and beyond, at and within the borders.

One of the tasks of law-enforcement agencies is to prevent and detect drug-related crime, and to conduct the necessary criminal proceedings. For this reason, law-enforcement bodies possess data, facts and information on the topic, sharing them with co-operating partners. Information sharing is considered a good practice that could increase the success of joint work. The development of the drug market shows the characteristics of the drug trade; therefore, it also has an impact on individual consumption: what can be obtained, and how and where it can be obtained. The type and quantity of drugs detected and seized in Europe or in a given state can influence the consumption habits of migrants and refugees: what are the popular, cheap, and/or available drugs?

Drug trafficking can be compounded by other crimes (e.g., trafficking of human beings, human smuggling) in which migrants and refugees may be involved, not always voluntarily. Therefore, information from law-enforcement agencies is crucial for professionals of social and health care sectors to better assess and address treatment and rehabilitation needs.

Drug production has profound negative consequences on the environment in the EU. Synthetic drug manufacturing produces significant amounts of hazardous waste. Dumping sites have increased as a result of adding additional steps for the conversion of (pre-) precursors into precursors and dumping sites require a long and expensive cleaning process. Outdoor cannabis cultivation significantly damages fauna and flora.[88]

7.2. State and characteristics of the drug market in Europe

Drugs are currently going through a particularly dynamic period in Europe.[89] For the past few years, we have been witnessing the emergence of new, increasingly dangerous substances to a high degree, and additionally the increasing prevalence of different types of substances in some areas. One of the emerging challenges is online drugs sales and postal mail distribution, largely caused by globalisation and new technology. This is a good example of how rapid change can take place in this field which challenges the drug monitoring capabilities of law-enforcement agencies. The proportion of online sales relative to the illicit drug market as a whole is relatively small but showing a rising trend. In light of the Covid-19 pandemic (or a similar case in the future), experts are likely to see an increase from the online market.

The drug market represents a major source of income for organised crime groups. The EU drug market was conservatively estimated to be worth about €30 billion in 2017. Cannabis accounted for 39% of the total, cocaine for 31%, heroin for 25%, and amphetamines and MDMA for 5%. Drug trafficking can also be linked to other crimes that impact the lives of refugees and migrants. These crimes affect the economy, society and the health care system.[90]

The Covid-19 pandemic has had a considerable impact on the serious and organised crime landscape in the EU. Criminals were quick to adapt illegal products, modi operandi and narratives in order to exploit the fear and anxieties of Europeans and to capitalise on the scarcity of some vital goods during the pandemic. While some criminal activities will return or have returned to their pre-pandemic state, others will be fundamentally changed by the Covid-19 pandemic.[91]

88. European Union Serious and Organised Crime Threat Assessment – EU SOCTA 2021, available at www.europol.europa.eu/publications-events/main-reports/socta-report.
89. This chapter is based on European Monitoring Centre for Drugs and Drug Addiction and Europol (2019).
90. European Monitoring Centre for Drugs and Drug Addiction and Europol (2019), Chapter 1.
91. European Union Serious and Organised Crime Threat Assessment – EU SOCTA 2021, available at www.europol.europa.eu/publications-events/main-reports/socta-report.

Globalised commercial markets require the transportation of goods across borders as rapidly and simply as possible using large volume shipments and containers. Drugs purchased online can be transported across Europe and delivered to consumers by post and parcel services. These are increasingly exploited by organised crime groups for drug-trafficking activities. The role of the "darknet" is also becoming increasingly important in the classic drugs market. However, social media networks, the open internet, and mobile communication apps such as telegram and flicker can also be critical in the sales of new psychoactive substances and subsequently drug abuse. These emerging trends and new modi operandi create new challenges for law enforcement.

Over 80% of reported criminal networks are involved in the trade of drugs, organised property crime, excise fraud, trafficking of human beings, online and other fraud or migrant smuggling. Nearly half of these are involved in the drugs trade (38%) (based on SOCTA 2021 data analysis). The illegal drugs trade continues to dominate serious and organised crime in the EU in terms of the number of criminals and criminal networks involved, as well as the vast amounts of criminal profits generated as part of the production, trafficking and distribution of illegal drugs. Much of the violence associated with serious and organised crime is related to the drug trade. The use of violence related to the drug trade has escalated notably in recent years. The trade of cocaine and cannabis in particular triggered a significant number of violent incidents, which included killings, shootings, bombings, arson, kidnappings, torture and intimidation.[92]

Illicit drug markets have both direct and indirect impacts on society that go far beyond the harm caused by the use of drugs themselves. In addition to the economic impact, drug-related deaths, and other harm to public health, there are broader consequences of drug markets, such as links with wider criminal activities and terrorism; the negative impact on the legal economy; violence in communities; damage to the environment; and the increasingly important issue of how the drug market can feed corruption and undermine governance.

Human trafficking and migrant smuggling may both have links with the drug trade when they are conducted by the same organised crime groups, although these links appear to be quite limited. More importantly, human trafficking and exploitation may also be linked to drug consumption or smuggling when individuals are enticed or coerced to be involved in low-level and expendable roles within the drug trade; for example, as workers in cannabis farms or transporters of drugs, or when drugs are used to facilitate sexual exploitation. These forms of coercion and exploitation may not always be recognised.

Consequently, smuggled migrants are vulnerable to coercion and exploitation, potentially because of their disadvantaged position in the destination country or because they become indebted to the smugglers. People smuggling usually leads to trafficking and further exploitation and in such cases the involvement of illegal drugs is common, especially when the persons are coerced into smuggling of illegal drugs while en route to their final destination (Ventrella, 2017).

The European drug market is constantly and rapidly changing, with a significant number of new psychoactive substances appearing in the last decade. Illegal substances are either manufactured domestically or smuggled into Europe from other regions of the world. South America, West Asia and North Africa are important sources of drugs entering Europe, and China is a source of new psychoactive substances and precursors. In addition, some drugs and precursors are transported across Europe to other continents.[93] More information regarding characteristics of different substances available in Europe and their smuggling route can be found in Appendix III.

Crime prevention and drug prevention are also part of the activities of law-enforcement agencies. Therefore, non-governmental organisations, the civil sector, the community of citizens, welfare workers, therapists and other state organisations and stakeholders should work in co-operation with law-enforcement agencies in this area as well. For this reason, we need to draw attention to this aspect as part of the handbook.

7.3. Drug-related crime prevention co-operation

The aim of crime prevention is crime reduction and thus to improve the subjective sense of security of the population by preventing them from becoming perpetrators or victims and reducing the incidence of crime.

The fight against drug-related crimes is not just a matter of law enforcement but of society as a whole. There is a need for family and community unity, as well as the development of a force that unites society. This is especially necessary in places where children and young people are at increased risk such as in schools, public cultural institutions, entertainment venues, or even on the streets. The success of programmes for children and juveniles is unthinkable without considering the environment of the target groups which include the family, the school and the parents.

92. European Union Serious and Organised Crime Threat Assessment – EU SOCTA 2021, available at www.europol.europa.eu/publications-events/main-reports/socta-report.

93. European Monitoring Centre for Drugs and Drug Addiction and Europol (2019), Impacts and drivers of drug markets, p. 13.

The partners in crime prevention:

- state organisations
- NGOs
- associations, communities
- individuals
- companies
- local governments
- civil society.

The aim of crime prevention:

- to reduce the quantity of crimes
- to improve the sense of security of individuals.

The direction of crime prevention:

- prevention from becoming an offender
- prevention from victimisation
- reducing the opportunities for crime.

Crime prevention measures:

- to reduce the risk of becoming an offender or victim – education, awareness raising
- to reduce the opportunities for crime – monitoring, checking, safe environment, social support, provision of health care.

The forms of crime prevention:

- long-term programmes
- short-term projects
- events.

Drug prevention among migrants, asylum seekers and homeless people

The partners in drug prevention:

- NGOs, field workers
- health companies
- target group associations, communities
- individuals
- employers, local business actors (bars, transport companies, shop owners)
- law-enforcement agencies
- local governments.

The aim of drug prevention is to reduce the quantity of crimes and to improve the sense of security of the individuals. This is the task of all partners in co-operation.

The direction and measures of drug prevention:

- prevention from becoming an offender:
  - with education, awareness-raising campaigns, social support, job creation, provision of health care
- prevention from victimisation:
  - with education, awareness-raising campaigns, social support, job creation, provision of health care
- reducing the opportunities for crime:
  - with improving co-operation activities of law-enforcement agencies at national and international level
  - with building safe community life in co-operation with the communities.

The forms of crime prevention:[94]

- environmental prevention programmes:
  - to create a safe and legal environment – to be informed what behaviours are allowed;
  - physical approaches – to design safe cities and landscapes, bars, shops together with habitants, owners, communities;
  - economic approaches – to establish appropriate taxes, prices for alcohol, tobacco;
- school-based and workplace-based prevention: to identify the problem at the micro level and the actors; to organise long-term and short-term projects and events to inform and educate the actors (students, employees, HR experts, teachers, other workers);
- media-based prevention programmes: the short- or long-term campaigns directly to the large target groups with relatively minimal expense used by all forms of media (online, offline, television, radio, internet);
- family-based prevention programmes: to teach parents, children, and other family members to develop their co-operation, to recognise their needs, to talk about and express emotions, to learn responsibility, to manage difficult situations;
- community-based prevention programmes: at macro or micro level to organise different programmes, events, projects to target the community that the individuals belong to; the large family, religious community, local youth, district, temporary settlements – to teach them to live together; to identify each other's needs and emotions; to find the key role people for support of the target individuals; to create community to help each other.

Family and community-based drug prevention programmes are considered the most effective among migrants, asylum seekers and homeless people. The micro and macro environment can affect these individuals. Most of them face language barriers at school, at the workplace, and in the target countries. That is why they do not understand media campaigns, do not watch local television, or listen to radios. When they have the opportunity to go to school or work, it is difficult to understand other people. Their family

94. European Prevention Curriculum – European Monitoring Centre for Drugs and Drug Addiction 2019.

and community speak their language, follow their habits and rules. Drug prevention programmes must focus on family and community members. The special personal circumstances of refugees and migrants (linguistic, cultural barriers) and the associated health risks of drug consumption make them a particularly vulnerable group.

7.4. Recommendations for law-enforcement professionals

In view of the previously mentioned facts, and in addition to basic knowledge relating to drugs and their use, it is imperative to recognise the unique situation of drug users and dealers among migrants, refugees, and homeless people. It is necessary to understand the asylum seeker's living situation, financial means and resulting consumption patterns. Law-enforcement professionals also need to understand the drug use patterns in the country of origin of migrants and refugees who use drugs, as well as the hidden network, threats, and structure of multicultural communities.

Law-enforcement officers need to co-operate with social and health professionals when the refugee or migrant is involved (as victim, witness or perpetrator) in criminal proceedings. Ongoing contact in these three areas allows the person to be able to testify, for which he or she must become both medically and mentally fit. This is a special challenge for law-enforcement professionals in addition to linguistic and cultural constraints. Given this information, training modules for law-enforcement professionals need to be expanded.

In order to ensure successful co-operation, a joint training involving law-enforcement and social and health care professionals is proposed, where different expectations, professional procedures and solutions can come to the surface during discussions.

A major problem in many European countries is that justice departments, which include both judiciary and law-enforcement services, have been underfunded due to not being seen as a priority for the past three decades. Owing to this underfinancing, there is a structural shortage of financial and human resources available for the judiciary and law-enforcement services in many European countries. Law-enforcement officers wish to acquire the above trainings to implement in their countries, but that would require recruiting more law-enforcement officers first. Moreover, each officer should receive specialised training depending on where they are in the field, with an emphasis on ensuring fundamental rights and freedoms. Nevertheless, it is often the case that law-enforcement officers are not sufficiently trained in this, on the one hand due to a budget shortage, and on the other due to a staff shortage, which forces them to take on too many different tasks, thus not leaving sufficient time to provide customised care if necessary. It is therefore essential to increase policy makers' awareness of these issues, as they are at the foundation of deciding on priorities and budgets.

Advice to law-enforcement professionals:

- Law-enforcement professionals should co-operate with social and health professionals, cultural mediators, interpreters, local communities and NGOs to improve the situation of refugees and migrants in the host country.
- The complexity of the position and the vulnerability of migrants or refugees (drug use, coercion, exploitation) involved in criminal proceedings as a witness, victim or perpetrator should be clarified during the proceedings.
- All professionals – and especially law-enforcement officers – should recognise that exploitation and coercion experienced by migrants and refugees might result in the development of delinquent behaviour (including drug trafficking and smuggling) and the development or the continuation of substance use.
- In addition to the health damage caused by substance use, law-enforcement professionals need to recognise that the refugee or migrant does not speak the language of the target or host country, does not understand cultural customs, and may even jeopardise the success of the procedure. In light of this understanding, law-enforcement professionals should be adequately trained and should focus on improving their intercultural skills.

7.5. Recommendations for policy makers

These issues emphasise the need to ensure the adequate resourcing and prioritisation of supply reduction activities, including not only law-enforcement interventions and investigations, but also activities to enhance international co-operation on the national, regional and European level. This must be accompanied by necessary co-operation in the field of demand reduction, in which specialists of social and health care systems design the treatment, care and healing after being provided with critical information from law-enforcement agencies. Furthermore, law-enforcement professionals need to be aware of the details of treatment and its impact on the individual as it also affects the success of criminal proceedings.

Guiding principles on prevention, harm reduction and treatment of substance use disorder and other addictions for refugees, migrants and IDPs

Overview

1. While paying attention to pre-migration exposure to violence and distress factors is important, it is also vital to create prevention policies that consider the ongoing stressors related to the experience of displacement itself. This means that reception systems must aim to increase protective factors and facilitate the related legal procedures to minimise ongoing stress amongst migrants, refugees and IDPs.
2. Since many of the challenges that are faced when dealing with substance use and refugees stem from cultural difference, communication skills and intercultural competence are extremely important. Multidisciplinary teams are recommended, and low-threshold responses to legal and illegal substances are encouraged, as well as providing informative material in different languages.
3. Every intervention should be trauma informed, as it can potentially improve patient engagement, treatment adherence and health outcomes. Additionally, reception facilities and hosting centres should ideally have medical teams that are interdisciplinary, consisting of a physician in addition to a psychiatrist, or clinical psychologist, drug counsellor, mental health nurses, and other psychosocial staff. The staff should also have received training on ethical standards and guiding principles.
4. It is vital that during all stages of the process, from screening all the way through to treatment and rehabilitation, the integration of the members of the vulnerable communities into local communities is prioritised, with special attention being given to the integration of women and children who are often the most vulnerable group.
5. It is important that decisions be made with the input of members of the target population. By giving the members of the target population control over the decisions that affect them, it can help them to feel more settled in their environment and more responsible for their actions, which is important in recovery from substance use disorders.

I. Screening

Screening can be an effective tool in both preventing the spread of highly contagious diseases and identifying vulnerable persons who are at a greater risk of developing substance use disorders. The screening process may vary by location, depending on the needs and capabilities, but it should always be carried out by trained professionals, and done in a way that provides support to those who are identified as having certain pre-existing conditions. The main principles presented in this document are:

1. Initial medical examinations or health screening should take place upon arrival, on the grounds of general health needs assessments and public health protection.
2. While the extent of a screening may vary, they should at least involve the identification of subjective problems and objective findings.
3. Wherever possible, these screenings should be carried out by practitioners experienced in infectiology, or travel medicine, pneumology and addictology. Alternatively, screenings may be successful if there is good co-operation on case management by different consultant professionals, each with a basic knowledge of migration aspects, vulnerability and addictions.
4. The feasibility of screenings may be impacted by multiple factors, therefore when deciding whether to include screening into the reception process, it is important to consider the current capabilities to perform a medical exam, and to provide tailor-made interventions when needed.
5. Screenings may prove vital in reducing the probability of new addiction cases, and therefore it is important to have strong referral systems and networking of professionals to provide the necessary support to those who are found to need it during the screening process.

II. Prevention

Prevention policies targeting migrants, refugees and IDPs have the aim of limiting the development of substance use and drug-related problems as well as the development of addictive behaviours among these target groups before they even begin.

While there is no one-size-fits-all prevention intervention, the guiding principles sketch out some of the most important factors that will allow for everyone looking to implement such policies to have a clear vision of what fundamental ideas their intervention policies should come from.

At the core of prevention is the idea that while migrants, refugees and IDPs may not have a higher prevalence of substance use disorders, people who experience forced or involuntary migration are at a higher risk for substance use disorders for reasons including coping with traumatic experiences, co-morbid mental health disorders, acculturation challenges and social and economic inequality. By focusing on prevention policies, the aim is to address this trauma and the mental health issues to stop the substance use problem at its core. The guiding principles focus on ways to implement prevention policies effectively, and in a way that pays close attention to the most vulnerable groups within the target population, in particular women and children.

Professionals working on prevention with the target groups should consider the following aspects:

1. While paying attention to pre-migration exposure to violence and distress factors is important, it is also vital to create prevention policies that consider the ongoing stressors relating to the experience of displacement itself. This means that reception systems must aim to increase protective factors and facilitate the related legal procedures to minimise ongoing stress amongst migrants, refugees and IDPs.
2. A central concern of all prevention policies should be to allow for the integration of members of these vulnerable communities into local communities, whether it be by guaranteeing children access to education in local schools, providing housing in local communities, or granting access to other public social, health and educational services which put these members of these target populations in a position to interact with the local society, ideally decreasing the social stigma they face, and allowing them to feel more comfortable and stable in their new environment.
3. It is important that community prevention policies are also put into place, whereby members of the community itself are active participants in the process of change, as this can lead to positive health behaviours caused by engagement in deliberation, decision making and change. This can be done by engaging all key actors ranging from public entities to religious leaders and providing space for promotion of shared responsibility and active participation in the development of community initiatives.
4. Promoting prevention strategies within families is also very important as it can be a powerful protective factor in the lives of children and youth. Examples include encouraging the development of open communication within families, developing dialogue competences, and nurturing parental involvement to develop children's emotional well-being.
5. Within these policies, special attention must be given to women and children who are often the most vulnerable groups. For women, it is important to provide the necessary support to address the gender-based violence they may have experienced, by connecting them with the proper resources, while also ensuring their continued protection. For both groups, access to safe and humane living conditions is vital, as is implementing tailor-made prevention projects for each group.

III. Harm reduction

The harm reduction model is an alternative to the moral and criminal models that traditionally responded to the problem of substance abuse and based their interventions on the abstinence model. This model aims to reduce the harms and risks associated with the use of addictive substances, and treats substance use disorders as chronic, preventable, treatable, relapsing and recoverable brain diseases. The main axes of this approach are pragmatism, humanism, and no abstinence imposition. This is not to say that those who wish to reach abstinence will not be allowed to do so, but rather abstinence is not the only goal to be achieved in the short term by this approach.

Professionals working on harm reduction with the target groups should consider the following aspects:

1. The main principles of harm reduction are as follows:
   a. high-risk behaviours are a social construct;
   b. high-risk behaviours are here to stay;
   c. high-risk behaviours may be both adaptive and maladaptive;
   d. harm reduction does not seek to pathologise high-risk behaviours;
   e. harm and harm reduction exist on a spectrum;
   f. individual behaviour is embedded in the larger social construct;
   g. harm reduction is fundamentally pragmatic, not theory-driven;
   h. harm reduction is an ethical practice.

2. There are certain challenges that practitioners of this method have reported with regard to refugee and migrant populations. Many of the challenges stem from cultural differences, namely the language barrier and difficulty connecting with the personal characteristics of refugees, and they also see a general mistrust towards services, which can occasionally make it difficult to assist members of the target population.
3. To address challenges, communications skills and intercultural competence are extremely important. Multidisciplinary teams are recommended, and low-threshold responses to legal and illegal substances are encouraged, as well as providing informative material in different languages.
4. At the policy level, harm reduction programmes should focus on creating points of service in the community and encouraging the development of an integrative approach to the implementation of the programmes that takes the thoughts of the target population into account.

IV. Treatment

Treatment of drug addiction within migrant and refugee populations poses more challenges than the treatment of substance use issues within the general population. There are many reasons for this, but some of the most common include difficulties in accessing healthcare and social services, cultural and linguistic barriers, and difficulties with motivating members of this population to seek help. Due to these challenges, it is even more important for there to be strong treatment options available for refugees and migrants, that are specifically aimed at helping them recover.

Professionals working on treatment with the target groups should consider the following aspects:

1. Every intervention should be trauma informed, as it can potentially improve patient engagement, treatment adherence and health outcomes. It is particularly important within the target population because of the high level of comorbidities present, including post-traumatic stress disorder, anxiety, depression and psychosis, often caused by the difficulties faced by this population (violence, lack of stability, poor living conditions, etc.).
2. Reception facilities and hosting centres should ideally have medical teams that are interdisciplinary, consisting of a physician in addition to a psychiatrist, or clinical psychologist, drug counsellor, mental health nurses, and other psychosocial staff. The staff should also have received training on ethical standards and guiding principles.
3. Ideally, these programmes at reception centres should work as "bridges" into treatment centres, while also facilitating incorporation into the different rehabilitation programmes that are developed in the centres.
4. The treatment process is considered more effective if personal and group therapeutic procedures are included, meaning things like motivation through counselling in a transcultural way, the provision of language lessons and motivation to participate are important, or the development of a therapeutic relationship are important.
5. Following treatment comes rehabilitation, which can be especially difficult for migrants, refugees and IDPs as they are likely to face double stigmatisation due to their backgrounds. Therefore, it is vital that rehabilitation centres work to establish a sense of belonging amongst their members, while also promoting the building of connections with the local community and ensuring that they have a safe place to live while recovering.

Appendices

Appendix I – Israel: Country profile and screening management

Country characteristics	Israel is classified as a destination country since most migrants lack the financial capacity to move to Europe or America
Inflow	Reached a peak of around 60 000 people in 2012-2013 but decreased to 28 000 in 2021
Accommodation	Apartments or shelters
Professionals included in screening in the facility	Professionals from different disciplines with expertise and experience working with the target population, and knowledge of culture-sensitive approaches Fieldworkers, SUD counsellors, key figures from the community (e.g., religious leaders, educators speaking the language), cultural mediators, translators
Use of psychoactive substances within target group	The use of psychoactive substances amongst refugees and asylum seekers is frequent. The abuse of alcohol, whether home-made or branded, is also common. When abused by those who are frustrated or depressed, it can lead to aggressive behaviours and is often associated with sexual violence. The most popular substances amongst the target group in Israel are khat, cannabis, and new psychoactive substances (NPS), generally named "Mr Nice Guy", which consists of a mix of synthetic cannabinoids, synthetic cathinones and empathogenic substances together with other toxic substances or anti-depressants
Health services provided	Asylum seekers are granted basic health services including: – emergency medical services – pregnancy and new-born follow up and monitoring. Examples of clinics in Israel include: – first outpatient clinic for refugees and asylum seekers opened in 1998 by Physicians for Human Rights (PHR) with volunteer physicians and medications donated by pharma companies. They deliver both primary and secondary medical services and connect patients to hospitals or relevant organisations to improve their well-being; – the Terem Clinic operates in co-operation with the Ministry of Health and delivers medical services for asylum seekers. They are also granted mental health services, partially by the Ministry of Health, but also by certain NGOs which have developed a strong relationship with UNHCR (The United Nations Refugee Agency). Examples of these organisations include: – ASSAF (Aid Organization for Refugees and Asylum Seekers) – organises group psychotherapy for those in need. – HIAS (Hebrew Immigrant Aid Society) – funded in 1888 to assist Jews fleeing pogroms in Russia to address the psychosocial well-being of disabled mental health patients and victims of gender-based violence. – Elifelet – focuses on children and youth, and provides baby-sitting for the children of refugees, while also helping to open new kindergartens for the children of migrants, refugees and IDPs.

Screening procedures	– The first step in this process is to establish trust with the group, which tends to be sceptical of official figures, and reassure them that confidentiality will be kept.
	– In order to perform a rapid and reliable assessment, the planning of all stages is fundamental as well as a standard training for all staff members, delivering basic information on the cultural norms and characteristics of the group, including the type of challenges and traumas they experienced, and teaching basic practices such as:
	  – training in health interviews;
	  – use of urine sticks for the detection of psychoactive substances;
	  – use of assessment questionnaires, and information on the secondary and tertiary services available;
	  – ways of referral and a list of the key professionals ready to co-operate.
	– During the assessment process, relevant and informative handouts translated into English, Arabic and Tigrinya should be available and distributed.
	Among the most used questionnaires aiding the assessment and problem detection of SUD are: CAGE, AUDIT C for alcohol problems, and ASSIST (recommended by the World Health Organization, which also suggests brief intervention). These questionnaires (which should be translated into the mother tongue) are easy to use, relatively short and evidence-based.

Appendix II – Slovak Republic: Country profile and screening management

Country characteristics	Migration according to asylum seekers' transit or destination country
Inflow	Low or medium
Accommodation	Asylum and quarantine facility
Algorithm of reception	1. Administrative reception – registration 2. Medical examination 3. Accommodation
Professionals included in screening within the facility	– Practitioner (experienced in infectiology and pneumology) – Nurse (experienced in addictology) – Psychologist (NGO worker)
Health services provided	Asylum seekers: – Emergency health care – Indicated health care upon individual assessment (beyond emergency health care) – Refugees or people with other forms of international protection: – Standard public health care services
Medical examination and screening procedures	– History – family, personal, toxicological, epidemiological and vaccination data – Physical examination – TB, HBC, HCV – Detection of subjective difficulties – Objective findings on internal medicine examination – Laboratory, serological and biochemical tests (HBsAg, anti-HIV1/HIV2, syphilis, anti-HCV) – Urine examination – Rectum examination and cultivation – Parasitological examination and cultivation – Chest X-ray – Covid-19 assessment (antigen, PCR) – Optional examinations: – Psychological evaluation – Professional examination – TB Mantoux II, trachoma
Referral system	– Organised by practitioner

Appendix III – Characteristics of the drug market in Europe: classification per substance

Cannabis[95]
Cannabis is the most widely used illicit drug in Europe. The psychoactive ingredients of cannabis have increased significantly over the past 10 years resulting in an increase in public health problems, such as a rise in the number of psychotics-like emergency presentations. There are two main cannabis products on the market: cannabis plant (marijuana) and cannabis resin (hashish). International reports say that herbal cannabis is produced mainly in Latin America, Albania and some other Western Balkan states in Europe. In addition, European-grown cannabis production has been on the rise for several years. As for hashish, it is produced in Morocco and usually arrives in Europe via the Spanish coasts. Within Europe it is transported by couriers, cars, lorries, international buses and, to a lesser extent, yachts and small aircraft.
Heroin[96]
Afghanistan continues to be the world's largest producer of illicit opium, and most of the heroin found in Europe is presumably produced there or in neighbouring Iran and Pakistan. Heroin production in Europe remains very low. It enters Europe via four main smuggling routes. The two most critical are the so-called "Balkan Route" and the "Southern Route". The "Balkan Route" goes through Turkey to the Balkan countries (Bulgaria, Romania or Greece), and from there to Western Europe. Different branches (southern, central, northern) of the Balkan Route have appeared. Over recent years, the Southern Route has become increasingly trafficked, with heroin shipments from Iran or Pakistan arriving in Europe by air or sea, either directly or via African countries. Other routes include the "Northern Corridor" and the road through the South Caucasus and the Black Sea.
Cocaine[97]
The cocaine market is the second largest illicit drug market in the EU. Surveys estimate that about 4 million people in the EU have used cocaine in the past year. The majority of cocaine users worldwide are found in North and South America and western and central Europe. Cocaine is mainly produced in Bolivia, Colombia and Peru and transported to Europe by air freight, general aviation (GA) aircraft, postal services, magnetic vehicles, yachts, and by sea in containers.[98] A number of indicators point to a significant increase in cocaine trafficking activities into the EU over recent years, including estimations that the global manufacture of cocaine is at an all-time high.[99]
Synthetic drugs[100]
Europe's synthetic drug market, particularly in respect to stimulants like amphetamine, MDMA, and methamphetamine, is evolving rapidly. Within the stimulant market, these drugs compete for market alongside cocaine and several new psychoactive substances. In most EU countries, amphetamine continues to be more commonly used than methamphetamine, though there are growing signs of a gradual diffusion of methamphetamine use. All three drugs are produced in Europe. The production of MDMA and amphetamine is concentrated in the Netherlands, and to a lesser extent Belgium. Methamphetamine production mostly occurs in central Europe, particularly in and around the Czech Republic. Synthetic drug production in the EU is highly profitable due to the proximity of consumers.

95. European Monitoring Centre for Drugs and Drug Addiction and Europol (2019), Ch. 3, Cannabis.
96. Ibid., Ch. 4.
97. Ibid., Ch. 5.
98. Ibid., Ch. 5.
99. United Nations Office on Drugs and Crime (2020).
100. European Monitoring Centre for Drugs and Drug Addiction and Europol (2019) Ch. 6.

New psychoactive substances (NPS)[101]

New psychoactive substances (NPS) are mainly used as drug substitutes. In many cases, the materials are produced by Chinese chemical and pharmaceutical companies and transported to Europe where they are transformed into products, packaged, and sold. To a lesser extent, India is also an important new psychoactive substance source (sold as medicines). Some illicit laboratories were detected in the Netherlands, Belgium and Poland (synthetic cathinone).

According to experts, some of the reasons for the decline may be that European governments have taken measures to ban new substances (Clause Catch All), and that China has introduced surveillance measures and criminal proceedings against laboratories producing new substances.

Problems attributable to synthetic cannabinoids appear to be growing, as their relatively low cost, easy availability, and high potency are factors in increased use among marginalised groups, including the homeless and prison populations. In addition, new synthetic opioids are a growing cause for concern, with a rapid increase seen in the number of fentanyl derivatives, substances particularly associated with health problems, including fatal poisoning.[102]

Over 400 new psychoactive substances were detected within Europe's drug market in 2019. At the end of 2020, the EMCDDA was monitoring around 830 new psychoactive substances, 46 of which were first reported in Europe in 2020.[103]

Medicines

Globally, the sale of falsified, counterfeit, substandard and unauthorised medicines is big business and a serious and growing public health problem, which has been fuelled by globalisation. The potential for huge profits has also led to the involvement of organised crime groups, although the relationship between these groups and the drug market remains poorly understood. Alongside the health risks posed by using such medicines, consumers also face the risk of being victims of fraud by buying from this market.[104] Although injecting drug use has been declining in Europe for the past decade, it remains a major cause of drug-related harms. Considerable differences exist between countries, both in levels of injecting drug use and in injecting practices and substances used. While primarily connected to heroin use, other drugs, including amphetamines, cocaine, synthetic cathinones, opioid substitution medications and other medicines, are also injected. With high-risk drug consumption practices still a significant problem, the provision of effective treatment and early detection of shifts in the substances available on the drug market remain key drug policy issues for targeting resources. Heroin was also found in the majority of syringes in Budapest and Oslo, while opioid substitution medications were commonly detected in syringes in Helsinki (buprenorphine), Prague (buprenorphine) and Vilnius (methadone).[105]

101. Ibid., Ch. 7.
102. Ibid., Ch. 7.
103. European Monitoring Centre for Drugs and Drug Addiction (2021).
104. European Monitoring Centre for Drugs and Drug Addiction and Europol (2019), Ch. 1.
105. European Monitoring Centre for Drugs and Drug Addiction (2021).

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The Pompidou Group is the Council of Europe International Cooperation Group on Drugs and Addictions. As an enlarged partial agreement of the Council it is open to the member states as well as to non-member states from Europe and other parts of the world. As of 1 October 2017, the Group gathers 39 countries from Europe and beyond.
Only a balanced, multifaceted approach brings together the potential benefits of different strands in drug policy. Drug policy has to be innovative and evidence based. It has to involve prevention, harm reduction, treatment and enforcement. On these principles the Pompidou Group provides knowledge, support and solutions for effective and humane drug policies.

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