



European Monitoring Centre  
for Drugs and Drug Addiction



JOINT REPORT BY THE EMCDDA AND EUAA  
**Professionals working in reception  
centres in Europe: an overview of drug-  
related challenges and support needs**

October 2023

## About this report

This report describes the context of substance use and the utilisation of healthcare services among applicants for international protection in EU+ countries. This joint EMCDDA-EUAA study aims to identify the key issues and define recommendations based on the needs expressed by a sample of professionals working in reception facilities.

## About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 25 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

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PDF ISBN 978-92-9497-899-8 doi:10.2810/82540 TD-03-23-172-EN-N

Luxembourg: Publications Office of the European Union, 2023

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## Acknowledgements

EMCDDA contractors: Charlotte De Kock and Tereza Černíková; EMCDDA staff: Klaudia Palczak and Jane Mounteney; EMCDDA trainee: Fatima El Kach, and EUAA staff: Mila Mancheva, Sharon Kassahun and Francesca Vietti.

Special acknowledgements to the members of the EUAA Network of Reception Authorities and the Vulnerability Experts Network; the EMCDDA National Focal Points; the invited experts from EU+ countries who responded to the survey and participated in the expert focus groups, and the external reviewers Anja Busse and Marie-Claire Van Hout.

The study and the report have been implemented in the framework of the EU4Monitoring Drugs project funded by the European Union.

## List of abbreviations

CEAS	Common European Asylum System
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMN	European Migration Network
EUAA	European Union Agency for Asylum
EU+ countries	Member States of the European Union and Associated Countries <sup>(1)</sup>
FRA	European Union Agency for Fundamental Rights
FG	Focus group
IP	International protection
MS(s)	Member State(s) of the European Union
NGO	Non-governmental organisation
OAT	Opioid agonist treatment
PTSD	Post-traumatic stress disorder
PWUDs	People who use drugs
RN	EUAA Network of Reception Authorities
RC	Reception centre
RCD	Reception Condition Directive
SUDs	Substance use disorders
TCN	Third-country national
VEN	EUAA Vulnerability Experts Network
WHO	World Health Organization

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(1) Any references to EU+ countries in this publication are limited to EU Member States with the sole addition of Norway and Switzerland, who are both part of the EUAA Network of Reception Authorities and the EUAA Vulnerability Experts Network.

## Definitions (in alphabetical order)

<b>Applicant for international protection</b> <sup>(2)</sup>	A third-country national or stateless person who has made an application for international protection in respect of which a final decision has not yet been taken.
<b>Asylum seeker</b> <sup>(3)</sup>	In the EU context, a third-country national or stateless person who has made an application for protection under the Geneva Refugee Convention and Protocol in respect of which a final decision has not yet been taken.
<b>Beneficiary of international protection</b>	A person who has been granted refugee status or subsidiary protection status. <sup>(4)</sup>
<b>Beneficiary of subsidiary protection</b>	A person who has been granted subsidiary protection status. <sup>(5)</sup>
<b>Drug-related or substance-related responses or interventions</b> <sup>(6)</sup>	An action that focuses on altering substance use trajectories by promoting positive developmental outcomes and reducing risky behaviours and outcomes.
<b>Drug use</b> <sup>(7)</sup>	Refers to the use of psychoactive substances controlled under the United Nations conventions, such as heroin, cocaine, cannabis and prescription medicines used non-medically, but also those that are not controlled under UN conventions — for example, new psychoactive substances — although the latter group may be controlled under national Member State laws.
<b>Dublin case</b>	Applicants for international protection who are waiting on the outcome of the Dublin procedure or are waiting to be transferred to the responsible Member State are referred to as ‘Dublin applicants’ or ‘Dublin cases’. The Dublin procedure is the determination of which Member State is responsible for an examination and it precedes the examination of an application for international protection.
<b>Irregular migrant</b> <sup>(8)</sup>	In the EU context, a third-country national present in the territory of a Schengen state who does not fulfil, or no longer fulfils, the conditions of entry as set out in Regulation (EU) 2016/399 (Schengen Borders Code) or other conditions for entry, stay or residence in that EU Member State.
<b>Migrant</b> <sup>(9)</sup>	In the EU/EFTA context, a person who either (i) establishes their usual residence in the territory of an EU/EFTA Member State for a period that is, or is expected to be, at least 12 months in length, having usually been resident previously in another EU/EFTA

<sup>(2)</sup> Art. 2(h) of Directive 2011/95/EU (Recast Qualification Directive).

<sup>(3)</sup> Derived by EMN from Art. 2(b) of Council Directive 2005/85/EC (Asylum Procedures Directive).

<sup>(4)</sup> Art. 2(b) of Directive 2011/95/EU (Recast Qualification Directive).

<sup>(5)</sup> Art. 2(b, f, g) of Directive 2011/95/EU (Recast Qualification Directive).

<sup>(6)</sup> European Monitoring Centre for Drugs and Drug Addiction (2019), *European Prevention Curriculum: a handbook for decision-makers, opinion-makers and policy-makers in science-based prevention of substance use*, Publications Office of the European Union, Luxembourg.

<sup>(7)</sup> European Monitoring Centre for Drugs and Drug Addiction (2019), *European Prevention Curriculum: a handbook for decision-makers, opinion-makers and policy-makers in science-based prevention of substance use*, Publications Office of the European Union, Luxembourg.

<sup>(8)</sup> Derived by EMN from the definition of ‘illegal stay’ in Art. 3 of Directive 2008/115/EC (Return Directive).

<sup>(9)</sup> Derived by EMN from Eurostat’s concepts and definitions database and the UN Recommendations on Statistics of International Migration.

	Member State or a third country; or (ii) having usually been resident previously in the territory of an EU/EFTA Member State, ceases to have their usual residence in the EU/EFTA Member State for a period that is, or is expected to be, at least 12 months in length.
<b>Misuse of medicines or non-medical use of medicines</b> <sup>(10)</sup>	The use of a psychoactive medicine for self-medication, recreational or enhancement purposes, with or without a medical prescription but outside of accepted medical guidelines.
<b>High-risk drug use</b>	Recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high probability/risk of suffering such harms. <sup>(11)</sup>
<b>Reception</b> <sup>(12)</sup>	In the context of the Common European Asylum System (CEAS), the full set of measures and processes implemented to ensure that applicants for international protection benefit from their rights under the Reception Conditions Directive, namely to have an adequate standard of living, and to have their material, healthcare and psychosocial needs, and any potential special reception needs and vulnerabilities, identified and addressed, from the moment of making their application until a final decision is taken.
<b>Reception facilities (EMN Glossary)</b>	All forms of premises used for the housing of applicants for international protection and other categories of migrants and refugees.
<b>Reception system</b> <sup>(13)</sup>	The collective infrastructure consisting of facilities, equipment, services and human resources, including legal framework and funding, used to provide adequate reception conditions for applicants for international protection during the asylum process and prepare them for the possible outcomes of their asylum application.
<b>Refugee</b> <sup>(14)</sup>	In the EU context, either a third-country national who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership of a particular social group, is outside their country of nationality and is unable or, owing to such fear, unwilling to avail themselves of the protection of that country, or a stateless person who, being outside of their country of former habitual residence for the same reasons as those mentioned above, is unable or, owing to such fear, unwilling to return to it, and to whom Art. 12 (Exclusion) of Directive 2011/95/EU (Recast Qualification Directive) does not apply.
<b>Substance use</b> <sup>(15)</sup>	Refers to the use of tobacco products, alcohol, volatile substances (inhalants) and other substances such as heroin,

<sup>(10)</sup> European Monitoring Centre for Drugs and Drug Addiction (2021), *Non-medical use of medicines: health and social responses* [[https://www.emcdda.europa.eu/publications/mini-guides/non-medical-use-of-medicines-health-and-social-responses\\_en](https://www.emcdda.europa.eu/publications/mini-guides/non-medical-use-of-medicines-health-and-social-responses_en)]

<sup>(11)</sup> See [https://www.emcdda.europa.eu/drugs-library/pdu-problem-drug-use-revision-summary\\_en](https://www.emcdda.europa.eu/drugs-library/pdu-problem-drug-use-revision-summary_en)

<sup>(12)</sup> Quoting definitions from IATE (ref. IATE Handbook): European Union, 'term [reception]', *IATE terminology database*, accessed on 3.4.2022, link to IATE entry [<https://iate.europa.eu/entry/result/3591884/en>]

<sup>(13)</sup> Quoting definitions from IATE (ref. IATE Handbook): European Union, 'term [reception system]', *IATE terminology database*, accessed on 3.4.2022, link to IATE entry [<https://iate.europa.eu/entry/result/3620638/en>]

<sup>(14)</sup> Art. 2(d) of Directive 2011/95/EU (Recast Qualification Directive).

<sup>(15)</sup> European Monitoring Centre for Drugs and Drug Addiction (2019), *European Prevention Curriculum: a handbook for decision-makers, opinion-makers and policy-makers in science-based prevention of substance use*, Publications Office of the European Union, Luxembourg.

	cocaine, cannabis and psychoactive prescription medicines used non-medically.
<b>Third-country national</b> <sup>(16)</sup>	Any person who is not a citizen of the European Union and who is not a person enjoying the European Union right to free movement, as defined in Art. 2(5) of the Regulation (EU) 2016/399 (Schengen Borders Code).
<b>Vulnerability assessment</b> <sup>(17)</sup>	Specific examination of an applicant for international protection for the purpose of identifying any need for special reception conditions and/or procedural guarantees and referring them to the appropriate authorities for adequate support.

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<sup>(16)</sup> Art. 3(1) of Directive 2008/115/EC (Return Directive) and Art. 2(6) of Regulation (EU) 2016/399 (Schengen Borders Code).

<sup>(17)</sup> Quoting definitions from IATE (ref. IATE Handbook): European Union, 'term [vulnerability assessment]', *IATE terminology database*, accessed on 3.4.2022, link to IATE entry [<https://iate.europa.eu/entry/result/3620636/en>]

## Introduction

In recent years, the rise in humanitarian emergencies worldwide has led to an increase in displaced people entering Europe from a wide variety of third countries, including a high number of arrivals from the Middle East (mainly Syria), Afghanistan and Africa over the past decade, but also more recent arrivals from the war in Ukraine. <sup>(18)</sup> As a result, challenges linked to the mental and physical health of migrant populations <sup>(19)</sup> have been high on the agenda of host countries (EMCDDA, 2022; EMCDDA, 2017). There have also been concerns stemming from an elevated vulnerability among different groups of migrants and challenges in their access to healthcare in Europe (WHO, 2018; 2019).

In 2020, the European Union Agency for Asylum (EUAA) conducted two studies on mental health concerns among applicants for international protection and on related challenges for asylum and reception professionals in EU+ countries (EUAA, 2020; 2021). The findings indicated that three quarters of respondents working with applicants in asylum and reception facilities regularly encounter applicants with mental health concerns. The signs of mental health concerns most commonly reported by applicants were anxiety and substance use, including the use of illicit drugs and alcohol. A sizeable minority also observed the misuse of medicines among applicants for international protection (IP).

While the migration and substance use nexus in Europe is not new and has indeed been the focus of various studies (Domenig et al., 2007; EMCDDA, 2013; EMCDDA, 2017; Lemmens et al., 2017), increase in migration since 2015 has heightened concerns related to substance use in migrant populations and highlighted the need to develop appropriate responses in host countries and reduce health inequalities linked to migration status (De Kock et al., 2017; Stöver et al., 2018; De Kock et al., 2020).

More specifically, previous studies have explored the nature of substance use and access to healthcare and specialised services among people who use drugs (PWUDs) and who have migration backgrounds (Domenig et al., 2007; EMCDDA, 2013; EMCDDA, 2017; Lemmens et al., 2017). However, there is still limited data and knowledge related to the circumstances and needs of a specific subpopulation of migrants who use drugs, namely refugees and applicants for international protection. Also, the increase in humanitarian crises and the growing displacement of people around the globe highlight the need to close the knowledge gap in order to develop appropriate responses in host countries (De Kock et al., 2017; Stöver et al., 2018; De Kock et al., 2020).

In 2021, the EMCDDA and EUAA entered into a partnership with the aim of identifying the needs of reception authorities in EU+ countries in relation to their work with IP applicants who have drug use problems. By conducting an assessment study with professionals working in reception facilities, the joint effort sought to identify drug consumption patterns among IP applicants as observed by reception professionals, determine staff knowledge in the area of drugs, and clarify any needs for better management of drug-related problems. The study also aimed to examine barriers and facilitators to the implementation of drug-related responses in the reception context.

This joint EMCDDA-EUAA report focuses on the identification of action steps, including the development of practical tools and outputs to support reception

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<sup>(18)</sup> While this is an important population of displaced people at present, it is not discussed in the report.

<sup>(19)</sup> The migrant population is a heterogeneous group that encompasses people with migration backgrounds, ethnic minorities, refugees, asylum seekers and undocumented migrants.



authorities in EU+ countries to identify and respond to drug-related problems among applicants for international protection.

## Context and background

### Substance use among migrants and refugees

While the broader literature on prevalence and patterns of substance use among migrant and ethnic minority populations in Europe is scarce (Humphris and Bradby, 2017), the data on refugees, applicants for IP and irregular migrants is particularly limited (Priebe et al., 2016). <sup>(20)</sup>

Where studies do exist, there appears to be some consensus that substance use prevalence rates among refugees are generally lower than they are among host populations, and the difference may reflect substance use behaviours in their countries of origin (Harris et al., 2019). This is sometimes called the 'healthy migrant effect', a phenomenon that occurs when the health of immigrants upon arrival is better than their native-born counterparts. However, studies suggest that the advantage wanes over time, with the prevalence of substance use becoming increasingly similar to that of the general population. Some factors that contribute to the trend include uncertainty about the asylum application, detention, the unavailability of migrant-friendly health and social services, social and cultural barriers to integration, and a loss of family and social networks (Hurcombe et al., 2010; Horyniak et al., 2016; Priebe et al., 2016; WHO, 2018).

An example here is provided by Harris et al. (2019), who studied a nationwide cohort of over 1.2 million people aged up to 32 years old, including over 17 000 refugees, to investigate incidence rates of substance use disorders (SUDs). They found that refugees and other types of migrants had similarly lower rates of all SUDs than Swedish-born individuals. Research among longer-settled refugees (Bogic et al., 2012), however, has indicated that their rates of SUDs converge over time with the rate for Swedish-born individuals.

Although the findings of Harris et al. did not differ substantially by the migrants' region of origin, some studies do suggest at a population level that refugees with Afghani background may have a higher prevalence of substance use (Schaffrath et al., 2016), possibly resulting from an overall high population substance-use prevalence in Afghanistan (FRA, 2017; El-Khani et al., 2021).

Other causes for concern have also been raised in the literature. For example, adverse socio-economic living conditions, particularly pre- and post-migration, may contribute to a higher risk of substance use (Hjern et al., 2004). In this vein, Horyniak et al. (2016) found that, globally, harmful alcohol use among refugees and asylum seekers ranged between 17-36 % in refugee camps and only 4-7 % in community settings. The higher prevalence of harmful alcohol use and other drugs in humanitarian settings may be due not only to higher exposure to adversity, stress and traumatic events, but also to limited resources and a health infrastructure characterised by insufficient training for professionals on the subject of SUD interventions (Greene et al., 2021).

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<sup>(20)</sup> This section of the report ('contextual information') makes use of a diverse set of terms to describe displaced populations. They may go beyond the study's target group, which is made up of applicants for international protection and refugees. Still, they provide valuable insight into the interpretation of the results. Moreover, all the terms used in the section are in line with the referenced sources.

More recently, perceived trends in the use of alcohol, inhalants, opioid-based medicines and benzodiazepines among young refugees and immigrants have been highlighted in the media in Belgium, Denmark, Germany, the Netherlands and Sweden. These patterns, however, remain largely unconfirmed by empirical studies (De Kock et al., 2017; Nordgren, 2017; Hunt et al., 2018).

Finally, a 2018 exploratory study in Greece highlighted an increase in refugee psychiatric referrals and emergencies, including those related to substance use problems (Nikolaou, 2018). Also, a recent survey among over 30 000 refugees and migrants in 170 countries <sup>(21)</sup> commissioned by WHO (WHO, 2020) reported a perceived worsening of mental health status owing to COVID-19 and an increased use of drugs and alcohol among those living in reception centres or on the streets.

## **Insights into substance use among applicants for international protection and persons granted protection**

Gaining some insight into the potential causes and aetiology of substance use can help to inform the development of appropriate responses. For instance, there is some evidence to suggest that not only do (pre-)migration circumstances (e.g. trauma and substance use in home country) contribute to PTSD, depression (Lindert and Schimina, 2011; Knipscheer et al., 2015) and substance use (Bogic et al., 2012; Brendler-Lindqvist et al., 2014; Horyniak et al., 2016), but similarly so do post-migration circumstances and experiences (e.g. long waiting times for a decision on legal status, social isolation and a lack of social support, the lack of education and employment opportunities, financial strains, poor access to mental health services, stress and perceived discrimination).

A study on the aetiology of alcohol and other drug disorders among young refugees (Posselt et al., 2014; Posselt et al., 2015) established that the following issues influence substance use: pre-migration experiences of torture and trauma; familial factors of intergenerational conflict; post-migration adjustment difficulties in terms of language, culture, education and employment; exposure to and availability of substances; maladaptive coping strategies and self-medication; and hindered access to information and services.

Applicants for IP are exposed to a range of factors that can increase their risk of developing alcohol and drug use problems. Indeed, the literature highlights factors at the individual level, such as traumatic experiences, educational levels, family separation, family and socioeconomic status; factors at the environmental level, including work environment and social exclusion; and factors at the institutional level, such as the lack of a multisectoral approach in services, poor monitoring of addiction among refugees, and a lack of access to health, education and social services (Taşdemir et al., 2020).

Experiences during transit on challenging migratory routes can also have an impact on levels of trauma experienced by IP applicants upon arrival (UNICEF, 2017; Médecins du Monde, 2019; Carnassale and Marchetti, 2022). Moreover, individuals may face a range of stressors, especially shortly after their arrival in Europe, including language barriers, unemployment and acculturation issues. In Greece, for instance, the confluent intersection of the economic crisis and the refugee 'crisis' has been pointed out by Nikolau (2018) as a risk for substance use among refugees. <sup>(22)</sup> Also, a Norwegian study demonstrated that post migration-related stressors are closely related to poor mental health and chronic pain, which can sometimes be

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<sup>(21)</sup> In total, 33.6 % of respondents resided in WHO European region countries.

<sup>(22)</sup> The author uses the term 'refugees' to denote applicants for international protection as well.

interrelated. Moreover, chronic pain is often treated with painkillers and may lead to higher prescribed medicine use and sometimes misuse (Strømme et al., 2021). Re-traumatisation of applicants can also be experienced in the context of the asylum procedure (Saroléa et al., 2021).

Additionally, refugees are at higher risk of post-traumatic stress disorder (PTSD) (Giacco et al., 2018). PTSD is subsequently a risk factor for substance use (Roberts et al., 2015). Knipscheer et al. (2015) established that PTSD symptom severity and depression were significantly associated with a lack of refugee status and an accumulation of traumatic events.

A number of migrants experience forced detention based on their immigration status, which can aggravate their pre-existing mental and physical health conditions when detention settings are characterised by insufficient healthcare, inadequate nutrition, deficient living conditions, a lack of privacy and a lack of culturally sensitive services (Van Hout et al., 2020). A systematic review of migrant detention policies (von Werthern et al., 2018) found that both detention duration and greater exposure to trauma prior to detention were positively associated with the severity of mental health symptoms.

Qualitative studies among IP applicants and refugees in Belgium (De Kock et al., 2017), Germany (Lindert et al., 2021) and Turkey (Taşdemir et al., 2020) confirm that substance use is a way both to escape the past and to cope with psychosocial difficulties in the present.

#### **Recent drug trends in Europe based on the *European Drug Report 2022* <sup>(23)</sup>**

- Drug availability remains at high levels across the European Union (in some cases, such as cocaine, even surpassing pre-pandemic levels) and potent and hazardous new substances are still appearing.
- Cannabis remains the most popular illicit drug in Europe. But cannabis products are becoming increasingly diverse, including extracts and edibles (high THC content) and CBD products (low THC content).
- Injecting drug use is associated with serious health problems, such as infectious diseases, overdose and deaths. While heroin injecting is in decline, there are growing concerns around the injecting of a broader range of substances, including amphetamines, cocaine, synthetic cathinones, prescribed opioids and other medicines.
- New psychoactive substances continue to appear in Europe at the rate of one per week, posing a public health challenge. Synthetic cannabinoids are the largest group monitored by the EU Early Warning System, followed by synthetic cathinones.
- The war in Ukraine has added to the uncertainty of Europe's drug situation. People who access drug treatment in Ukraine will account for a small proportion of those seeking refuge in the European Union. These individuals will need continuity of treatment as well as services tailored to their specific needs and language. More generally, those fleeing conflicts are likely to have suffered severe psychological stress, making them potentially more vulnerable to substance misuse problems in the future. The war could also cause shifts in trafficking routes, as criminals exploit vulnerabilities or avoid affected areas.

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<sup>(23)</sup> European Monitoring Centre for Drugs and Drug Addiction (2022), *European Drug Report 2022: Trends and Developments*, Publications Office of the European Union, Luxembourg

## Utilisation of health and social services by migrants, applicants for IP and persons granted protection

The evidence concerning health status and access to healthcare services among migrants in Europe is scant and heterogeneous. No systematic reviews are available in the area and the monitoring of migrant status in substance use treatment is limited (Kluge et al., 2012; Winters et al., 2018; De Kock et al., 2020; De Kock, 2021).

However, some comprehensive national studies on service conducted in Germany, the Netherlands and the Nordic countries, indicate that the utilisation of services, including substance use treatment among migrants (excluding applicants for IP), is generally lower than it is among non-migrant populations (Kohlenberger et al., 2019; Björkenstam et al., 2020), but it is likely to increase with time of stay (Kieseppä et al., 2019).

Moreover, existing research suggests that the inequities that refugees and asylum seekers tend to face when accessing mental health and psychosocial support services in destination countries may lead to lower treatment engagement (Satinsky et al., 2019).

The literature also provides insights into barriers to accessing specialised mental health or substance-use related service among migrants. For instance, the review conducted by Satinsky et al. (2019) on mental health and psychosocial support service utilisation and access among refugees and applicants for IP in Europe identified a number of major barriers, such as legal status, language (and lack of interpreters), help-seeking behaviours, lack of awareness, stigma, and negative attitudes towards and by providers. Most frequently cited barriers include scheduling conflicts, long waiting lists, and a lack of knowledge about doctors (Mangrio and Forss, 2017; Mangrio et al., 2018; Kohlenberger et al., 2019; Nikendei et al., 2019). In addition, Priebe et al. (2016) highlight a lack of knowledge of legal entitlements and the healthcare system in the host country, poor command of the host country language, cultural beliefs about mental health, and cultural expectations towards healthcare professionals.

A recent EUAA survey (2020) among professionals working in reception settings found that a large share of respondents were either hesitant or viewed the reception system in their country as not sufficiently equipped to support IP applicants with mental health concerns. The main identified challenges to the provision of support were a lack of resources in terms of budgets and specialists, a lack of awareness in terms of cultural sensitivity and mental health literacy, and a lack of streamlined/standardised approaches.

Other challenges identified in the literature involve the distant location of clinics and hospitals that provide medical assistance to applicants, the limited access to some specialised medical care, bureaucratic practices and constraints that hinder otherwise legally guaranteed healthcare access, the lack of resources and efficient provision of (some) health services for local populations that likewise affects applicants, and the differing quality of healthcare provision across regions within a given Member State that affects the quality of access for applicants <sup>(24)</sup> (Mangrio and Forss, 2017; Mangrio et al., 2018; Kohlenberger et al., 2019; Nikendei et al., 2019).

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<sup>(24)</sup> Public sources discussing challenges in the access to healthcare by applicants and refugees include: EASO Asylum Report series; ECRE Asylum Information Database (updates March–June, 2021); Migrant Integration Policy Index (website), available at: <http://www.mipex.eu>; Chiarenza et al., 'Supporting access to healthcare for refugees and migrants in European countries under particular migratory pressure', *BMC Health Services Research*, July 2019

In addition, applicants' access to general healthcare and specialised healthcare, such as mental health and substance use treatment services, depends on the organisation of the national healthcare systems in EU+ countries, particularly their approach to the issue of healthcare inclusion of migrants and foreign residents and their capacities to design and implement medical support for applicants in view of their specific situation and needs. A literature review by Lebano et al. (2020) indicates an under-prioritisation of the needs of migrants and refugees in Europe in areas such as mental healthcare, preventive care and long-term care.

## Healthcare for IP applicants in EU+ countries

The recast Reception Conditions Directive (2013) <sup>(25)</sup> lays down common standards for the reception and provision of reception conditions, including healthcare, for applicants for international protection. These standards are transcribed differently into national laws, leading to diverse modalities in the organisation of reception and access to healthcare for applicants across Member States. Varying approaches are also observed in EU Associated countries (see below).

### Access to healthcare for IP applicants in EU+ countries <sup>(26)</sup>

Healthcare provision for IP applicants in Member States and Associated countries can be accessed at various levels including an initial medical screening <sup>(27)</sup> of applicants upon arrival and the provision of emergency healthcare. Initial medical check-ups may be performed by medical practitioners onsite or by commissioned private companies, non-profit organisations, dedicated hospitals or local healthcare authorities either onsite or at referred hospitals.

In many EU+ countries <sup>(28)</sup> applicants for IP have full access to the public healthcare system under the same or similar conditions as citizens. This may become effective immediately from the start of the asylum procedure or after an initial waiting period during which emergency healthcare is rendered. In some Member States, access to the national healthcare system is provided free of charge, while in others, it is associated with the payment of insurance and/or certain medical service fees that are also required of citizens. In the latter case, some Member States have established schemes to support applicants in the payment of any required fees, for example with dedicated funds provided by the national authority or by international organisations through AMIF <sup>(29)</sup> projects. In some EU+ countries, child applicants receive full and free access to the national healthcare system with rights that are the same as those of child citizens, while adult applicants are provided with partial or against-payment healthcare system coverage.

Medical care for applicants who are housed in EU+ reception facilities is most often organised as a combination of on-site medical services and referrals to external healthcare providers. On-site medical staff can include nurses, medical doctors and

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<sup>(25)</sup> Directive 2013/33/EU, Laying down Standards for the Reception of Applicants for International Protection (recast), available at: <https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:180:0096:0116:EN:PDF>

<sup>(26)</sup> The summary relies on the EUAA non-public overview of healthcare for IP applicants in EU+ countries including information collected through an exchange with the EUAA Network of Reception Authorities and from publicly available sources.

<sup>(27)</sup> EMN Ad-hoc Query on Health Care Provision for Asylum Seekers, March 2020; Asylum Information Database (AIDA), Country reports, Updates: March–July 2021

<sup>(28)</sup> EMN Ad-hoc Query on Health Care Provision for Asylum Seekers, March 2020; Additional public source consulted with regard to public healthcare access for applicants include: Asylum Information Database (AIDA), Country reports, Updates: March–June 2021

<sup>(29)</sup> [https://home-affairs.ec.europa.eu/funding/asylum-migration-and-integration-funds/asylum-migration-and-integration-fund-2021-2027\\_en](https://home-affairs.ec.europa.eu/funding/asylum-migration-and-integration-funds/asylum-migration-and-integration-fund-2021-2027_en)

also sometimes psychologists, who are available at fixed hours on all or some weekdays. In some cases, nurses are available on a 24-hour basis. Referrals to external healthcare providers can be facilitated by medical staff present in the reception centres, by outpatient clinics working with reception facilities, by medical stations at reception facilities, or through contracted intermediary private or non-governmental actors. In some Member States, asylum seekers in reception facilities are always referred to local healthcare services.

### **Reception systems in EU+ countries <sup>(30)</sup>**

The majority of EU+ countries designate one authority to take responsibility for the reception of applicants for international protection, while a minority of EU+ countries require the involvement of several authorities at the national level or include entities both from the national and regional levels or from the regional level only. While policymaking and capacity management are typically centralised, the organisation of the daily operations of facilities is more diverse and can include centralised, mixed and decentralised approaches.

In most EU+ countries, the reception path is divided into stages: arrival, stay in reception, and end of reception (outflow), which can include either integration in the country or return. The division of the stages is not always clear-cut, and not all applicants in each country go through each stage in a chronological manner.

Reception accommodation can be provided in different forms: reception facilities which might envisage beds in containers and/or actual buildings, and/or the provision of private housing, such as apartments. All EU+ countries rely to some extent on group accommodation to provide material reception conditions, including housing, food and clothing, which can be provided in kind, as financial allowances or in vouchers, or as a combination of these methods together with a daily expenses allowance. When available, small-scale or individual accommodation is typically reserved for vulnerable applicants and those with special needs or for later stages of the reception path. Reception facilities can also be linked to the type of asylum procedure that an applicant is channelled into, for example applicants in the accelerated procedure or the Dublin procedure.

The majority of EU+ countries allocate reception places (i.e. assign an applicant to a specific reception facility, for example based on the availability of places) rather than using dispersal quotas, which aim to balance the distribution of applicants among the different regions of a country.

Although most residents in reception facilities are applicants for international protection, a minority may be persons already granted protection who are facing difficulties finding independent accommodation after positive decisions on their application request have been issued.

Reception centres are often open facilities where applicants may be allowed to exit during the day and return in the evening. Following arrival in the country and in the reception facility, people applying for asylum will need to undergo specific steps such

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<sup>(30)</sup> For a comprehensive overview of the organisation of EU+ reception systems, see: EUAA, *Overview of the organisation of reception systems in EU+ countries*, Situational Update Issue No 8, available at: [https://euaa.europa.eu/sites/default/files/publications/2022-01/2021\\_situational\\_update\\_issue8\\_reception\\_systems\\_EN\\_0.pdf](https://euaa.europa.eu/sites/default/files/publications/2022-01/2021_situational_update_issue8_reception_systems_EN_0.pdf)

as registration, documentation, provision of information, medical screening, identification of special needs and immediate support. After the first stage of arrival, applicants will have access to various support services in and/or out of the reception centre during their stay in reception, depending on national legal provisions, and they may also be able to pursue employment, vocational/language training and schooling (for children). In addition, various social and recreational activities can be organised for residents by the respective reception authority, by a partnering NGO or by the local community. These activities might be adapted based on the age, gender and special reception needs of applicants.

## Vulnerability and persons in a vulnerable situation in the context of asylum and reception

In the context of migration and international protection, vulnerability is a characteristic or situation of a person or group of people in need of special reception conditions and/or additional procedural guarantees, which may also affect their qualification for international protection. <sup>(31)</sup> In addition to vulnerability, the instruments of the Common European Asylum System (CEAS) use the concepts of special needs, special reception needs and special procedural guarantees, each referring to the key scope of ensuring that all asylum seekers are enabled equally to access the reception system, participate in asylum procedures and have their needs assessed on the base of their specific situation. <sup>(32)</sup> Member States have an obligation to identify and assess special needs and provide adequate support to applicants in a situation of vulnerability. <sup>(33)</sup>

The non-exhaustive list of categories of vulnerable persons denoted in Art. 21 RCD (recast) include: '[...] minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation [...]'. The non-exhaustive list of indicators denoted in Recital 29 APD include '[...] age, gender, sexual orientation, gender identity, disability, serious illness, mental disorders or as a consequence of torture, rape or other serious forms of psychological, physical or sexual violence [...]'. Both the categories of vulnerable persons and the list of indicators that CEAS instruments denote are non-exhaustive, and an individual approach is required to consider the particular circumstances of each applicant and understand their needs.

## A study assessing the experiences and needs of professionals working in reception centres

In 2021, the EMCDDA and EUAA conducted a study to record the experiences and needs of professionals working in reception settings in EU+ countries with respect to

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<sup>(31)</sup> Quoting definitions from IATE (ref. IATE Handbook): European Union, 'term [vulnerability]', *IATE terminology database*, accessed on 15.3.2023, link to IATE entry [<https://iate.europa.eu/entry/result/3591898/en>]

<sup>(32)</sup> References to vulnerabilities or special needs in CEAS instruments: RCD (recast) Recital 14, Arts. 2(k), 11, 17(2), 18(3) and (5), 19(2) and 21–25; Dublin III Regulation Recital 13, Arts. 6, 8, 31 and 32; APD (recast) Recitals 29 and 30, Arts. 2(d), 15(3)(a), 24, 25 and 31(7)(b); QD (recast) Recitals 19, 28 and 41, Arts. 4(3)(c), 9(2)(f), 20(3) and (4), 30(2) and 31

<sup>(33)</sup> Articles 21, 22 RCD (recast); Recital 29 APD and Article 24 APD (recast)

drug-related issues among IP applicants and related challenges. The main purpose was to inform and guide the development of new tools to improve responses. Specifically, the study aimed to explore the observations and perceptions of reception professionals with regard to current substance use patterns, risk factors and risk groups among applicants in reception settings, and to identify staff knowledge and training needs in the area together with any barriers and facilitators to the implementation of substance use-related responses in reception settings.

## Methods and tools

The study involved an online survey and focus groups that were targeted at managers, social workers, psychologists and reception officers who are active in the asylum and reception sector as well as staff who engage daily with residents of the centres.

The online survey, which was open from 30 August to 8 October 2021, was distributed to EU+ countries via the EUAA Network of Reception Authorities <sup>(34)</sup> and the Vulnerability Expert Network. <sup>(35)</sup> The questionnaire contained 24 items that covered the following areas:

- drug use and drug-related problems in reception settings: situation, challenges and concerns
- drug-related responses in reception centres: available responses, gaps and needs
- current knowledge of reception centre staff on drug use and related responses and attitudes towards drug use.

In addition to the online survey, four focus groups were held to clarify and deepen knowledge gained from the survey. The focus groups took place online, and each lasted 2.5 hours and had between three and six participants (16 in total), who were professionals and volunteers working with IP applicants in reception, including medical doctors, nurses, psychologists, managers and coordinators of the centres as well as local and international NGOs that provide psychosocial support in reception facilities. The results of the focus group discussions are highlighted below in the results section.

## Limitations

Several limitations should be considered when interpreting the survey results. First, the results represent perceptions of substance use based solely on the professional experiences of the respondents. The results do not give any insight into the prevalence of substance use in European reception settings, because it was not the focus of the study. Nevertheless, the participation of IP applicants and the gathering of their views and opinions in a follow-up study might be of benefit to complement the picture of substance use in EU reception facilities.

Second, the survey items on knowledge about substance use are not exhaustive. The items were designed to gain a rough insight into the knowledge and perceptions of reception staff. Future research should develop and validate the questionnaires.

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<sup>(34)</sup> At the time of the survey, 25 EU Member States were represented in the EUAA Network on Reception Authorities (not represented: Denmark and Estonia). At the same time, some associated and third countries are part of RN: Norway, Serbia and Switzerland.

<sup>(35)</sup> At the time of the survey, 20 EU Member States were represented in the steering group (national authorities) and the advisory group (civil society organisations) (not represented: Croatia, Estonia, Hungary, Italy, Lithuania, Luxembourg and Slovenia).



Lastly, although the survey had a satisfactory response rate, the results are not representative of all EU+ countries and can therefore not be extrapolated to every context.

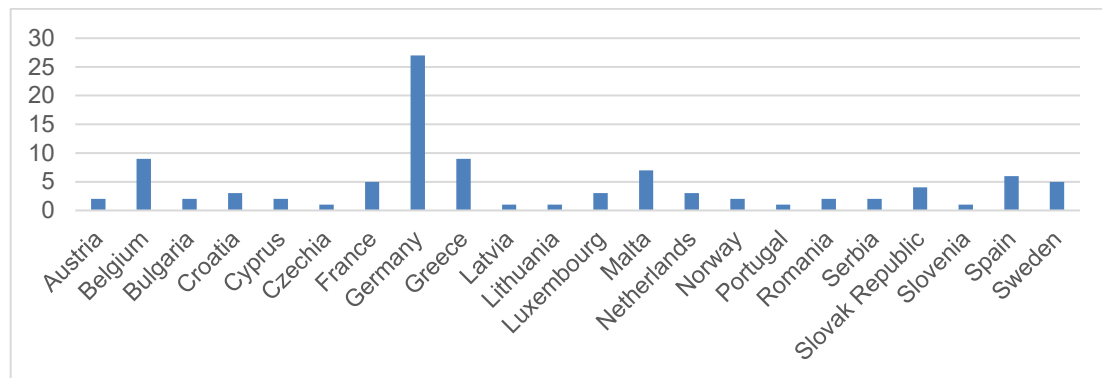
## Results

### Sample characteristics

A total of 98 survey responses were received, representing 21 EU Member States plus Norway. Over a quarter of respondents were based in Germany.

FIGURE 1

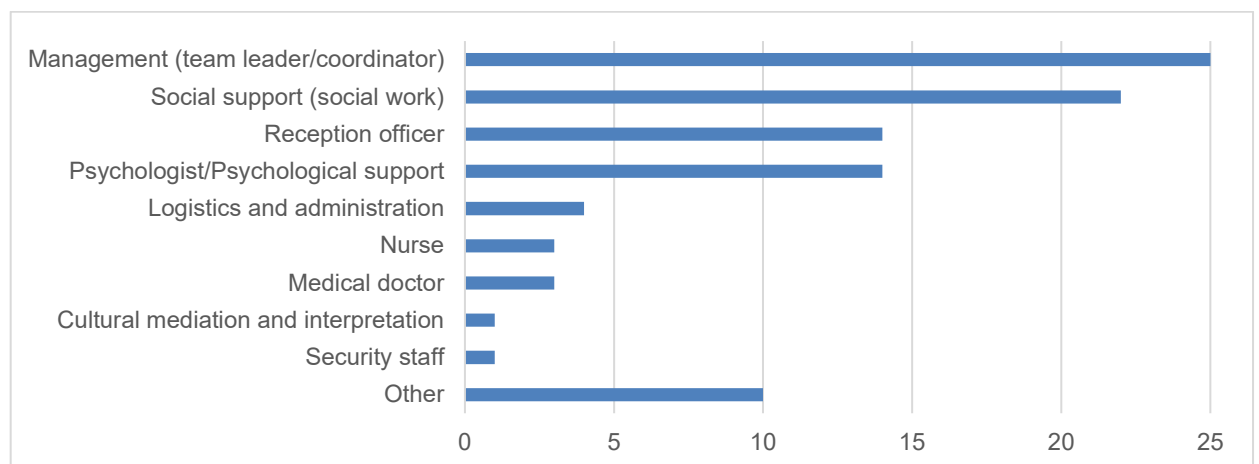
#### In which country do you work? (Q1)



Around a quarter of survey participants had a managerial role (26 %), with the next most common respondent categories being social workers (22 %), psychologists (14 %) and reception officers (14 %). The remaining categories included nurses, medical doctors, staff in charge of logistics and administration, cultural mediators and security staff.

FIGURE 2

#### What best describes your position and role in the reception setting? (Q2)



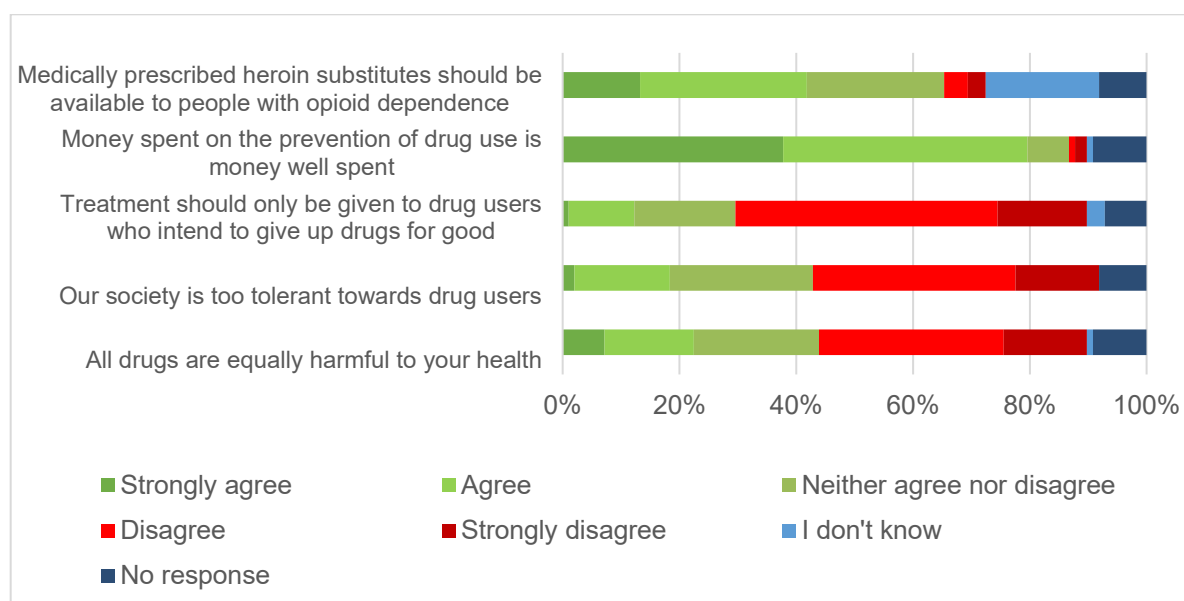
A majority of respondents (56 %) reported working in settings where all types of asylum applicants are accommodated. About half of these settings (47 %) also accommodate applicants with vulnerabilities. <sup>(36)</sup>

### Attitudes towards substance use

The attitudes and beliefs of reception professionals towards people who use drugs and towards substance use-related interventions were measured through five items adopted from the Irish Drug Misuse Research Division's nationwide study (Bryan et al., 2000).

FIGURE 3

### Attitudes and beliefs towards substance use and related interventions (Q22)



There was very strong support for the view that money spent on prevention strategies is 'money well spent' (80 %). Only a small number of respondents believed that treatment should be conditional on a commitment to abstinence (12 %).

There was some uncertainty about the provision of medically prescribed heroin substitutes, with half of the respondents answering 'neither agree nor disagree', suggesting that knowledge of these evidence-based interventions may be limited.

A majority of respondents disagreed with the statement that society is 'too tolerant towards drug users' (but it is worth noting that 18 % agreed).

### Knowledge about substance use and related interventions

Respondents were presented with a series of true factual statements on substance use and related harms, and asked to self-assess their current levels of knowledge. This part of the survey was also regarded as an active provision of information in the subject area.

Overall, self-assessed substance use-related knowledge was relatively high (see Figure 4).

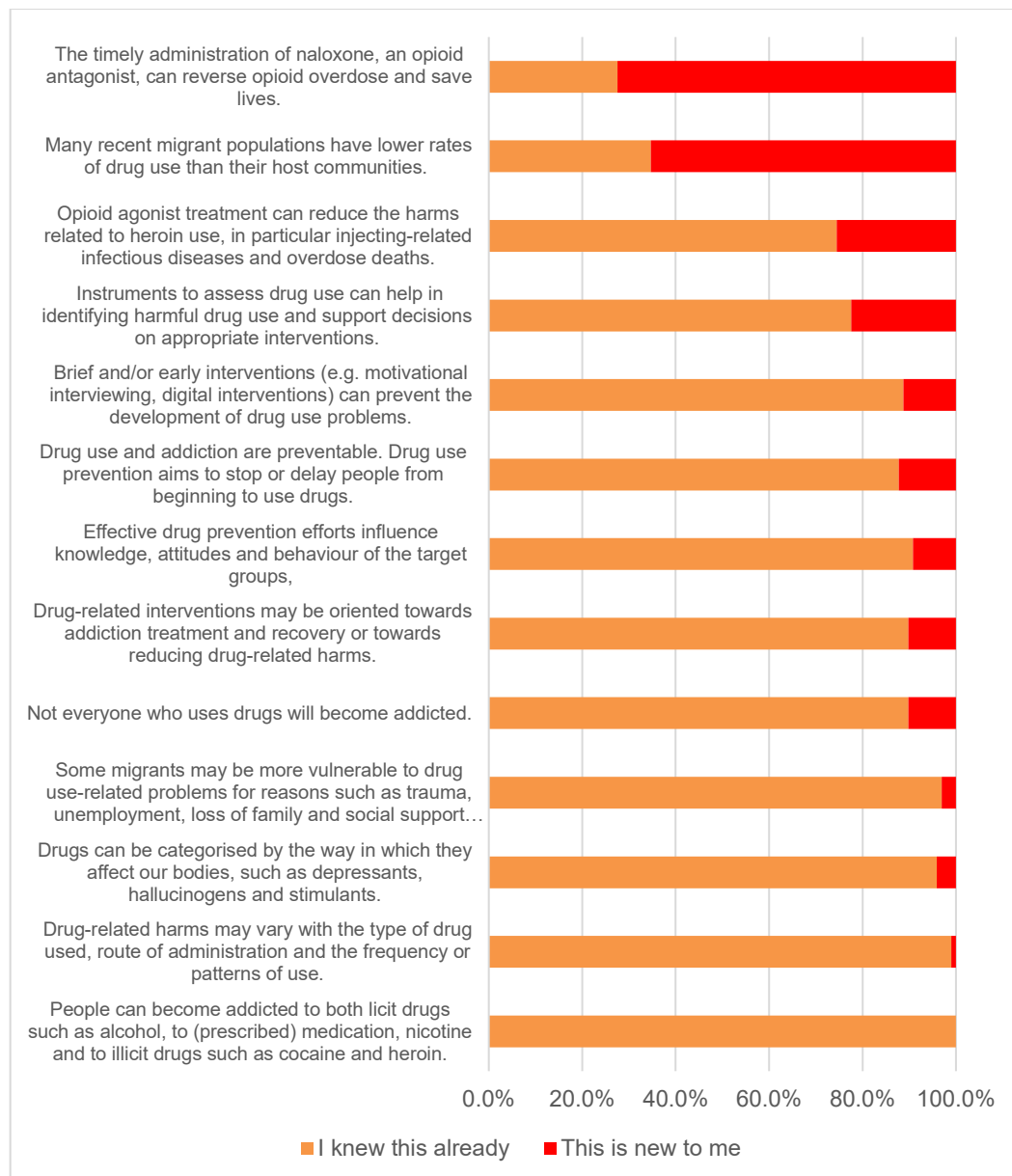
<sup>(36)</sup> See the paragraph on vulnerability and persons in a vulnerable situation in the context of asylum and reception on page 15.

Respondents were quite knowledgeable overall about the general aims of substance use-related interventions (90 %), assessments of substance use severity (78 %), brief and early intervention (89 %) and drug prevention (91 %). In line with the attitudinal questions (Q22, see Figure 4), respondents were less knowledgeable particularly in the area of harm reduction and treatment, including the administration of naloxone to reverse overdose (28 %) and some opioid agonist treatments (75 %).

Areas of more limited knowledge included the fact that recent migrant populations have lower rates of substance use than their host communities, which only a third of respondents already knew.

FIGURE 4

**Answers to 'this is new to me' or 'I knew this already' (Q6)**

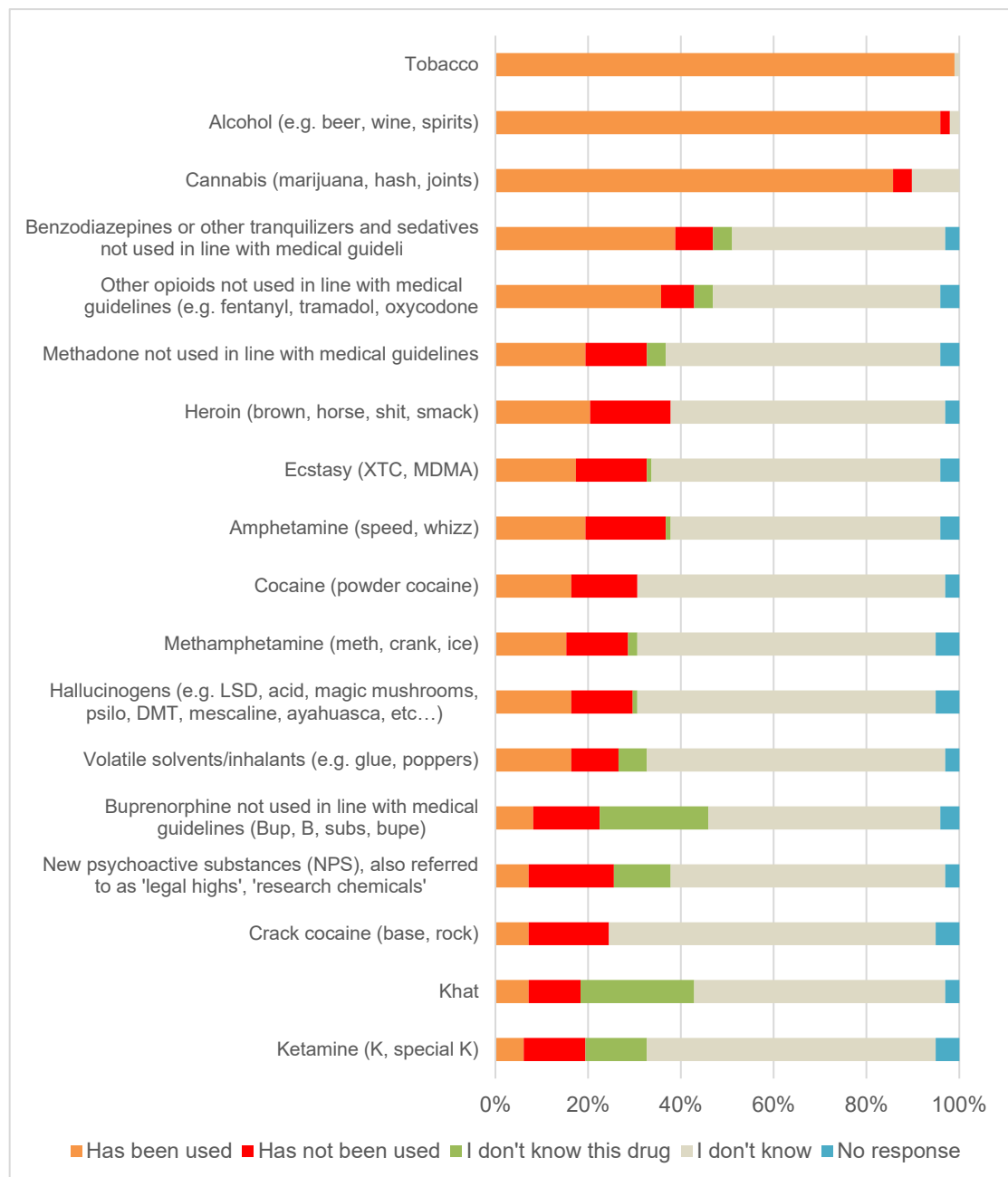


## Substance use in the reception setting

Respondents were asked which types of substances, to the best of their knowledge, had been used in the past 12 months by residents in the setting where they work. Tobacco, alcohol and cannabis were the most frequently mentioned, followed by benzodiazepines and opioids other than heroin (see Figure 5 below). For many of the predefined substances, participants indicated that they did not know whether they were used.

FIGURE 5

**To the best of your knowledge, which drugs have been used in the past 12 months by residents in the reception setting where you work? Please tick all answers that apply (Q9)**



Eleven respondents commented in the open field that prescribed medicines such as opioid-based medicines (e.g. Tramadol©) and benzodiazepines such as clonazepam (e.g. Rivotril©) are misused.

Respondents' opinions are divided on the severity of substance use as a problem in reception settings. Specifically, 27 respondents regard it as a major problem and 50 respondents regard it as a problem sometimes, accounting together for 79 % of the total. By contrast, around a fifth of respondents consider that it is rarely a problem.

With regard to substance use-related critical incidents, a fifth (20 %) of respondents regard them as a major problem, 35 % regard them as a problem, and 45 % consider that they are never or rarely a problem.

*Many focus groups participants reported the misuse of prescribed medicines as a significant problem among IP applicants. In particular, they mentioned pregabalin (Lyrica©), whose misuse was linked either to consumption in the home country (e.g. North African countries) or to being prescribed or obtained for the first time in a transit country such as a Greece (e.g. as part of the stock of medicines in reception centres). The misuse of opioid-based medicines (e.g. Tramadol©) and benzodiazepines such as clonazepam (e.g. Rivotril©) and diazepam was also reported.*

*With regard to the availability of medicines, participants reported that they could be obtained by IP applicants legally in EU+ countries for medicinal purposes. They also pointed to their availability in pharmacies (with or without prescription) and in reception settings. Moreover, they indicated that medical guidelines for medicines differ between EU+ countries. Some EU+ countries were described as countries with restricted access to psychoactive medicines, while others were said to have easy over-the-counter availability of psychoactive medicines.*

*Participants also stressed the impact on patterns of drug use arising from the availability of a certain type of drug in the host country (e.g., crack cocaine in some countries, new psychoactive substances in other countries, etc.). These may change over time and depend on the country or the services received by applicants.*

*Lastly, participants often reported a problematic use of alcohol.*

### Reasons for substance use

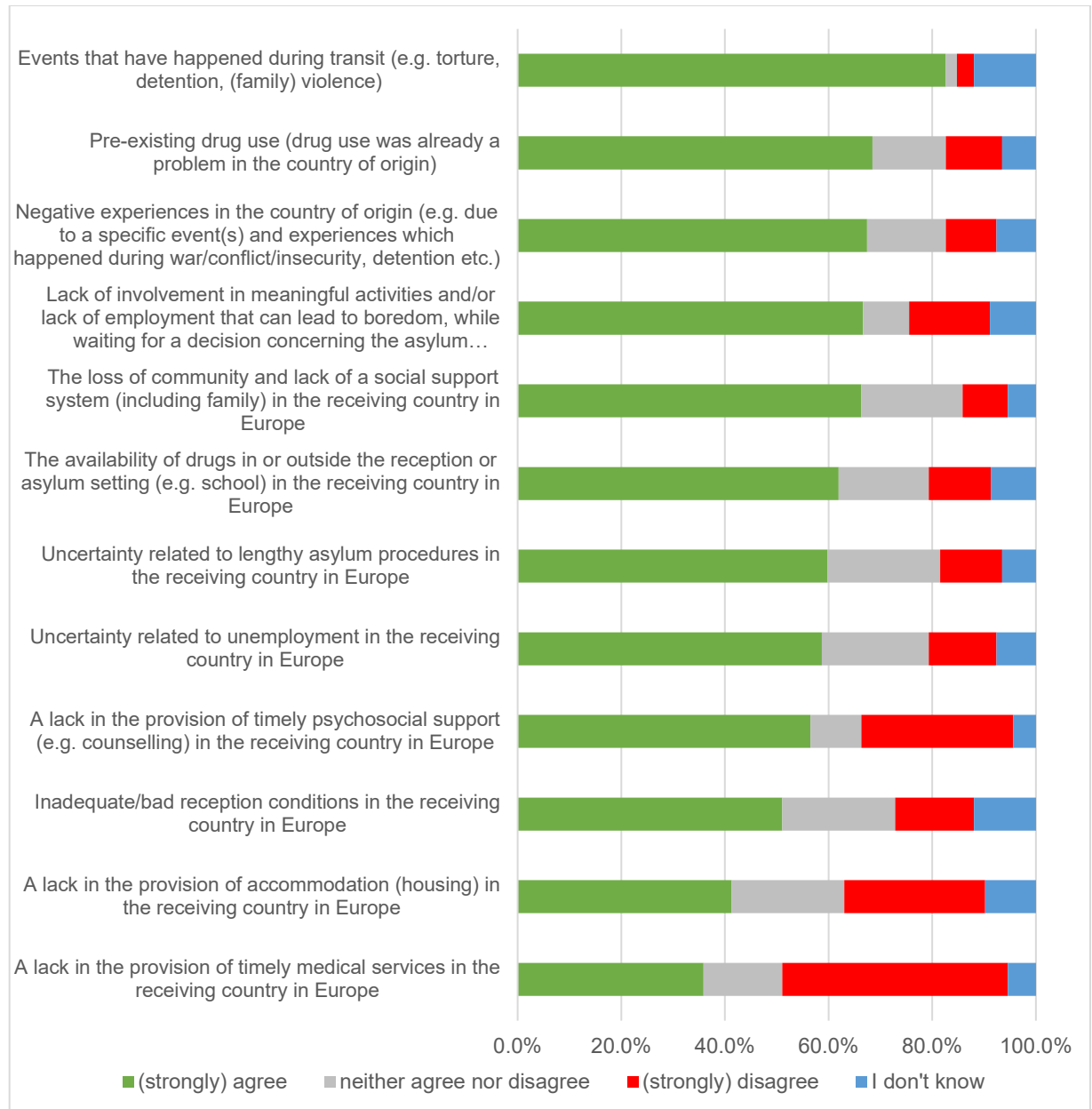
Respondents were asked what, in their experience, substance use among IP applicants was mainly linked to. The response options can be categorised as pre-, during- and post-migration reasons. The following reasons stand out as being most often answered with 'agree' or 'strongly agree'.

<b>Country of origin/transit (pre- and during-migration reasons)</b>	<b>Receiving country in Europe (post-migration reasons)</b>
Events that happened during transit (e.g. torture, detention, violence) (78 %)	Loss of community and lack of social support system (61 %)
Pre-existing substance use (already a problem in the country of origin) (64 %)	Lack of involvement in meaningful activities and/or lack of employment while waiting for decision (61 %)
Negative experiences in the country of origin (owing to specific events and experiences which happened during war/conflict/insecurity/detention/etc.) (63 %)	Availability of drugs in and outside of reception facility (58 %)

An interplay of pre-, during- and post-migration factors is perceived to be linked to substance use among applicants for IP. Traumatic experiences prior to migration or during transit, such as torture, detention and violence, as well as pre-existing substance use can be compounded by the unfavourable realities that applicants may face in receiving countries, which can include a loss of social support systems and a lack of involvement in meaningful activities (61 %), uncertainty related to lengthy asylum procedures (56 %) or unemployment (55 %), the lack of provision of psychosocial support (53 %), and inadequate reception conditions (45 %).

FIGURE 6

**In your experience, what is drug use <sup>(37)</sup> among applicants mainly linked to? (Q11)**



<sup>(37)</sup> The survey uses the term 'drug use' as defined in the definition box on page 5.

*While focus group participants assumed that some applicants had experience of drug use in the country of origin, they also stressed post-migration factors, for example having nothing to do and a lack of perspective, facing isolation and experiencing a need to belong and connect, and seeking a way to cope with difficult emotions or inadequate reception conditions.*

*All participants in the focus groups considered substance use to be a problem in the reception setting. The reasons for the problem were attributed mainly to the availability of substances on the one hand and exposure to a multitude of risk factors on the other hand. They also pointed out that mental health and medical concerns can be a reason for use.*

*Medicines are prescribed by doctors or are available on the black market. They can be easily accessible in pharmacies in some Member States without a prescription. The existence of open drug scenes near reception facilities was described by some participants as a problem for young applicants.*

#### **Applicants at higher risk of drug use**

Respondents were asked to indicate specific groups of applicants particularly vulnerable to drug use. A majority of respondents (65 %) indicated young/single men (n=26) including unaccompanied minors, while others highlighted those with long waiting times for their asylum decision and uncertainty about the outcomes of the asylum procedure (n=15) and Dublin cases (n=8). They also mentioned other personal vulnerabilities relating to age, gender, family situation, illness, mental health problems and coping skills (n=11). Three respondents highlighted the important influence of substance use habits in the countries of origin.

*Focus group participants were also of the opinion that boys and young men are most vulnerable to substance use. Participants highlighted that those with precarious living conditions (near open drug scenes) are more vulnerable. Three participants highlighted that young men are often on the move, hard to reach and do not ask for help, which is why outreach work is needed. Lastly, their proneness to engage in substance use was also linked to prevalent substance use in their home country.*

#### **Problems resulting from substance use**

The survey asked respondents about the type of problems related to the use of alcohol, the use of illicit substances and the misuse of medications (Q10) that they had witnessed or were aware of in the past 12 months in the reception setting where they work. Mental health problems were perceived as a relatively significant consequence of all three types of substance use (illicit substances, n=67; alcohol and prescribed medication, n=54 each), as were social problems such as a lack of employment, conflicts with family, other residents and staff, experiences of stigma and lack of trust. Violence was also high on the list of consequences related to alcohol use (n=73), the use of illicit substances (n=57) and to a lesser extent the misuse of medicines (n=20). School neglect and educational problems were perceived to be of lesser but still notable consequence for those using alcohol (n=30) and illicit substances (n=28).

## Substance use related interventions in the reception setting

### Assessment of substance use

A quarter of respondents reported that an assessment of substance use took place during the intake procedure, with 22 % specifying that it occurred during medical intake. A total of 15 % of respondents indicated that an assessment took place only during the stay at the reception facility, while 7 % of respondents indicated that it took place by means of a vulnerability assessment. It could also be initiated after a critical incident (7 %). Lastly, 19 % of respondent were not aware of any such an assessment and another 12 % indicated that it never takes place.

*Participants distinguished two instances where substance use can be identified: upon arrival in the general medical assessment or vulnerability screening; or later on as a result of a substance use-related incident (e.g. aggression). Moreover, an assessment is not seen by the participants as useful in transit locations (because, for example, there is not enough time to implement any psychosocial intervention or there is a lack of such interventions) as compared to 'end' locations. Focus group participants stated that there was no standardised way of assessing substance use that is aimed at identifying intervention needs. The reasons for not having or using such an assessment is insufficient training as well as understaffing in the reception setting. In addition, staff do not have the necessary tools at their disposal to conduct this type of assessment.*

*There was consensus on the need to have an assessment process linked to the provision of drug-related support. However, the majority questioned whether screening for substance use upon arrival was a good practice. It was argued that applicants might not be ready to disclose their substance use right away due to trauma, mistrust, and concerns over more pressing issues. It was suggested that the assessment of drug use and related needs might best be conducted outside the framework of vulnerability assessment.*

### Other interventions in the reception setting

Almost half of respondents (48 %) in the survey indicated that the reception facility where they work provides substance use-related responses and interventions.

When asked in an open-ended follow-up question to specify what interventions take place, respondents indicated referral to specialist treatment outside the reception setting (12 %), the provision of social and psychological support within the reception setting (13 %), the prescription of opioid agonist treatment (7 %), and prevention interventions (5 %).

Another six respondents reported specific interventions in the reception setting, namely motivational interviewing, cognitive behavioural therapy and individual therapy. Also, two respondents indicated that there is a protocol to respond to substance use-related problems.

*Focus group participants confirmed that referral is the main intervention in the reception setting. Participants did mention offering some prevention interventions in and outside the reception setting (e.g. in schools). Several participants, however, noted that prevention alone will be insufficient because the reception conditions and context of poverty expose applicants to many risk factors for substance use. They opted for a more holistic approach and tackling risk factors.*

*In some reception centres, opioid agonist treatment (OAT) is available. One example from a Member State involved an external service that is available for and targeted*



*at applicants, offering them a broad range of interventions from prevention, OAT and a therapeutic community to assisted living and training.*

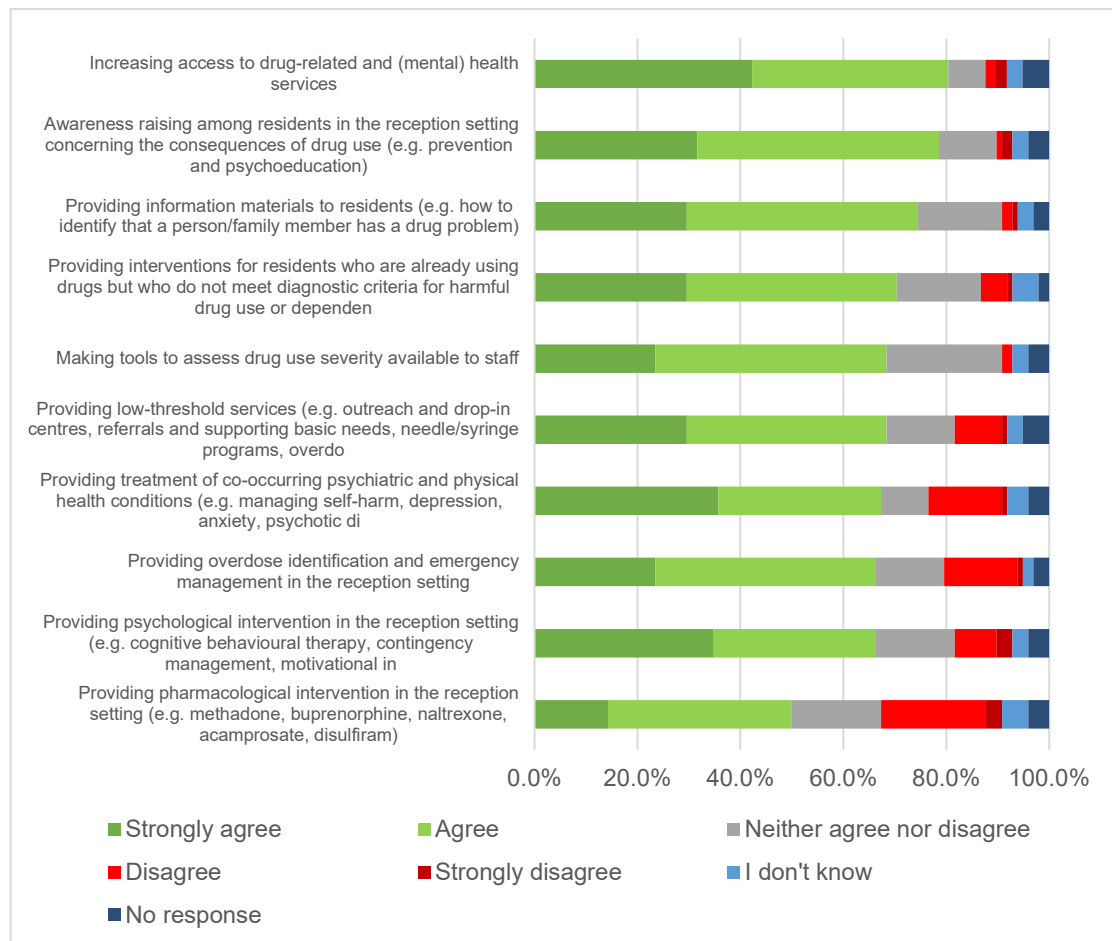
**Priority interventions in reception**

Respondents identified the interventions that they regarded as a priority in the reception facility where they work. All the interventions listed in the survey, ranging from prevention to pharmacological treatment, are regarded as a priority by over half of the respondents. The following three types of interventions, however, were most frequently identified as a priority.

1. Increasing access to substance use-related and (mental) health services (80 %)
2. Awareness raising among residents in the reception setting concerning the consequences of substance use (e.g. prevention and psychoeducation) (79 %)
3. Providing information materials to residents (e.g. how to identify whether a person/family member has a drug problem) (75 %)

**FIGURE 7**

**Which of the items below should be considered a main priority in the reception facility you currently work in? (Q21)**



## Challenges in implementing substance use-related interventions

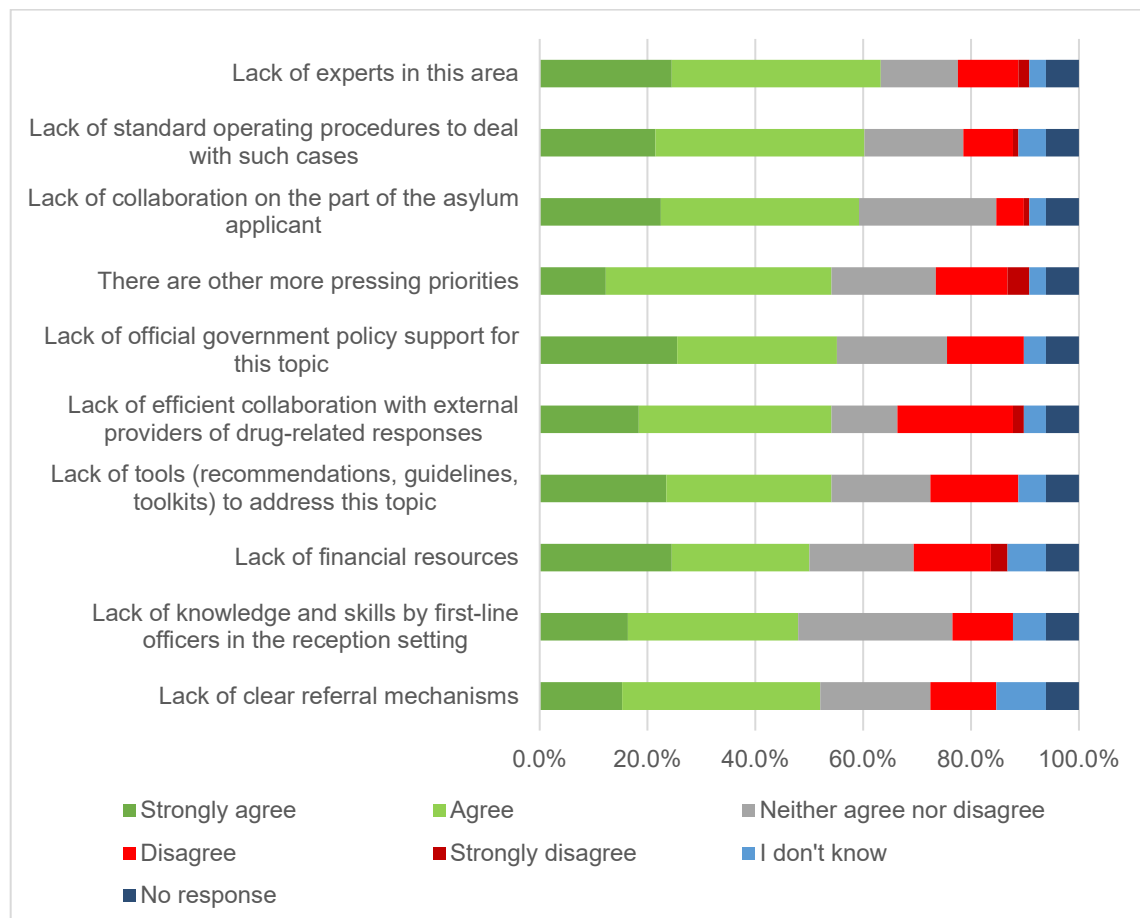
When asked about the main challenges or barriers that hinder the implementation of substance use-related responses in the reception setting, over half of respondents agreed that all of the given challenges and barriers contributed. The top three are listed below.

1. Lack of experts and expertise in the subject area (63 %)
2. Lack of standard operating procedures to deal with substance use cases (60 %)
3. Lack of collaboration on the part of the applicant (59 %)

In the open-ended follow-up question, respondents raised a number of additional reasons, such as the lack of political engagement and a lack of public debate on the subject ('asylum applicants are not a priority'), a lack of financial resources, a lack of time to deal with the subject, a lack of staff training, and applicants' need for translation. One respondent noted, *'It is a topic that most co-workers are afraid of'*. Another respondent stated that the implementation of substance use-related responses is difficult in transit countries: *'The main challenge is that my country is mostly a transit country for applicants so they don't stay long enough to implement substance use-related responses'*.

FIGURE 8

**According to your experience, what are the main challenges or barriers that hinder the implementation of substance use-related responses in the reception setting? (Q20)**



*During the focus groups, a majority of participants pointed to a lack of expertise on the topic of substance use and related responses among professionals working in reception facilities, noting that it was a barrier for implementing substance use-related interventions. They also pointed to limited accessibility in terms of health rights, administrative issues and distance from or absence of services near the reception setting, which can all hinder intervention among IP applicants.*

*Participants also highlighted a lack of prevention or difficulties in doing prevention when the living conditions of the individuals involved are already hard and they face competing problems. Challenging contexts for IP applicants sometimes include difficult reception conditions, which may contribute to additional trauma, stigma concerning PWUDs, and an unwelcoming environment for IP applicants. Several respondents emphasised that the reasons for substance use/misuse should be considered holistically and that reception conditions and policies can contribute to mental health and well-being and a reduced or increased risk of substance use/misuse within the target group.*

*A few participants pointed out that there is a lack of interpreters and mediators, which could be a reason why applicants do not seek help.*

*Finally, some participants noted that substance use-related interventions for applicants are not a political priority. Moreover, the collaboration between the policy domains of migration and health could be better coordinated at the national level.*

## **Policy support in targeting substance use among applicants for IP**

When asked whether there are any local or national policies targeting the implementation of substance use-related support in the population of applicants (Q15), a majority said no or admitted that they did not know (86.7 %). Some of the respondents who said yes were referring to general drug-related policies (n=4), law enforcement acts (n=4) or external coordination mechanisms provided by different governmental or non-governmental organisations (n=4).

## **Substance use-related support to applicants in reception settings**

### **Established procedures to support applicants**

The majority of respondents (59 %) indicated that there are none or that they do not know of any established procedures that they could apply in support of applicants with substance use-related problems. The remaining 41 % who responded positively pointed to collaboration between the reception settings and external partners, such as specialised health services provided by NGOs on a formal or informal basis. Some respondents mentioned that procedures do exist, but that a lack of coordination together with practical problems, such as waiting lists, language issues and a lack of adaptation of the available services to applicants' context and needs, may pose an issue for access to and retention in the services involved.

*'We established our own pathway for the application of mephenon© (methadone) by doctors, our own psychiatric nurses and a service of nurses for the medication.'*

*'There are informal pathways with drug treatment centres. However, there are still challenges concerning the need for timely medical services and for a culturally adjustable approach to the population of asylum applicants. Currently, we're working on the establishment of a formal partnership with the health authorities in this field.'*

## Training and intervention needs

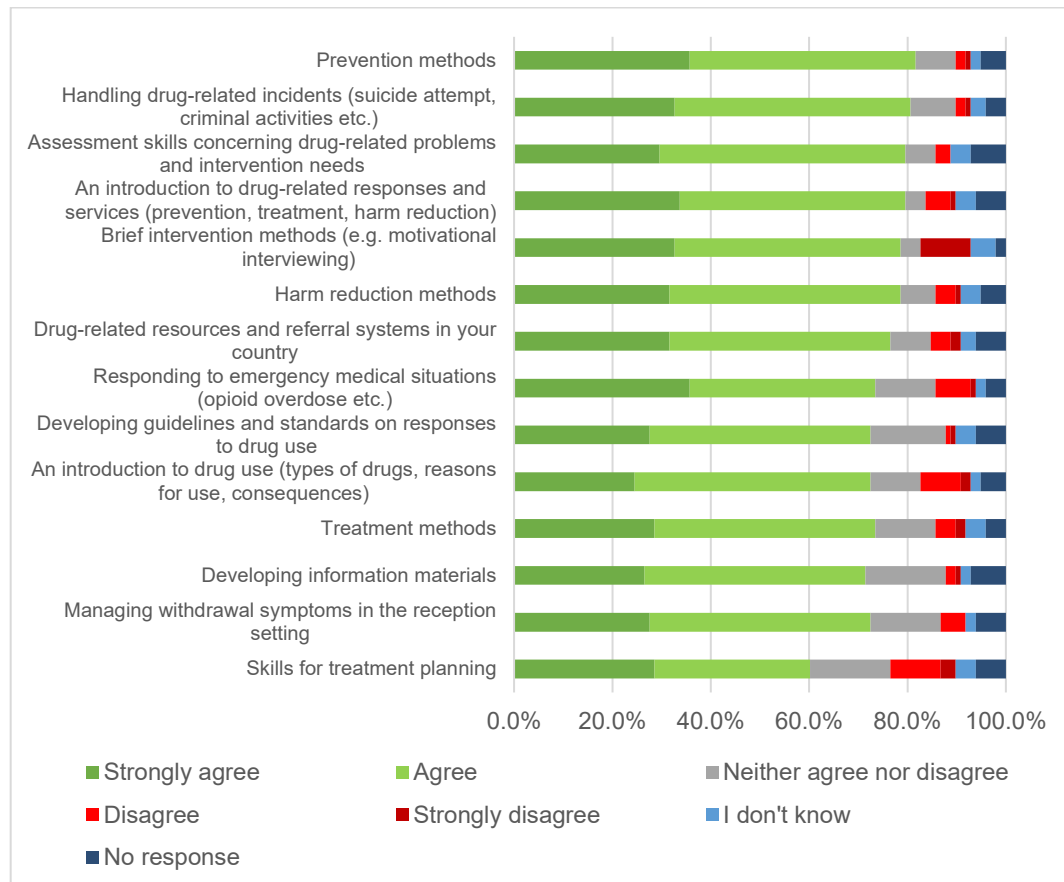
A majority of respondents did not receive any training on the topic of substance use among applicants (n=71, 72 %) (Q4), whereas 28 % did receive such training as a part of their work in the reception setting or their initial professional training.

Over half of respondents (62 %) indicated that they have few of the required skills and competences in the subject area, but would benefit from additional support and/or training to acquire the necessary skills and competences to address substance use among applicants. By contrast, 25 % of respondents felt confident about their skills and competences. In all function categories, respondents answered that they would benefit from additional support and/or training, although the need appears to be especially high among management (n=14), social support/social workers (n=13) and workers in logistics and administration (n=5).

When asked whether any substance use-related training is available for support staff in the reception facility where they work (Q17), the majority of respondents answered that this was not the case as far as they knew (n=61, 62.2 %). Respondents indicated that when substance use-related training is available, it is provided by organisations working in the drugs area, sometimes organised as a one-day training session held in the reception centres.

FIGURE 9

**Would training on any of the following topics enable you to better address drug problems among the applicants you work with? (Q19)**



In terms of training that would enable them to better address drug problems among applicants, respondents ranked a variety of suggested topics (see Figure 9). Notably, prevention (81.6 %) and handling substance use-related incidents (80.6 %) scored quite high. Treatment planning ranked lowest, but was still answered positively by 59 respondents (60.2 %).

An open-answer option allowed participants to indicate any other topics that they would find useful. By and large, the participants' answers confirm the mentioned domains. However, four respondents also note that they would like to acquire skills on how to approach and engage someone in a conversation concerning his or her substance use and how to provide both individual and social counselling (i.e. support in other life domains).

*Focus group participants were asked to share ideas on how substance use-related responses for IP applicants could be enhanced.*

- 1. Training on substance use-related topics to increase knowledge and awareness of professionals in reception settings (including medical staff) and professionals working with IP outside reception settings (including GPs in health centres)*
- 2. Governmental support for the topic in terms of resources, staff (including cultural mediators and drug counsellors) and access to health services*
- 3. Collaboration and coordination between*
  - a. Regional: reception setting and substance use-related settings*
  - b. National: policy domains of health and migration*
  - c. EU: professionals in reception settings across EU+ countries (creation of a community of practice)*
- 4. Prevention activities targeting applicants for international protection, including their engagement in meaningful activities, the creation of life perspective, and the provision of drug-related information*
- 5. Standardised screening procedures and early interventions*

*When asked what the EUAA and the EMCDDA could do to enhance substance use-related responses for IP applicants, participants mainly emphasised the need to create a network of information and knowledge exchange (i.e. a community of practice) between experts in different Member States. Participants felt the need to exchange experiences on new trends in drug use across Member States and the drug treatment options available for IP applicants, and they expressed a need to be consulted more to inform the agencies' actions in the subject area. They also raised a need for the provision of prevention tools, screening assessments, documentation guidelines, and support in their implementation.*

## Discussion and conclusions

This is the first European study to assess the needs and record the experiences of professionals working in reception settings in EU+ countries with respect to drug-related issues among IP applicants and related challenges. The results of the study are intended to inform future activities aimed at supporting the implementation of substance use-related responses in reception settings.

The survey (n=98) – including 21 EU Member States and Norway – was completed by managers, social workers, psychologists and reception officers who are active in the asylum and reception sector and are therefore the correct audience. To provide a more in-depth understanding of the survey results, the survey was supplemented by four focus groups involving medical doctors, nurses, psychologists and reception officers who have expertise in the drug field and/or who work with applicants.

### Perceived substance use: tobacco, alcohol, cannabis and medicines

The literature shows that much remains to be done in the domain of understanding substance use prevalence and interventions among applicants for IP in Europe. The few available European studies demonstrate that the prevalence of substance use is generally lower than it is for non-migrant populations but that it increases over time after arrival in Europe.

Almost 80 % of survey respondents regard drug use as a problem in their reception settings. They report that the use of tobacco, alcohol and cannabis is most common in the reception context, followed by misuse of medicines (obtained on prescription or not). The misuse of medicines, including opioid-based medicines (e.g. Tramadol©) pregabalin (Lyrica©), buprenorphine (Subutex©) and benzodiazepines such as clonazepam (e.g. Rivotril©), was specifically highlighted as an area of growing concern.

In addition, participants confirm the view that the types of substances used by applicants for IP are linked with substance use habits in both the reception country and the home country of applicants. One implication is that prevalence and patterns of use may well vary significantly across Member States (also depending on available drug treatment protocols) as well as by the migration history of IP applicants. As a consequence, Member States may require a range of tailored responses to meet their specific situation and needs. This should be based on a proper needs assessment and a definition of the barriers and facilitators to the implementation of drug-related responses in each specific reception context.

Among those most at risk of substance use, respondents highlight single young men, including unaccompanied minors and those who face long waiting times for the asylum decision and uncertainty about the outcomes of the asylum procedure.

### Need for assessment, early intervention and harm reduction alongside prevention and referral to substance use treatment

Both survey and focus group respondents report that there is currently no standardised way of assessing substance use in reception settings and this is confirmed in the literature (Marth et al., 2021). Where assessment occurs, it usually takes place as part of the (medical) intake procedure or the vulnerability assessment.

With regard to interventions addressing substance use in the reception context, the main response is reported to be referral to mainstream treatment services.

Nevertheless, referral is not always successful because of the lack of accessibility to specialised services (e.g. related to language barriers, lack of health insurance, and special fees to be covered) or the lack of referral protocols (Kohlenberger et al., 2019; Nikendei et al., 2019; Björkenstam et al., 2020; Führer et al., 2020; De Kock 2021).

The challenge of increasing access to substance use-related and (mental) health services emerges as a high priority for reception centre staff. They explain that waiting lists, language barriers and a lack of cultural adaptations of the available interventions are a threat to the accessibility of the services involved. In addition, the geographical accessibility of the services or the absence of services in the community can be a problem.

In countries considered transit destinations by applicants for IP, substance use interventions may be hampered, as authorities may have less capacity to work with target groups that they believe will spend only a short time in their country. The risk lies in missing a need, failing to seize on the opportunity to provide support, and especially not following through on continuity of care for those in treatment.

Additionally, a need was flagged for more prevention and awareness raising in reception settings. Still, a lack of experts in the subject area and a lack of collaboration on the part of the applicant are pointed out as the main barriers to implementing such interventions.

Overall, respondents were supportive of investing in substance use prevention, treatment and harm reduction responses, and saw the many potential benefits both for applicants and for staff in reception settings. Specifically, there was a clear need expressed by reception staff related to screening procedures, including the development or adaptation of existing assessment tools, recommendations for standard operating procedures, referral paths and the sharing of good practices.

More broadly, addressing substance use problems among applicants for IP needs to be prioritised at the policy level with more collaboration between the policy domains of migration and health. Also, asylum and drug services need to cooperate in order to implement adequate responses.

EU-level cooperation aimed at community creation and the sharing of knowledge and good practice was also stressed as necessary in responding to drug-related problems in the context of reception settings.

Focus group participants highlighted the need to view substance use among applicants for IP from a holistic perspective by tackling its root causes, which are often closely related to post-migration factors and the conditions in host countries.

## **A need for training for professionals in the reception setting**

While professionals overall reported some basic knowledge of drug-related issues, a majority indicated that their knowledge was insufficient to deal with substance use-related issues in the reception setting. For example, over 70 % of respondents were unaware of the fact that the administration of naloxone could reverse the deadly consequences of an overdose. The need for more training was highlighted in a number of key areas, including implementation skills in prevention interventions (e.g. awareness raising, dialogue skills, etc.) and in harm reduction and treatment interventions (e.g. assessment skills, opioid agonist treatment, naloxone to reverse overdose consequences), as well as the acquisition of more insight into contemporary trends in drug use. A future training offer should therefore be tailored to the needs of different staff profiles in view of their responsibilities within the

reception context and the respective substance use prevention, referral and intervention efforts that are needed.

## Ways forward

Based on the study results and the needs expressed by professionals in supporting their work on substance use-related problems in the reception context, recommendations for medium- and long-term developments are set out below in three main areas: capacity building, response development and implementation, and research and monitoring.

### Capacity building

- Development and/or adaptation of training materials concerning substance use and responses among IP applicants tailored for different groups of reception professionals and aimed at increasing awareness and understanding of substance use problems, social and structural determinants of health in substance use disorders among applicants, and the planning and implementation of adequate drug-related responses.
- Creation of a community of practice for experts from different disciplines and fields – primarily asylum/reception and drug professionals – to share knowledge, including information on drug use and drug-related trends and experience in delivering drug-related responses in the reception context.

### Response development and implementation

- Development and/or adaptation of substance use screening and assessment tools as well as related standard operating procedures to facilitate the organisation and support provided to IP applicants with substance-related problems in the reception context.
- Development of joint European guidance to facilitate the delivery of evidence-based drug-related prevention interventions and other responses in the reception context with a specific focus on guiding principles, quality standards and key components of interventions and their adaptations to specific populations and settings.
- Development of a compendium of good practices for addressing drug use and related problems among applicants for IP in the European Union. The compendium should be informed by mapping the tools and practices already implemented at the international, national and community levels in the areas of planning, adaptation, implementation and evaluation of interventions targeted at asylum seekers and refugees in the reception context, giving special attention to specific profiles such as unaccompanied children, women, young people and staff.

### Research and monitoring

- Further efforts in monitoring and research to deepen knowledge of the phenomenon and provide an evidence base for designing and implementing relevant and context-specific drug-related responses to applicants for IP.
- Future research and monitoring to be focused on the health needs of applicants for IP, including drug use and related problems, as well as barriers and facilitators at macro, meso and micro levels with respect to the implementation of responses.



- Finally, where specific needs are identified, new services for prevention and treatment need to be developed and evaluated in order to expand the currently limited evidence base.

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