

# REPORT on Services for vulnerable Migrants who use Drugs in the EU (SEMID-EU)

**Prepared by:** ISGlobal (Lena van Selm, Trenton M White, Jason Doran, Christina Pujol, Camila A Picchio, Jeffrey V Lazarus) as part of the SEMID-EU project team.

**Funding:** European Commission

Vers: 3 November 2022

**Disclaimer:** The content of this report represents the views of the author only and is his/her sole responsibility. The European Commission does not accept any responsibility for use that may be made of the information it contains.

## Introduction

Europe has a long history of migration, including migration into Europe and between member states. A migrant has been defined by the United Nations as “any individual who lives in a country temporarily or permanently apart from his or her usual place of residence for at least a year.”<sup>1</sup> When describing the health issues of migrants, it is important to differentiate between the different categories of people covered by the term ‘migrant’, since different categories can encompass different characteristics and needs. Research and policy papers regularly refer to several categories of migrants, such as immigrants, economic migrants, labour migrants, refugees, internally displaced persons, unaccompanied minors, sans-papiers (undocumented migrants,) and asylum seekers. In this report, we employ the term migrant to refer to all types of first-generation migrants, including undocumented migrants, unless there is a particular reason to use a more specific term. European Union (EU) member states recognise the right to health for migrants, which includes that member states “refrain from denying or limiting equal access for all persons, including migrating persons, to preventive, curative and palliative health care.”<sup>2</sup> In practice however, this basic human right has not been fully implemented in many EU countries. Asylum-seekers and undocumented migrants, in particular, face barriers in accessing healthcare services.<sup>3</sup>

As of January 2021, about 5.3% of the EU’s total population consisted of (non-EU citizen) migrants, with an estimated 23.7 million documented non-EU citizens living in the EU.<sup>4</sup> Since the 1990s, many economic migrants have moved from central, eastern and south-eastern Europe to Western Europe. Between 1990 and 2015, almost 20 million people left the central, eastern and south-eastern Europe region; and 80% of these migrants left for western Europe.<sup>5</sup> In 2015 and 2016, migration to the EU from Middle Eastern and sub-Saharan African countries peaked, driven in part by high levels of conflict in these regions. In 2019, 3 million persons were issued a first residence permit in the EU.<sup>6</sup> In 2022, nearly 5 million refugees have been estimated to have fled conflict from Ukraine into Europe.<sup>7</sup>

People who use drugs need access to specific healthcare and social services. Although many migrant groups in Europe have lower rates of substance use than host populations, several risk factors make them particularly vulnerable to engaging in problematic drug use.<sup>8</sup> These include traumatic experiences during the migration journey (e.g. dangerous travel, violence, including race- and gender-based violence), as well as after migration (e.g. trauma from racial discrimination and stigma<sup>9</sup>), social disengagement (exacerbated during the pandemic), unemployment, and poverty. Migrants who are single and/or alone and those who migrate from a culture where the use of a specific substance is more common (e.g. opium) are at increased risk for problematic drug consumption in their new host country.<sup>10</sup> This vulnerability can be further aggravated by poor



knowledge about and access to treatment services,<sup>7</sup> as well as higher treatment drop-out rates;<sup>11</sup> language barriers; lack of social protection (i.e., health insurance and other social security benefits); and/or fear of experiencing stigma and discrimination, including deportation, for seeking information or support.<sup>12</sup>

European cities witness a growing number of migrants at risk of using drugs and who suffer from general health issues as well as from specific diseases, such as HIV, hepatitis C, and tuberculosis,<sup>13,14</sup> with often limited access to health and social services, including essential harm reduction and drug treatment services. For example, a study conducted in France found that repression of people who use drugs in their countries of origin influenced many eastern Europeans who use drugs, mainly from Armenia, Georgia, the Russian Federation and Ukraine, to migrate into the EU.<sup>15</sup> In addition, many migrants are currently entering the EU from Ukraine, a country with relatively high levels of injecting drug use. Recent estimations suggest that between 3,848 and 15,391 people who inject drugs have fled from Ukraine to different EU countries. Although, to date, most migrants are women and children and initial information suggest that the numbers of drug users within the migrant population is low, these dynamics might change over time with for example more men migrating.<sup>16</sup> Finally, a global survey conducted by the World Health Organization (WHO) among migrants and refugees reported that as a result of the COVID-19 pandemic, the use of drugs and alcohol increased by 20%.<sup>17</sup> Despite this increase of migrants at risk of using drugs in the EU, little information is available on the actual drug use among and characteristics of this population. In addition, the use of and access to healthcare services for migrants who use drugs remains largely unknown.

## Aim

1. To assess drug use characteristics and care issues affecting migrants who use drugs, including the identification of individual service access and service user issues; and
2. To provide a baseline characterization of existing services for migrants who use drugs in the EU, including the identification of health system barriers or limitations to their access and use.

## Methods

### *Systematic Literature Review*

The databases Pubmed/Medline, Cochrane Library, PsychInfo and CINAHL, were searched using the search terms shown in **Table 1**. Four hundred fifty-eight unique studies were identified and reviewed based on title and abstract by two different researchers (LvS and JD). Inclusion criteria were all studies published from 1 January 2010 to 30 April 2022 that included information on illicit drug use among first-generation migrants within the EU and the United Kingdom (UK). Illicit drugs are defined as drugs for which non-medical use has been prohibited by international drug control treaties.<sup>18</sup>

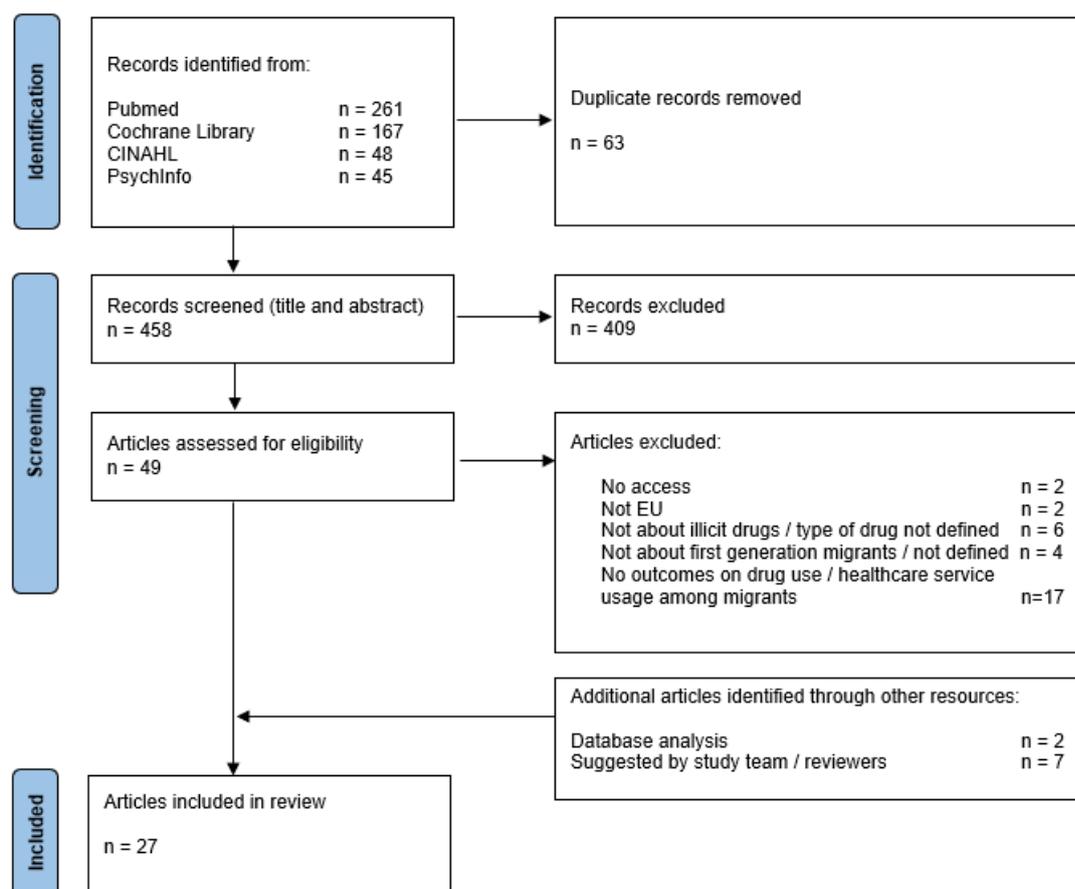
**Table 1: search terms**

Search	Query
#1	"Europe" OR "Austria" OR "Belgium" OR "Bulgaria" OR "Croatia" OR "Cyprus" OR "Czech Republic" OR "Denmark" OR "Estonia" OR "Finland" OR "France" OR "Germany" OR "Greece" OR "Hungary" OR "Ireland" OR "Italy" OR "Latvia" OR "Lithuania" OR "Luxembourg" OR "Malta" OR "Netherlands" OR "Poland" OR "Portugal" OR "Romania" OR "Slovakia" OR "Slovenia" OR "Spain" OR "Sweden" OR "United Kingdom" OR "England" OR "Wales" OR "Scotland"

#2	“Migrant*” OR “Immigrant*” OR “Migration” OR “Asylum seeker*” OR “Refugee*” OR “displaced persons” OR “sans papiers”
#3	“drug misuse” OR “drug abuse” OR “drug related disorders” OR “drug dependence” OR “substance dependence” OR “substance misuse” OR “substance abuse” OR “substance related disorders” OR “amphetamine related disorders” OR “cocaine related disorders” OR “crack cocaine” OR “heroin dependence” OR “morphine dependence” OR “opioid related disorders” OR “street drugs” OR “intravenous” OR “addict*” OR “drug related”
#4	#1 AND #2 AND #3

Forty-nine studies were selected for full-text assessment by the same two researchers. Studies were excluded if: a) drugs / addiction was not defined or if no separate findings were presented for illicit drugs (e.g. alcohol, cannabis and illicit drugs presented combined); b) migrant population was not defined or no separate findings presented for first-generation migrants; c) if main study outcomes were not directly related to drug use among migrants or access to healthcare among migrants who use drugs; and d) if the study was not conducted in the EU or the country was not clearly defined (see **figure 1**). Additional relevant articles were searched by manually searching for references and reviewing the grey literature via Google Scholar and via suggestions from the research team and reviewers.

**Figure 1: PRISMA flow diagram.**



### *Database analysis*

Eight European Union (EU) countries were purposely selected for a rapid database review: Denmark, France, Germany, Greece, Hungary, Italy, the Netherlands, and Poland. The four project countries of the SEMID-EU intervention were selected as well as four additional countries, aiming to create a more representative country for the EU as a whole. The database review aimed to identify available information on epidemiological data on drug use among migrants in the EU, the health and support needs of these populations and the quality of services offered. We searched the Institute for Health Metrics and Evaluation's Global Health Database (GHDx), which hosts source data for Global Burden of Disease (GBD) studies for the selected countries between 2010 and 2022, using GBD's relevant pre-existing keywords, specifically, "domestic migration", "international migration", "drug consumption", "drug use disorders", "illicit drug use", "cocaine use disorders", "cannabis use disorders", "opioid use disorders", "amphetamine use disorders", "alcohol use disorders". The GHDx contains databases on vital registration, demographic and epidemiological surveillance, administrative and census data, and published studies. In addition, for these eight countries the national focal points of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) were contacted to request relevant databases or information. Finally, a panel of 57 experts on migration and / or drug use were asked whether they were aware of any surveys, studies, databases, cohorts or other aggregated data for the selected countries.

The identified information was assessed for containing the following information: 1) epidemiological data on drug use among migrants; 2) healthcare services for migrants who use drugs data; 3) data on healthcare service use; 4) data on access to services for migrants who use drugs. In addition, the databases were assessed for cultural competency data and service quality data. Cultural competency was defined as containing information services for migrant women or drug users, languages spoken at the healthcare centre, and/or training provided for healthcare workers working with people with migration or minority ethnic backgrounds. If databases were expected to include relevant data based on the initial database assessment access was requested and the data were reviewed.

## **Results**

### *Systematic literature review and database analysis*

Eighteen studies identified through the literature search were selected for inclusion. Searching the GHDx, a total of 85 databases and studies were identified for Denmark (5 databases, 1 study), France (12 databases, 1 study), Germany (6 databases, 5 studies), Greece (8 databases, 2 studies), Hungary (5 databases), Italy (15 databases, 2 studies), the Netherlands (3 databases, 3 studies, 1 webpage) and Poland (8 databases, 8 studies). Access to the "Survey of Health, Ageing and Retirement in Europe (SHARE)" database was obtained for further in-depth assessment, but no data on migrants and drug use were identified. Finally, none of the databases and two studies (by Schulte *et al.* and Wenz *et al.*) identified by the GHDx database analysis, were included for analysis. Of the eight EMCDDA focal points contacted, those from Hungary and Poland declared not to have any specific information on migrants who use drugs, France reported to be conducting a study on the situation of unaccompanied minors and drug use in the country and the other focal points did not respond. Finally, eight members of the expert panel responded to the question on identifying databases and other relevant information sources. After review by the writing team, most suggestions were not included since they did not contain relevant information on migrants and drug use. Finally, two Belgian studies were selected for analysis.

A total of 27 studies identified by the systematic literature review (n=18), the database analysis (n=2) and suggested by project team members and reviewers (n=7) were included for analysis. An overview of these studies is shown in **Table 2**. Studies were conducted EU wide (n=2), in the Nordic countries (n=1), Germany (n=7), Sweden (n=5), Belgium (n=2), France (n=2), Italy (n=2), Spain (n=2), Austria (n=1), Finland (n=1), Portugal (n=1) and the Netherlands (n=1).

#### *Drug use in migrant populations versus in the general population*

Prevalence data on drug use among migrant populations compared to the general population in the EU varies widely between and within countries (**Table 3**). For example, a French national study found lower levels of harmful substance use (psychostimulants, opiates, hallucinogens, volatile solvents, cannabinoids, sedatives and / or anabolic steroids) among first-generation migrants compared to the general population (0.31% versus 0.56%).<sup>19</sup> From a sample of people who inject drugs in eight German cities, migrants made up between 9.2% (Leipzig) and 30.6% (Berlin) of the sample,<sup>20</sup> which was higher than the percentage of migrants in the general population: 7.8%-8.9% between 2011-2014.<sup>21,22</sup>

On the other hand, in Italy, among people with tuberculosis, young migrants were less likely to inject drugs than those born in Italy.<sup>23</sup> Similarly, a Swedish nationwide registry study among people living with HIV (PLHIV) and HIV-negative people showed that, in 2016, from the total sample of migrants living with HIV, 2% were former or present injecting drug users compared to 12% in the Swedish-born population, while in the Swedish HIV-negative population the prevalence of injecting drug use was estimated to be about 0.08%.<sup>24</sup> Likewise, from the people experiencing homelessness that attended specialized services for (n=1072) in Gerona, Spain, migrants (N=619, 57.7% of the total sample) suffered less from opiate dependency compared to Spanish natives (19.1% versus 31.4%), while no significant differences were found in dependency on cocaine, cannabis or hypnotics nor in the prevalence of psychoactive substance use disorders.<sup>25</sup> In addition, the level of poly-consumption was higher among Spanish native homeless than among migrant homeless (32.9% versus 20%).<sup>25</sup> However, another Spanish study among people who inject drugs in Catalonia, found that migrants were more likely to use both heroin and cocaine (11.3%) compared to natives (8.9%).<sup>26</sup> In Italy, migrant heroin users were less frequently poly-users than Italian heroin users (30% versus 73%) but were more often found to be in stage 3 of heroin addiction, defined as a stage where the individual is completely oriented towards substance seeking by any means (93% versus 23%).<sup>27</sup> Compared to Belgian nationals, non-nationals were 4.40 times more likely to be admitted to drug dependence services with opioid as a primary substance and 1.48 times more likely to have cocaine as a primary substance. Belgian clients were more likely to have stimulants (OR = 4.60) or hypnotics (OR=1.53) as a primary substance.<sup>28</sup>

**Table 3: Drug use among migrants versus among the host population**

Country	Author	Population	Sample size	Type of drugs	Drug use in migrants vs nationals
Belgium	De Kock <i>et al.</i> <sup>28</sup>	People using drug dependency services	32,715	Opioid, cocaine	Higher
Belgium	De Kock <i>et al.</i> <sup>28</sup>	People using drug	32,715	Stimulants, hypnotics	Lower

		dependency services			
France	Guardia <i>et al.</i> <sup>19</sup>	General population	27 242 non-migrants and 1911 (first generation) migrants	Psychostimulants, opiates, hallucinogens, volatile solvents, cannabinoids, sedatives and / or anabolic steroids	Lower
Germany	Wenz <i>et al.</i> <sup>20</sup>	People who inject drugs	2077	Injecting drugs use	Higher
Italy	Ingrosso <i>et al.</i> <sup>23</sup>	People with tuberculosis	7817 migrants	Injecting drug use	Lower
Italy	Maremmani <i>et al.</i> <sup>27</sup>	People who use heroin	30 migrants and 30 non-migrants	Poly-drug use	Lower
Spain	Calvo <i>et al.</i> <sup>25</sup>	People experiencing homelessness	1072	Opiates	Lower
Spain	Calvo <i>et al.</i> <sup>25</sup>	People experiencing homelessness	1072	Cocaine, cannabis or hypnotics nor in the prevalence of psychoactive substance	No difference found
Spain	Saigí <i>et al.</i> <sup>26</sup>	People who inject drugs	309 migrants and 439 non-migrants	Heroin and cocaine	Higher
Sweden	Carlander <i>et al.</i> <sup>24</sup>	People living with HIV	1873 people living with HIV and 4428,778 HIV-negative individuals.	Injecting drug use	Lower

### Characteristics of migrants who use drugs

In Catalonia, Spain, compared to Spanish-born injecting drug users, migrants who inject drugs were found to be younger, higher educated and more likely to live alone. They started injecting at a later age, injected more frequently with less syringe sharing and their perceived health status was poorer, compared to Spanish-born injecting drug users.<sup>26</sup> All migrants who use heroin included in an Italian study suffered from post-traumatic stress disorder in more severe forms than their Italian counterparts. In addition, they more frequently reported life events and losses that are potentially traumatic.<sup>27</sup> In France, Russian-speaking migrants that use drugs had a higher education level than French-speakers that use drugs (43.0% versus 27.6% had followed post-secondary education). However, Russian-speakers more often lived in precarious situations (i.e. in squatting properties or living on the streets or in non-profit housing), compared to their French counterparts (89.9% versus 49.3%). Russian-speakers more often consumed cocaine (45.7% vs 26.8% for French-speakers), heroin (38.6% vs 16.4%) and morphine sulphates (30.9% vs 19.2%) and used less crack (18.2% vs 41.8%). Concerning injecting drug use, almost all Russian-speakers that use drugs had injected at least once in their life (95.5% vs 62.1% of French speakers) and 75.0% had injected at least once in the last month (versus 24.2% of French speakers). In addition, reported shared syringe or needles during the life was similar to Russian-speakers (62.3%) versus French-speakers (64.4%). Finally, the

level of HCV seroprevalence in Russian-speakers (88.5%) was twice as high as in French-speakers (44.3%).<sup>29</sup>

#### *Country of origin and differences between migrant populations*

From the 27 studies included, 16 included information on the country of origin of the included migrants. The largest groups per study were from former Yugoslavia states (n=3), eastern Europe (n=3), Russia (n=3), North Africa (n=2), Iran (n=2), Afghanistan (n=1), Brazil (n=1), Georgia (n=1), Lithuania (n=1), Syria (n=1), Turkey (n=1), Ukraine (n=1), the Maghreb countries (Algeria, Libya, Mauritania, Morocco, and Tunisia; n=1) and sub-Saharan Africa (n=1). A complete overview is included in **Table 3**.

Few studies compared drug use among migrant populations. In Finland, a study among Russian, Kurdish, and Somali migrants found that current or previous injecting drug use was very rare in all groups.<sup>30</sup> In Spain, migrant injecting drug users from eastern Europe tended to be younger than migrants from other countries (59% versus 42% were 20-33 years old) and had been in Spain for a shorter period of time (76% versus 45% arrived within the last 5 years). They had a higher education level (89% versus 78% had completed at least secondary level education) and had a higher employment rate (29% versus 18%). Finally, they used higher proportions of heroin, had better-perceived health status, and lower use of drug treatment centres (28% versus 49%).<sup>26</sup>

#### *Initiation of drug use*

In Spain, most migrants started using drugs in their country of origin (77% of eastern European migrants and 75% of migrants from other countries).<sup>26</sup> Similarly, in Germany, from a sample of 116 Irani and Afghan refugees that use drugs, 55.2% became drug dependent in their home countries before arrival to Germany. Over half of this group had undergone drug dependence treatment in their home country and 34% bought methadone for withdrawal symptoms during the journey to Germany.<sup>31</sup> In Spain, from migrants who started using illicit drugs in their country of origin, 84% from eastern Europe and 71% from other origins had arrived within the last 5 years. Migrants who started using in their host country had spent more time in Spain, with 59% from eastern Europe and 16% from other origins having arrived in the last 5 years. In addition, migrants who started using illegal drugs in their host country generally started using at a later age, with 85% and 90% being over 20 years at the time of their first drug injection for eastern Europe and other origins, respectively, while for migrants who started in their country of origin this was 35% and 33%.<sup>26</sup>

Eastern European migrants who inject drugs that started in their country of origin used heroin alone in 97% of the cases, while the ones that started in Spain injected either heroin alone (54%) or together with cocaine (29%). Injecting drug users migrating from non-eastern European countries who started using in their country of origin also mainly used heroin (76%), while the ones that started in Spain more frequently injected cocaine (44%). Irrespective of the country where they started using, eastern European migrant injecting drug users mainly used cocaine plus heroin, while migrants who inject drugs from other countries mainly used cocaine alone.<sup>26</sup>

#### *Factors associated with drug use among migrants*

A Swedish study found that for both migrants and native-born Swedes' neighbourhood poverty was associated with drug abuse.<sup>32</sup> In several countries it was found that migrant drug users had lower incomes or employment rates compared to native-born drug users. In Italy, compared to native Italian heroin users, migrants who use heroin more often reported an inadequate income level, somatic complications and legal problems.<sup>27</sup> However, a Swedish study found that HIV-positive

migrants that were formerly or currently injecting drugs had a higher probability of being employed compared to their Swedish-born counterparts.<sup>24</sup>

Having a social network and being religious are associated with reducing the risk of substance abuse. In Sweden, immigrants living in an area with a high concentration of immigrants had a lower risk of officially-recognized drug involvement while native-born Swedes living in neighbourhoods with high percentages of immigrants had a higher risk of officially-recognized drug involvement.<sup>32</sup> Male Syrian refugees in Germany reported that substance abuse is widely rejected by social, religious (Islam), and family norms in Syria. Therefore, family cohesion was reported as the main reason for preventing substance abuse.<sup>33</sup> This is in line with the finding that in Spain most migrant drug users were found to live alone.<sup>26</sup> In addition, in an outpatient clinic for transcultural psychiatry and migration-related disorders in Vienna, Austria, it was found that substance use was more common among migrants that were not religious (10.2%), versus Muslims (4.1%), Christians (6.9%), Jews (7.8%) and other religions (10%).<sup>34</sup>

Reasons for substance abuse reported by Syrian refugees are escaping from memories of traumatic events and feelings of loneliness, boredom and lack of connection experienced as a result of the present reality in the host country.<sup>33</sup>

#### *Hospital admission and mortality*

Studies on hospital admission and mortality related to substance misuse in the Nordic countries show varying results. Two studies in Sweden found that refugees identifying as male were at higher risk of hospital admission related with substance misuse compared to Swedish-born males, while for refugees identifying as female the risk was found to be lower compared to Swedish-born females.<sup>35,36</sup> Likewise, refugees in Denmark had a higher risk of hospital admissions with a substance abuse diagnosis compared to Danish-born men. For refugee women in Denmark and for both men and women in Norway these risks were similar to those for locally-born people of the same sex.<sup>36</sup> On the other hand, a Swedish longitudinal registry study (n= 15,012) found that migrants born outside the Nordic countries were 61% less likely to die of the effects of drug use compared to the native Swedish population.<sup>37</sup>

#### *Availability of drug dependence services for migrants*

Between 2007-2010, Welbel *et al.* conducted questionnaires to identify mental health care services in 14 EU countries: Austria (Vienna), Belgium (Brussels), The Czech Republic (Prague), France (Paris), Italy (Rome), Germany (Berlin), Hungary (Budapest), Ireland (Dublin), The Netherlands (Amsterdam), Poland (Warsaw), Portugal (Lisbon), Spain (Madrid), Sweden (Stockholm), and the United Kingdom (London). Sweden and Hungary were excluded from the analysis due to a low number of services identified and a low response rate. In the remaining 12 countries, 30% of the services provided drug dependence treatment, with Amsterdam (49%) and Warsaw (43%) scoring highest and Lisbon (19%), Vienna (17%) and Prague (11%) scoring lowest. In addition, it was found that in 20% of mental health services drug dependence was an exclusion criterion from receiving treatment. This was mainly the case in Lisbon (43%), Amsterdam (38%), Berlin and Rome (both 27%) and the lowest percentages were found in Madrid (12%) and Paris (7%). In all countries, of the drug dependence treatment services identified (n=180) 60% offered services for both alcohol and drug dependence, while others offered specialized alcohol (25%) or drug (17%) treatment. Specialised drug dependence services for refugees/asylum seekers were identified in 8 out of 12 of cities: Berlin (4), Amsterdam (3), Rome (3), London (2), Paris (2), Vienna (2), Dublin (1) and Warsaw (1), but not in Brussels, Lisbon, Madrid and Prague. Furthermore, drug dependence services targeting undocumented migrants were found in 6

out of 12 of cities: Berlin (2), Rome (2), London (1), Paris (1), Vienna (1) and Warsaw (1). Overall, among all centres offering addiction treatment, 10% included addiction services for refugees/asylum seekers and 4% for undocumented migrants.<sup>38</sup> Although the multicounty study did not identify addiction services for migrants, the study by Santos *et al.* on mental health and undocumented migrants in Portugal reports that the refugees included in the study were treated at integrated drug dependence centres, receiving methadone and buprenorphine treatment.<sup>39</sup>

#### *Use of drug dependence services among migrant populations*

Several studies found migrants to be underrepresented in drug dependence services. An analysis of drug dependence service data in Germany found that first-generation migrants were underrepresented in drug dependence services compared to their representation in the general population. In 2012, the users of these services being migrants was 9.1%, compared to 13.4% of migrants in the general population.<sup>40</sup> Likewise, migrant opioid users in Germany were underrepresented in opioid substitution treatment services, compared to German-borne opioid users.<sup>41</sup> Among first-generation migrants, men were underrepresented in drug dependence services for stimulants, sedatives and cannabis, but slightly overrepresented in cocaine and opioid services, while women were underrepresented in all categories. These findings were stable over time (2007-2012).<sup>40</sup> In Catalonia, Spain, migrant injecting drug users were also found to make less use of drug treatment centres.<sup>26</sup> In France, half (49.9%) of Russian-speaking migrants that use drugs engaged in substitution treatment, compared to 75.6% of the French-speakers.<sup>29</sup> In a national Swedish cohort study, no significant differences were found between immigrants and the host population in addiction treatment use.<sup>42</sup>

Although migrants are often underrepresented in drug dependency services, an analysis of non-German offenders under custodial drug dependence treatment in accordance with the § 64 German Criminal Code (StGB) found that the percentage of non-Germans involved in court orders (14.4-18.1%) was almost twice as high as expected based on the percentage in the general population (8.8-9.7%). In addition, between 2010 and 2015 this proportion grew 2.5 times more than the increase on non-German persons in the total population.<sup>43</sup> However, among women non-Germans are underrepresented, making up 9.2% of the total 64 convictions versus 16% of the total population. Non-German offenders are overrepresented in convictions between three and ten years, but underrepresented in convictions between six months and two years.

Finally, a report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) addressing drug-related needs of displaced Ukrainians estimates that the number of people who were receiving opioid agonist treatment (OAT) in Ukraine arriving in neighbouring EU countries is relatively low (195-782). However, these data are difficult to estimate and the increased use of drug dependence services could impact existing OAT services in host countries. For example, in Hungary, Romania or Poland, the arrival of the projected amount of displaced people in need of OAT treatment could represent a 20% increase in use of services.<sup>16</sup>

A study identifying support needs among Irani and Afghan refugees that use drugs in Germany showed a high willingness of engagement in drug dependency services. Seventy-five percent reported wanting to receive detoxification treatment, 54% wanted withdrawal treatment and 43% opioid substitution therapy (OST). In addition, 52% wished for support with the asylum application and 51% for help with housing.<sup>31</sup>

### *Accessibility of drug dependence services for migrant populations*

A Belgian study interviewing substance use and migration experts and coordinators of substance use treatment services identified several factors related to the underrepresentation of non-nationals in these services. The majority reported that people not speaking Dutch were excluded from treatment in most residential treatment services (e.g. therapeutic communities, psychiatric hospitals). However, there were differences between types of residential treatment services. In psychiatric units of hospitals, for example, subsidized translators were available, while in psychiatric hospitals translational services were not subsidized and generally not available.<sup>44</sup> Likewise, staff working in harm reduction services centres in the Netherlands reported that, for migrants from Central and eastern Europe, language often forms a barrier to effective treatment, despite the option to use interpreter services. In addition, these populations often live in closed communities with other drug users from the same countries and often limited knowledge about and little affinity with Dutch drug addiction care services.<sup>45</sup>

Other barriers to care that were mentioned by Belgian substance use and migration experts were not having insurance, cultural barriers and a lack of knowledge about services. In addition, participants mentioned that general practitioners may not refer non-national clients to residential services if they expect they will not be admitted.<sup>44</sup> The main reasons reported by Syrian refugees in Germany for not accessing substance abuse treatment were stigma and shame.<sup>33</sup> In Germany, counsellors working in substance dependency care described access for undocumented migrants to these services as “problematic”. The main barriers they mentioned were lack of health insurance coverage and the difficulty to obtain accommodation in emergency shelters or to apply for social assistance. Undocumented migrants who received substance dependency care were granted access by the municipality on a case-by-case basis; however, and only exceptionally so. For migrants with temporary permits (up to six months) financing for substance dependency treatment was also difficult to obtain since insurances often do not cover all required services for people with a temporary permit. Other factors that were mentioned to be barriers to accessing care were fear of deportation and the lack of a working permit leading to an unstructured life.<sup>46</sup>

Bad experiences with drug dependency services in the country of origin can be a barrier to accessing care in the host country. Among Irani and Afghan refugees that use drugs in Germany, who did not receive any drug treatment in their home country 94% wanted to engage in detoxification treatment, while this was only 72% for people with detoxification experience in their home country and 40% for people with substitution treatment in their country of origin. Five refugees from Iran described detoxification treatment in their home country as “fenced and guarded camps” where people with drug dependence were withdrawn from substances without medical support.<sup>31</sup>

### **Conclusions**

This literature review first assessed the available information on prevalence of drug use among migrants as well as describing the characteristics of migrants who use drugs. Next, initiation of drug use and risk factors for engaging in drug use were analysed. Finally, availability, accessibility and use of drug dependency services among migrants who use drugs were described.

#### The main conclusions are:

- Prevalence data on drug use among migrant populations compared to the general population in the EU varies widely between and within countries.

- Migrants from eastern Europe, Russia and the former Yugoslavia / the Balkan states were the mostly represented groups among studies on migrants who use drugs in the EU.
- Poverty, living alone and trauma are risk factors for substance use among migrants, while religion and having a social network reduce the risk of substance abuse.
- Reasons for drug use among migrants include escaping from painful memories and loneliness, boredom, and lack of connection.
- Among drug dependence services studied in 14 EU capitals, only 10% included addiction services for refugees/asylum seekers and 4% for undocumented migrants.
- Migrants are often underrepresented in drug dependence services compared to their representation in the total population of their host countries.
- The main barriers to accessing drug dependency care were language, legal (including not having insurance) and cultural barriers. Other barriers were lack of knowledge about services, difficulty applying for social assistance, living in closed communities with other MWUD, stigma and shame and bad experiences with drug dependency services in the country of origin.

## References

1. Van Der Werf, J. *et al.* Public health guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA Public health guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA ii This report from the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori, with the support of Marieke.
2. Pace, P., Shapiro, S., Peiro, M. J. & Benedict, R. Migration and the Right to Health in Europe International Organization for Migration (IOM) Background Paper.
3. Rechel, B., Mladovsky, P., Ingleby, D., Mackenbach, J. P. & McKee, M. Migration and health in an increasingly diverse Europe. *Lancet* **381**, 1235–1245 (2013).
4. Migration and migrant population statistics - Statistics Explained. [https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Migration\\_and\\_migrant\\_population\\_statistics#Migrant\\_population:\\_23\\_million\\_non-EU\\_citizens\\_living\\_in\\_the\\_EU\\_on\\_1\\_January\\_2020](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Migration_and_migrant_population_statistics#Migrant_population:_23_million_non-EU_citizens_living_in_the_EU_on_1_January_2020) Date accessed: 20 June 2022.
5. Atoyan, R. *et al.* Emigration and Its Economic Impact on Eastern Europe. (2016).
6. Statistics on migration to Europe | European Commission. <https://ec.europa.eu/info/strategy/priorities-2019-2024/promoting-our-european-way-of-life/statistics-migration-europe> Date accessed: 15 June 2022.
7. Situation Ukraine Refugee Situation. <https://data.unhcr.org/en/situations/ukraine> Date accessed: 16 June 2022.
8. EMCDDA. *Health and social responses to drug problems*. [https://www.emcdda.europa.eu/system/files/publications/6343/TI\\_PUBPDF\\_TD0117699ENN\\_PDFWEB\\_20171009153649.pdf](https://www.emcdda.europa.eu/system/files/publications/6343/TI_PUBPDF_TD0117699ENN_PDFWEB_20171009153649.pdf) (2017).
9. Kirkinis, K., Pieterse, A. L., Martin, C., Agiliga, A. & Brownell, A. Racism, racial discrimination, and trauma: a systematic review of the social science literature. <https://doi.org/10.1080/13557858.2018.1514453> **26**, 392–412 (2018).
10. Lemmens, P., Dupont, H. & Roosen, I. Migrants, asylum seekers and refugees: an overview of the literature relating to drug use and access to services. (2017).
11. Nordt, C. *et al.* Long-Term Opioid Agonist Treatment Participation after First Treatment Entry is Similar across 4 European Regions but Lower in Non-Nationals. *Eur. Addict. Res.* **24**, 173–183 (2018).
12. UN AIDS. THE GAP REPORT 2014. (2014).
13. Lazarus, J. V. *et al.* Hepatitis C prevalence among the migrant population in Spain: A systematic review and meta-analysis. *Enferm. Infecc. Microbiol. Clin.* **37**, 222–230 (2019).
14. Tavares, A. M. *et al.* HIV and tuberculosis co-infection among migrants in Europe: A systematic review on the prevalence, incidence and mortality. *PLoS One* **12**, e0185526 (2017).

15. Tibi-Levy, Y., Serebryakova, D., Jauffret-Roustide, M. & Grp, A.-C. S. Migration experiences, life conditions, and drug use practices of Russian-speaking drug users who live in Paris: a mixed-method analysis from the ANRS-Coquelicot study. *HARM Reduct. J.* **17**, (2020).
16. EMCDDA. *Responsiveness and preparedness in addressing drug-related needs of displaced Ukrainians in EU countries bordering Ukraine*. [https://www.emcdda.europa.eu/system/files/publications/14753/EMCDDA\\_trendspotter\\_briefing-Ukraine.pdf](https://www.emcdda.europa.eu/system/files/publications/14753/EMCDDA_trendspotter_briefing-Ukraine.pdf) (2022).
17. World Health Organization. *World report on the health of refugees and migrants*. <https://www.who.int/publications/i/item/9789240054462> (2022).
18. Degenhardt, L. & Hall, W. Addiction 1 Extent of illicit drug use and dependence, and their contribution to the global burden of disease. *Lancet* **379**, 55–70 (2012).
19. Guardia, D., Salleron, J., Roelandt, J.-L. & Vaiva, G. Prevalence of psychiatric and substance use disorders among three generations of migrants: Results from French population cohort. *Encephale*. **43**, 435–443 (2017).
20. Wenz, B. *et al.* High variability of HIV and HCV seroprevalence and risk behaviours among people who inject drugs: results from a cross-sectional study using respondent-driven sampling in eight German cities (2011-14). *BMC Public Health* **16**, 1–14 (2016).
21. Bevölkerung mit Migrationshintergrund - Ergebnisse des Mikrozensus - Fachserie 1 Reihe 2.2 - 2011.
22. Bevölkerung mit Migrationshintergrund - Ergebnisse des Mikrozensus - Fachserie 1 Reihe 2.2 - 2014.
23. Ingrosso, L. *et al.* Risk factors for tuberculosis in foreign-born people (FBP) in Italy: a systematic review and meta-analysis. *PLoS One* **9**, e94728 (2014).
24. Carlander, C., Wagner, P., Yilmaz, A., Sparén, P. & Svedhem, V. Employment by HIV status, mode of HIV transmission and migrant status: a nation-wide population-based study. *AIDS* **35**, 115–123 (2021).
25. Calvo, F., Rived-Ocaña, M., Font-Mayolas, S. & Carbonell, X. Homelessness and mental health diagnose during the Great Recession (2008-2017): the effect of immigration. *Rev. Esp. Salud Publica* **95**, (2021).
26. Saigí, N. *et al.* Differences in illegal drug consumption between native and immigrants in a large sample of injected drug users in Catalonia (Spain). *Adicciones* **26**, 69–76 (2014).
27. Maremmani, I. *et al.* Can the migration process influence the clinical expression of heroin use disorder in migrants to Italy? *CNS Spectr.* **26**, 62–70 (2021).
28. De Kock, C., Blomme, E. & Antoine, J. Non-national clients in Belgian substance use treatment. *Drugs and Alcohol Today* **20**, 157–171 (2020).
29. Jauffret-Roustide, M. *et al.* Comparaison des profils, pratiques et situation vis-à-vis de l'hépatite C des usagers de drogues russophones et francophones à Paris, ANRS-Coquelicot Study, 2011-2013. *Bull. Épidémiologique Hebd. - BEH* **285–290** (2017).
30. Salama, E. *et al.* The prevalence of substance use among Russian, Somali and Kurdish migrants in Finland: a population-based study. *BMC Public Health* **18**, 651 (2018).
31. Kuhn, S., Zurhold, H., Lehmann, K. & Verthein, U. Drug Use and Special Needs of Refugees in Germany. *Suchttherapie* **19**, 140–147 (2018).
32. Mezuk, B. *et al.* Immigrant enclaves and risk of drug involvement among asylum-seeking immigrants in Sweden: A quasi-experimental study. *Drug Alcohol Depend.* **205**, 107666 (2019).
33. Lindert, J., Neuendorf, U., Natan, M. & Schäfer, I. Escaping the past and living in the present: a qualitative exploration of substance use among Syrian male refugees in Germany. *Confl. Health* **15**, 26 (2021).
34. Stompe, T., Ritter, K., Holzer, D., Topitz, A. & Wenzel, T. Alcohol- and substance abuse among mentally ill patients with migration background in Austria. *Neuropsychiatr.* **30**, 138–144 (2016).
35. Manhica, H., Gauffin, K., Almqvist, Y. B., Rostila, M. & Hjern, A. Hospital Admission and Criminality Associated with Substance Misuse in Young Refugees - A Swedish National Cohort Study. *PLoS One* **11**, e0166066 (2016).
36. Dunlavy, A. *et al.* Health outcomes in young adulthood among former child refugees in Denmark, Norway and Sweden: A cross-country comparative study. *Scand. J. Public Health* **14034948211031408** (2021).
37. Lundgren, L. *et al.* Immigration Status and Substance Use Disorder-related Mortality in Sweden: A National Longitudinal Registry Study. *J. Addict. Med.* **13**, 483–492 (2019).
38. Welbel, M. *et al.* Addiction treatment in deprived urban areas in EU countries: Accessibility of care for people from socially marginalized groups. *Drugs Educ. Prev. Policy* **20**, 74–83 (2013).

39. Santos, G., Soares, C., Rebelo, R. & Ferreira, P. Mental health and undocumented migrants in Portugal. *J. Public Ment. Health* **17**, 200–209 (2018).
40. Rommel, A. & Köppen, J. Migration und suchthilfe—Inanspruchnahme von leistungen durch menschen mit migrationshintergrund TT - Migration and addiction services—Utilization among people with a migration background. *Psychiatr. Prax.* **43**, 82–88 (2016).
41. Schulte, B. *et al.* Non-prescribed use of opioid substitution medication: Patterns and trends in sub-populations of opioid users in Germany. *Int. J. Drug Policy* **29**, 57–65 (2016).
42. Grahn, R., Chassler, D. & Lundgren, L. Repeated addiction treatment use in Sweden: a National Register Database study. *Subst. Use Misuse* **49**, 1764–1773 (2014).
43. Querengässer, J. & Traub, H.-J. Nichtdeutsche Staatsbürger im Maßregelvollzug gemäß § 64 StGB—Jahres- und Bundesländervergleich der Neuordnungen 2010–2015 sowie Gruppenbesonderheiten TT - Non-German offenders convicted according to § 64 of the German Criminal Code—Time trend, compari. *Forensische Psychiatr. Psychol. Kriminologie* **13**, 251–260 (2019).
44. De Kock, C. Equitable Substance Use Treatment for Migrants and Ethnic Minorities in Flanders, Belgium: Service Coordinator and Expert Perspectives. *Subst. Abus. Res. Treat.* **16**, (2022).
45. van der Gouwe, D., Diender, B., van Gelder, N. & de Gee, A. Recente inzichten in harm reduction voorzieningen in Nederland. <https://www.trimbos.nl/wp-content/uploads/2022/03/AF1980-Recente-inzichten-in-harm-reduction-voorzieningen-in-Nederland.pdf> (2022) Date accessed: 30 June 2022.
46. Deimel, D. Ausländerrechtliche Rehabilitationshindernisse in der Behandlung suchtkranker Migranten. *Suchttherapie* **14**, 155–159 (2013).

**Table 2: Summary of included studies**

Reference and setting	Study design	Aim	Population (sample size)	Origin migrants	Findings
Calvo et al. 2021  Spain	Transversal and observational study	Determine the prevalence of diagnoses of substance use disorders in individuals experiencing homelessness and analyse differences based on migration status.	People that attended specialized services for. the homeless (n=1072).	71% Africa (50% Morocco, 22% Mauritania (n=100), 16% Algeria and 3% Sahara) 14% Latin America, 9% eastern Europe and 5% other EU countries.	Migrants suffered less from opiate dependency compared to Spanish natives; no significant differences in cocaine, cannabis or hypnotics dependency nor in the prevalence of psychoactive substance use disorders. A lower level of poly-consumption among migrants was identified.
Carlander et al. 2021  Sweden	Nation-wide population-based register study	To compare employment in people by HIV status, mode of HIV transmission and migrant status.	1873 people living with HIV and 4428,778 HIV-negative individuals.	56% sub-Saharan Africa, 17% Asia and Pacific, 8% western Europe, 7% Latin America, 5% eastern Europe and Central Asia, 4% Middle East and North Africa and 1% North America.	From the total sample of migrants living with HIV, 2% were former or present injecting drug users compared to 12% in the Swedish-born population.
Deimel et al. 2013  Germany	Qualitative (interviews) and database analysis of legislative decisions on migrants with substance abuse	Explore access to substance dependence treatment of migrants in precarious resident situations.	Counsellors working in specialized substance dependency care institutions	Mainly Turkey, followed by Russia, Eastern Europe, Italy, Portugal, Spain and North Africa.	Barriers for substance dependence treatment were mainly related to a lack of documentation and therefore a lack of health insurance. Medical services are only provided on a case-by-case service by municipalities. In addition, fear of deportation and the lack of a working permit leading to an unstructured life were mentioned.
Dunlavy et al. 2021  Nordic countries	Longitudinal registry study	Comparing several health outcomes in young adulthood among child refugees who settled in the different immigration and integration	Refugees in Denmark (n=27,413), Norway (n=17,160) and Sweden (n=109,408).	<u>Denmark</u> : 12% Afghanistan, 6% Iran, 21% Iraq, 11% Somalia, 23% Former Yugoslavia <u>Norway</u> : 6% Afghanistan, 12% Iran, 8% Iraq, 8%	Compared to the native populations, hospital admission with a main or complementary substance misuse diagnosis was higher for migrant males in Sweden and Denmark but lower for migrant females in Sweden. For migrant males and females in

		policy contexts of Denmark, Norway and Sweden.		Somalia, 37% Former Yugoslavia Sweden: 3% Afghanistan, 10% Iran, 14% Iraq, 5% Somalia, 19% Former Yugoslavia.	Norway and migrant females in Denmark hospital admissions were similar to those for the native population.
EMCDDA 2022  EU member states	manual-based trendspotter methodology	Audit initial service response to the needs of displaced Ukrainians in neighbouring EU countries and identify factors that may help EU countries to better prepare for possible future needs in this area	Ukrainian refugees	Ukraine	Number of people receiving opioid agonist treatment in Ukraine arriving in neighbouring EU countries is relatively low (195-782 people). However, these data are difficult to estimate and the increased use of drug dependence services could impact existing opioid agonist treatment services in host countries.
Grahn et al. 2014  Sweden	Cross-sectional study	Identify predisposing, enabling, and need factors associated with history of number of voluntary addiction treatment episodes for individuals assessed for an alcohol and/or drug use disorder.	Swedish nationals with drug or alcohol use disorder (n=12,009) including first-generation migrants (n=1194).	NA	No differences were identified between immigrants and the native population in addiction treatment use.
Guardia et al. 2017  France	Cross-sectional study	This study provides an estimate of the prevalence of mental disorders among three generations of migration.	27 242 non-migrants and 1911 first-generation migrants, 4147 second generation migrants and 3763 third generation migrants.	Mainly Maghreb countries, Europe and African countries outside the Maghreb region.	Estimates identify higher levels of use of harmful substances and substance dependency among migrants compared to general population.
Ingrosso et al. 2014  Italy	Meta-analysis and systematic literature review	Investigate the relation of several factors, including intravenous drug use, on tuberculosis in foreign-born people.	7817 migrants (from 18 articles).	NA	Among people with tuberculosis, young immigrants (younger than 30 years) were less likely to inject drugs than Italians.

Jauffret-Roustide et al. 2017 France	Cross-sectional study	Describe the sociodemographic profiles, practices and access to care concerning hepatitis C among Russian-speakers that use drugs.	150 Russian-speaking people who use drugs and 689 Parisian non-Russian-speaking people who use drugs	Russian-speakers: Georgians (57.2%), Russians (16.1%), Chechens (9.8%) and Lithuanians (7.6%).	Russian-speakers had higher levels of education but more precarious living situations compared to French-speakers. In addition, they more often injected drugs, more often used heroin, cocaine and morphine sulphates, but less often crack, and they were less often using substitution treatment.
de Kock et al. 2020 Belgium	Cross-sectional study	Identify the main characteristics of and the types of services solicited by non-nationals in Belgium.	People registered in substance use treatment services (32,715)	NA	Compared to Belgian nationals, non-nationals were 4.40 times more likely to be admitted to drug dependence services with opioid as a primary substance and 1.48 times more likely to have cocaine as a primary substance. Belgian clients were more likely to have stimulants (OR = 4.60) or hypnotics (OR=1.53) as a primary substance.
De Kock et al. 2022 Belgium	Qualitative (semi-structured interviews)	Study factors related to underrepresentation of non-nationals in substance use treatment services in Belgium	Experts on substance use and migration and coordinators of substance use treatment services (21)	NA	The majority reported that people not speaking Dutch were excluded from treatment in most residential treatment services. In addition, it was mentioned that general practitioners may not refer non-nationals to these services if they expect them to be excluded.
Kuhn et al. 2018 Germany	Cross-sectional survey	Provide information on the nationality of drug-dependent refugees, their respective drug-use histories, consumption patterns and treatment needs.	116 drug dependant refugees who speak Farsi or Dari.	37.9 % Iranians, 31.9 % Afghans from Iran and 30.2 % Afghans from Afghanistan.	55.2% of drug users became drug dependent in their home countries. The majority wanted to enter in addiction treatment. This percentage was lower for people with addiction treatment experience in their home country.

Lindert et al. 2021 Germany	Qualitative (focus group discussions)	Investigate the perspective of male refugees from Syria and to foster specific knowledge and understanding of substance use.	Syrian refugees (n=19).	Syria	Reasons for substance use included escaping from painful memories, loneliness, boredom and lack of connection. Main reasons for preventing substance use were family cohesion and religion. Stigma and shame main reasons for not accessing treatment.
Lundgren et al. 2019 Sweden	Longitudinal registry study	Examining the association between first- and second-generation immigrant status and alcohol- or drug related mortality for those with risky substance use.	Adults who were assessed for risky substance use or an substance use disorder (n=15012).	NA	Individuals born outside the Nordic countries were less likely to die of drugs (not including alcohol-related causes) compared with individuals born in Sweden to parents also born in Sweden.
Manhica et al. 2016 Sweden	Longitudinal registry study	Investigate the patterns of hospital care and criminality associated with substance misuse in refugees who settled in Sweden as teenagers.	People aged 13 to 19 years when they settled in Sweden as refugees / related to a refugee (n=27,688).	34% Former Yugoslavia, 12% Horn of Africa, 17% Iraq, 6% Iran, 28% other non-European.	The rates of hospital care for male refugees were higher among unaccompanied refugees compared with Swedish males but lower in female refugees compared with Swedish females.
Maremmani et al. 2021 Italy	Naturalistic case-control study	Analyse the influence of the migration process on clinical expression of heroin use disorder, comparing migrants with the native Italian population.	Migrants with heroin use disorder (n=30) and Italians with heroin use disorder (n=30).	NA	Compared to Italian heroin users, migrant heroin users were less frequently poly-users but were more often found to be in stage 3 of heroin addiction. All migrant heroin users suffered from post-traumatic stress disorder in more severe forms.
Mezuk et al. 2019 Sweden	Descriptive study	Estimate of the impact of being placed into an “immigrant enclave” on risk of officially-recognized drug involvement among asylum-seeking immigrants.	Asylum-seeking immigrants (N=51,017).	Iran (26.9%), North Africa/other areas of the Middle East (24.4%), other parts of Africa (14.2%), Latin America (13.0%), eastern Europe (predominantly former Soviet Republics) (11.8%), and Asia (9.5%).	Immigrants living in an enclave had lower risk of officially-recognized drug involvement (ORDI). Native-born Swedes living in an enclave had higher risk of ORDI.

Querengässer et al. 2019 Germany	Cross-sectional study	Examining non-German versus German-born offenders under custodial addiction treatment according to § 64 of the German Criminal Code.	Non-German offenders under custodial addiction treatment	NA	The number of non-German offenders under custodial addiction treatment was almost double that of German-born offenders.
Rommel et al. 2016 Germany	Cross-sectional study	Describing use of addiction services among migrants populations, including trends over time.	People with a migration background (n=118.865 (2007) - 148.588 (2012))	NA	First generation migrants were underrepresented in addiction services compared to their representation in the general population.
Saigí et al. 2014 Spain	Cross-sectional study	Describe patterns of drug abuse, characteristics of the migratory process and the access and use of drug treatment centres in immigrant injecting drug users that use harm reduction programs in Catalonia, and to compare these to the characteristics of native injecting drug users.	Spanish-born injecting drug users (n=439) and immigrant injecting drug users (n=309)	57% from eastern Europe, other origins undefined.	Immigrant injecting drug users (IDU) tend to live alone more frequently, start injection at later ages, use and inject heroin more frequently and use drug treatment centres less frequently than native IDUs. immigrant IDUs attended drug treatment centres less frequently than native IDUs.
Salama et al. 2018 Finland	Cross-sectional study	Reporting on prevalence of substance use in Russian, Somali and Kurdish migrants in Finland, and the associations between substance use and socio-economic and migration-related background factors among migrants are analysed.	Finnish general population (n=1165) and Russian (n=702), Somali (n=512) and Kurdish (n=632) immigrants.	Russia (38%), Somalia (27%) and Kurdish migrants (34%).	Russian migrants used more cannabis than Kurdish migrants, while Somali migrants did not report any cannabis use. Injecting drug use was rarely reported (<0,2%) for all groups.
Santos et al. 2018 Portugal	Descriptive study	Estimate the prevalence of mental health disorders among undocumented migrants in a detention centre.	Undocumented migrants in detention centre (n=393).	Brazil (13%), Cape Verde (11%), Ukraine (8%), Bangladesh (6%) India (6%) and Morocco (6%).	11% of undocumented migrants were psychoactive substance users.

Schulte et al. 2016 Germany	Cross-sectional study	Examine non-prescribed use of opioid substitution medication and other drug use patterns among drug consumption room (DCR) clients, opioid substituted DCR clients, and patients recruited in opioid substitution treatment practices.	842 opioid users.	NA	Immigrant opioid users in Germany were underrepresented in opioid substitution treatment services, compared to German-borne opioid users
Stompe et al. 2016 Austria	Cross-sectional study	Reporting on substance abuse among migrants with a mental disorder.	Patients treated in clinic for transcultural psychiatry and migration related disorders (1726 first generation, 93 second generation).	Balkan states (29%), Turkey (24%), Caucasus region (16%), Middle East (16%), eastern Europe (7%), West Africa (5%), Western Europe (2%), USA (1%).	Substance abuse was more frequent in men than in women, and illegal drug use was rare. Cannabis use among migrants in the sample was lower than the prevalence in their countries of origin, with the exception of American and West-African migrants. Substance use was more common among migrants that were not religious.
Van der Gouwe et al. 2022 The Netherlands	Qualitative (interviews)	Providing insights in the daily practice of harm reduction centres in the Netherlands.	Staff from 116 harm reduction centres.	N / A	An increase in service use was observed by migrants from Central and eastern Europe. Barriers for treatment were language, the closed communities they live in and a lack of affinity with and knowledge of the Dutch addiction service system.
Welbel et al. 2013 14 EU member states	Cross-country study	Examining the accessibility of addiction treatment within services providing mental health care and support for people from socially marginalized groups in deprived urban areas across EU countries.	N / A	N / A	30% of services surveyed provided addiction treatment, and in 20% of mental health services, addiction was an exclusion criterion from receiving treatment. Of the services, 60% offered services for both alcohol and drug addiction, while others offered specialized alcohol (25%) or drug (17%) treatment.

Wenz et al. 2016  Germany	Cross-sectional study	Generate seroprevalence data on HIV and HCV among people who inject drugs and related data on risk behaviour.	2,077 people who inject drugs.	Eastern Europe and former Soviet Union (33%-81%) others not defined.	Among the sample of injecting drug users between 9.2% and 30.6% had a migration background.
------------------------------------	--------------------------	---	--------------------------------	--	---

**Abbreviations:** DRC: drug consumption room; EU: European Union; HIV: human immunodeficiency virus; IDU: Injecting drug user; ORD: officially-recognized drug involvement