

**SUBSTANCE USE AMONG
PEOPLE WITH A MIGRATION
BACKGROUND**
A COMMUNITY-BASED
PARTICIPATORY RESEARCH (CBPR)
PROJECT

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1 INTRODUCTION

1.1 Situating the research

The objective of this study is to contribute to a better understanding of the nature of substance use among four groups of people with a migration background and their access to substance abuse treatment centres in Belgium. In the last decade, research on Belgian people with a migration background has demonstrated that their presence in and access to general health care, including residential substance abuse treatment, is disproportionately low when compared to the general population (Blomme, 2016; Eggerickx et al., 2006; Lodewijckx, 2014; Rouws, 2007; Vassart, 2005). Furthermore, some people with specific migration backgrounds make less use of substance abuse treatment services than others (Derluyn et al., 2008). The under-utilisation of substance abuse treatment services and lower treatment completion rates among people with a migration background have been documented in the Belgian context (Vandeveldel et al., 2003; Verdurmen et al., 2004). Also, in the European context, research has demonstrated that people with a migration background appear to be under-represented in substance abuse treatment statistics (Fountain et al., 2004; Fountain et al., 2010).

The association between stressors in the social and physical environment and socio-economic status on the one hand, and health status on the other, is well documented (Schulz et al., 2008; Warnecke et al., 2008). Epidemiological research demonstrates that people with a migration background, because of the risk factors they are confronted with, are more susceptible to substance use disorders due to, among other issues, higher unemployment rates, limited language skills, fewer educational opportunities, discrimination, intergenerational conflict, acculturation difficulties and greater peer pressure (Otiniano Verissimo et al., 2014; Reid, 2001; Savage et al., 2014).

Little is known about the prevalence and nature of substance use among people with a migration background in Belgium (Burkhart et al., 2011; Derluyn et al., 2008; Fountain et al., 2004). Derluyn et al. (2008) made a significant contribution to the field, especially in relation to the care trajectories of substance users with a migration background in Belgium. The study demonstrated that some substance users who describe themselves as having a migration background have limited knowledge about the substances used, their effects and potential harm. For many, treatment is too difficult to access given their limited knowledge about the treatment offer and/or biased views on addiction and treatment among certain communities and their members. However, many drug treatment clients of non-Belgian origin do appear to be supported by their network and community. The findings also indicate that community organisations and institutionalised treatment services are interested in collaborating more closely to help those substance users who describe themselves as people with a migration background. Still, we know little about these phenomena and the reasons why the participation of these groups in treatment remains limited. Derluyn et al. (2008), for instance, raise some conceptual (e.g. distinguishing between people with a migration background) and methodological (e.g. recruiting via treatment services) issues that remain unresolved.

This study explains the patterns of substance use, expectations and needs of people with a migration background in substance abuse treatment. It also attempts to fill the knowledge gap in existing research on specific groups of people with a migration background (e.g. ethnic minorities). Asylum applicants, undocumented migrants and refugees, the Congolese community in Brussels, and the Turkish and Eastern European communities in Ghent have not been sufficiently studied when it comes to patterns and the nature of substance use and misuse (Derluyn et al., 2008), which is the reason for focusing on these populations. In conclusion, this study can inform innovative practices in mental health care, prevention and treatment practices.

The concept of “people with a migration background” is not applied as a primordial analytical category, nor as a statically bounded entity in this study (Cahnman, 1962; Said, 1979; Vermeulen et al., 2003; Wimmer, 2013; Zemni, 2009). The authors recognise the need to distinguish between the dynamic nature of cultural identities (Zemni, 2009), the unidirectional discourse of integration (Schinkel, 2008), and structural inequalities (Elchardus et al., 2012) when studying people with a migration background. Consequently, the complex interplay of these aspects will be elaborated upon by means of studying four populations, instead of one, and by employing mechanism-based qualitative inquiry instead of quantitative, variable based research.

1.2 Research questions and goals

This study asks two key research questions, namely:

- What is the nature and what are the patterns of substance use in the four populations analysed in this study?

- What are the expectations and needs of the four populations towards substance abuse treatment?

The use of alcohol and illicit substances among people with a migration background is understudied in the European context (Tieberghien et al., 2008). Professionals have signalled significant differences in the prevalence and nature of substance use among people with a migration background (Derluyn et al., 2008; Fountain et al., 2004). However, existing studies do not allow us to understand this phenomenon, because variables such as nationality, ethnic origin and type of substance use are often not operationalised in an equivalent way across the research. Furthermore, Belgian treatment facilities only offer limited information on the ethnic, migration and/or cultural background of their clients, which hinders quantitative analysis of the phenomenon.

Therefore, a qualitative and exploratory research design was deployed in order to increase the knowledge about the underlying mechanisms of substance use and the existing barriers concerning prevention and treatment services, both at the individual (micro) and the social (meso) level among people with a migration background. A total of 247 semi-structured interviews were conducted with substance users describing themselves as having a migration background or belonging to an ethnic minority, in order to understand individual, interpersonal, organisational and social determinants and the social mechanisms (Bernard, 2011; Bronfenbrenner, 2009) that inform substance and treatment use. One of the main goals during this research was to support the actual use of our research outcomes within these communities (see infra, chapter 3).

We studied the social mechanisms and intertwined individual factors that lead to substance misuse and service utilisation among undocumented migrants, asylum applicants and refugees, in the Congolese community in Brussels, and in the Turkish and Eastern European communities in Ghent. We focused on these groups because they are representative of the major migrant groups in Belgium, and because, so far, no extensive study on this topic has been undertaken in these populations (Derluyn et al., 2008). Although people with a Maghrebian migration background are also well represented in Belgium, we chose not to include them because they have been studied in previous research (see Derluyn et al., 2008; Laudens, 2013).

At the individual level, we analysed the relationship between acculturation processes, discrimination and ethnic identity formation as moderating factors in substance use, barriers and access to services. At the meso-social and macro-social level we focused on the interplay between ethnic conformity pressure, ethnic density and social capital in the urban context and substance use and treatment utilisation.

Existing research has led to little or no change or improvement, neither in local service provision, nor for people with a migration background or ethnic communities (Belone et al., 2014; Bogart et al., 2009; Fountain et al., 2004). Therefore, we addressed these issues by applying a community-based participatory research (CBPR) model. This model implies that the research questions were refined in close collaboration with the respective communities (see chapter 3).

1.3 Methodology

This report is the account of a 15-month research project. The CBPR model was a vital element in the project. Consequently, the model and the specific method of data collection, analysis and dissemination will be reported upon in a separate chapter (see chapter 4). In this chapter we also include our experiences in the four studied populations.

The preparatory phase of the project, however, consisted of a narrative literature review including peer-reviewed as well as grey literature on the nature and prevalence of substance use among people with a migration background, determinants of substance use and barriers to substance abuse treatment. We want to improve knowledge concerning substance use in people with a migration background, without adhering to cultural relativism. To this extent, we explored social mechanisms of ethnic boundary making that have already been studied in the Belgian context and may reveal risk and protective factors for problem substance use. Furthermore, we reviewed the existing literature on prevalence and research that links social and individual determinants to patterns of substance use in and access to substance abuse treatment for people with a migration background.

We included grey literature, i.e. publications that have not been peer-reviewed, with limited circulation, master dissertations and documents resulting from mailshots to professional (treatment and prevention) centres in Belgium requesting relevant reports of research undertaken in their areas. Some research reported in grey literature has used qualitative research methods or has been conducted by those with unique access to the people with a migration background under investigation. Some of this research may be lacking academic rigour, but we included all relevant literature we could identify. The result of this all-inclusive strategy is beneficial to building up a knowledge base in the dearth of relevant peer-reviewed publications. In the literature review, we focus on illicit substances, but where appropriate, the use of legal substances such as alcohol, prescription drugs, solvents, etc. is included.

We have included ethnic conformity pressure, the urban context, social capital and ethnic density as new sensitising concepts in the research of ethnicity and substance use. Furthermore we study acculturative stress, discrimination and ethnic identity. Hence, we allowed research questions and new concepts to emanate from the interviewed people with a migration background themselves because this could lead to novel findings and solutions grounded in the local instead of the academic context (Bogart & Uyeda, 2009; Charmaz, 2006; Salsberg et al., 2015). Consequently, rather than testing a hypothesis, the study mainly focused on collecting new, original data on the topics mentioned above and within the four particular populations. It is hence of an exploratory nature.

1.4 People with a migration background

In what follows we will defend our focus on “people with a migration background” throughout this study. We depart from the observation that lower socio-economic status (lower education, lower income and unemployment) is associated with the prevalence of mental disorders including substance use related problems (Chartier et al., 2014; de Graaf et al., 2012). Furthermore, we begin with the observation that people with a migration background are under-represented in substance abuse treatment (Vandevelde et al., 2003) and that they are more susceptible to a lower socio-economic status (Manço, 2004; Van Kerckem et al., 2013). Consequently, we should acknowledge a higher vulnerability but stress the fact that being a migrant or belonging to an ethnic minority group is not necessarily an indicator of vulnerability to substance use or misuse (Adrian, 2002; EMCDDA, 2013).

In doing so, it is necessary to take a closer look at the concept of ethnicity. This concept only emerges during the interaction of groups in society. Max Weber (in Wimmer, 2013) defines ethnicity as a subjectively felt belonging to a group that is distinguished by a shared culture and by common ancestry. This belief of belonging rests on cultural practices perceived as “typical” for the community, or on myths of a common historical origin, or on phenotypical similarities indicating common descent. Martiniello (2013) defines ethnicity by means of political and social differentiation on the one hand, and structural inequality in contemporary societies on the other.

In this line of thinking, the introduction of the concept of ethnicity in UK and US social sciences reflects the constitution of ethnic groups as interest-driven and lobbying actors in the political system (Martiniello, 2013). This concept of ethnicity implies that political communities are based on ethnic references. In this perspective, ethnicity is one of the variables of political mobilisation.

In social sciences, ethnicity is not based on objective differences between groups, but on the perception of the importance of these differences in social relations. Ethnicity is a social and political construct of perceived difference (Martiniello, 2013). The ethnic dimension is not always as relevant in all social relationships and contexts (Martiniello, 2013), since people may emphasise it in certain situations, while trivialising it in other contexts.

Martiniello (2013) distinguishes three levels to identify and analyse ethnicity: the micro, meso and macro level. At the individual (micro) level, ethnicity is largely subjective and refers to the feeling and the consciousness of belonging to an ethnic group possibly because of a shared migration background but also imputed by, for example, perceived discrimination, which can cause “reactive” ethnic identity (Hagedorn, 2008). At the meso-social level, ethnicity corresponds to ethnic mobilisation and ethnic collective action, structured by a collective ethnic identity (e.g. in community organisations). At the macro-social level, ethnicity refers to the structural constraints that shape ethnic identities, and provide individuals with a predetermined social position depending on their attributed belonging to an ethnic category.

Contemporary scholarship on ethnicity is usually based in Frederik Barth’s (Barth, 1969; 1998) non-substantialist notion of ethnicity. Barth argued that ethnic identity is a means to create boundaries that enables groups to distance themselves from one another and consequently argues that ethnic boundaries define a group rather than “the cultural stuff that encloses it”. He considers ethnic groups as transforming and dissolving entities by means of social and categorical boundaries. Wimmer (2013) activates Barth’s ethnic boundaries by infusing the analysis of how such boundaries are produced with a Bourdieusian perspective, and considering how these processes are entangled with non-ethnic boundary making processes. For Wimmer, ethnic boundary making and consequent ethnic identity should be studied in terms of power, networks and institutions, the main actors in ethnic boundary making.

Ethnic expression depends not only on individual rational choice, but also on the state’s impact on the perception developed about dominant and sub-dominant ethnic groups members, the resources for community organisations and the collective mobilisation and reciprocal recognition of ethnic groups in the political process. In this perspective, the state plays an important role in the processes of ethnic imputation. The recognition of ethnicity and its institutionalisation in politics increases the level of ethnic mobilisation among all ethnic groups and shape the boundaries of ethnic mobilisation and conflicts by defining the rules of political participation.

Depending on the context, ethnicity can be defined, on the one hand, by referring to common patterns such as language, collective memory, future projects, origin, physical appearance, dress codes, or, on the other, by reference to the boundaries between groups and the way these groups attempt to appear distinct (Leloup et al., 2008: 5). A particular element to be stressed is that once individuals identify with a particular ethnic community, they will be more likely to be subjected to social pressure with regard to appropriate behaviour and taboos, which can vary from one group to another.

1.5 Substance use

When studying substance use in people with a migration background, we support Muys’ (2010) argument that this phenomenon should be studied as a social construct within its context

(Berger et al., 1967). Previous studies have usually identified three determining factors of substance use among individuals with a migration background: post-traumatic stress syndrome, acculturative stress and goal-striving stress (Muys, 2010). These approaches offer important insights but they tend to isolate individual determinants and therefore often overlook the social embeddedness as well as the social origin of the phenomenon.

The definition of substance use and misuse in societies and even in academic debate should be regarded as a reflection of the nature of that society (Dingelstad, et al., 1996 in Muys, 2010, and its social institutions (Ruggiero 2000 in Muys, 2010), social values, expectations and milieu (Young, 1971). When studying the patterns and determinants of substance use and the barriers to treatment services from this social constructivist perspective, we are more interested in the forces that lie behind this use than in the prevalence itself. This enables us to study the social contexts of use that inspire individual choices as well as the aforementioned barriers.

Recognising that substance use in people with a migration background is in essence a social construct has had considerable implications for our research methods and principles. It primarily implied that the concept of substance use should be studied from the perspective of the communities and the people identifying with these communities. Any type and use of substances qualified for this study when it proved to be meaningful in the narratives of the respondents. We intended to rejuvenate existing research by studying substance use and access to treatment within the framework of ethnic boundary making (Wimmer, 2013) and social mechanisms (Hedström et al., 1998).

1.6 Substance use and society

In speaking of culture we have reference to the conventional understandings, manifest in act and artifact that characterize societies. The understandings are the meanings attached to acts and objects. The meanings are conventional and therefore cultural in so far as they have become typical for the members of that society by reason of inter-communication among the members. A culture is then an abstraction: it is the type toward which the meanings that the same act or object has for the different members of the society tend to conform.

(Redfort in Becker, 1963; 1991: 80)

Becker argues that being a regular substance user often implies positioning oneself in a subgroup. Becker's *Outsiders* (1963/1991) has deeply influenced sociological research on substance use. The concept of deviance is especially interesting for our research, because it offers a framework to study substance use as a social phenomenon, the role of social control and the relationship between insiders and outsiders in society. Outsiders are considered to be those who don't follow the rules of the dominant social group (Becker, 1963/1991). Becker employs a symbolic interactionist approach that enables him to analyse the actions of individuals and the meaning they give to these actions through the interaction and negotiation of social norms in society.

According to Becker, every social group institutionalises rules and attempts to apply these rules at precise moments and under certain circumstances. These social rules define situations and appropriate behaviour. This is especially true for certain people with a migration background (see *infra*). Those who break these rules are considered outsiders, or alienated from the group. Social rules are produced by social groups and are highly differentiated by social class, ethnic group, profession and culture. Different social groups do not necessarily share the same social rules. They develop different normative systems. The groups that

succeed in imposing their rules are those whose social position gives them resources and power (Becker, 1963/1991).

Becker (1963; 1991) defines different types of deviance. His typology allows us to discern several characteristics of substance use: its changing character through time and the social construction in a given society, its dynamic and interactive nature and the stages in user careers. In the case of our research, this typology impels us to distinguish between regular users and occasional users and to understand why some occasional users become regular or problem users and under which circumstances this is the case.

Being publicly designated as deviant is in fact crucial in the process of deviant behaviour (Becker, 1963/1991: 54). Being identified and stigmatised as deviant has important consequences in social life and on self-image. It is usually a prevailing identity category or social status that turns into a self-fulfilling prophecy. Deviant behaviour often clashes with expectations in other life sectors. One way to resist the social control that defines deviance is to amplify the deviance in one's social and individual life. Consequently, deviant motivations do not necessarily lead to deviant behaviour, but deviant behaviour induces deviant motivation over time.

DRAFT

2 THE PREVALENCE AND NATURE OF SUBSTANCE USE IN PEOPLE WITH A MIGRATION BACKGROUND

2.1 Prevalence

The link between immigration and substance use was first explored in US, UK and Scandinavian literature (Taïeb et al., 2008) by means of quantitative studies based in native versus migrant group comparisons. This research highlights the risk and protective factors of substance use among these groups based in variables linked to the acculturation model and the cultural identification model (see *infra*). The acculturation concept is linked to the risk factors of acculturation “stress” and adapting “too much” to home cultures, including taking on habits of substance use. Taïeb et al. (2008) criticise this dominant model because it seems to presuppose that adapting to a host country culture unilaterally implies abandoning the “home” country’s culture and that the adaptation process to a culture is quantifiable. A second model identified in the literature review of Taïeb and colleagues is the ethnic identity model, but the quantitative application of this model also leads to few conclusive studies on the causal relation between substance use and migration. A third category of models is classified as those studying the role of migration by means of studying specific migrant groups, and studies that do not use migrant groups as units of analysis.

Some studies do indeed demonstrate clear differences between “native born individuals” and migrants concerning the degree (more/less) of substance use and the type of substances used (Argeriou, 1997), whereas others state that there are few to no differences between these groups (Adrian, 2002). Further critique of Taïeb et al. (2008) in the face of quantitative analysis includes: (1) the lack of validity of the ethnicity category; (2) confounding cultural and non-cultural factors, such as socio-economic factors; (3) the transcultural validity of diagnosing categories; and (4) limits in quantitative measurement (of acculturation and ethnic identity).

In what follows we discuss UK and continental European literature concerning the prevalence and nature of substance use among people with a migration background. US-based epidemiological research has been described at length by Derluyn et al. (2008). We will not include this literature because the scope of our research is not quantitative, variable based nor epidemiological. We focus on UK and continental European literature because the concept of ethnicity has long been and still is an anathema in, for example French literature, and consequently little epidemiological and prevalence-oriented research on this topic is conducted within this tradition.

Scholars working in the tradition of rational choice theory and critical classical Marxism are less inclined to accept the concept of ethnicity as a unit of analysis, although both from a very different perspective. This has, in the rational choice tradition, resulted in more quantitative, variable-based research that considers individuals as units of analysis (Wimmer, 2013: 17). Critical study in its turn focuses on structural elements and social stratification, rather than ethnicity. Both traditions avoid some of the pitfalls of community and cultural studies. Consequently, very little literature on prevalence in specific migrant and ethnic minority user groups is to be found in these traditions. In our study we are inclined to adopt a midway perspective, instrumentalising the concept of ethnicity critically and taking structural and social stratification into account in our qualitative analysis of substance and treatment use.

Research in the United Kingdom (Ramsey et al., 2001 in Rassool, 2006) has indicated that the prevalence of substance use is lower among South Asians in comparison to white communities, although this discrepancy diminishes over time. Another UK study, (Moselhy et al., 2002), states that Asian participants report a higher use of opiates in comparison to the native population. The African-Caribbean group reports a higher use of crack-cocaine. Ecstasy, amphetamines and lysergic acid diethylamide (LSD) are said to be used less frequently by people with a migration background in the United Kingdom and are considered

drugs of white youngsters (Chaudry et al., 1997). However, khat is described as a specific substance that is often used by Somalian individuals, Yemenites, Ethiopians and Arabs from the Middle East (Fountain et al., 2004). A large-scale Swedish study (Hjern, 2004) demonstrates a significant increase in hospitalisation among second generation migrants for treatment of illegal substance use. This elevated risk, however, is almost completely neutralised when socio-economic indicators are taken into account. In this aspect, second generation migrants are struggling a lot more than the native Swedish population. A study of recently arrived refugees in Sweden demonstrates that these individuals use less psychotropic drugs when compared to native born Swedish people and that use increases after longer residence in Sweden (Brendler-Lindqvist et al., 2014)

Research among Afghan migrants in Germany demonstrates that problem alcohol use in this population is significantly correlated to acculturation stress and mental distress (Haasen et al., 2004). A study on khat chewing in East African and Arab migrants demonstrates that it has served a functional use of coping with stressful events both in the present and historically in these populations (Bongard et al., 2015).

Dutch research assesses that approximately 40–50% of registered substance users consist of people of Surinamese, Moroccan, Netherlands-Antillean or Turkish origins (Lempens et al., 2000 in Verdurmen et al., 2004). In the Netherlands increased substance use and earlier onset of substance use was found among migrant adolescents 10 to 20 years ago (Monshouwer, 2008; Monshouwer et al., 2005). These subjects have now become adults and their (former) substance use might have contributed to an increase in adult substance use disorders (de Graaf et al., 2005). The NEMESIS-2 study (de Graaf et al., 2012) shows that 19.1% of the respondents had experienced substance use disorders in their lifetime, and 5.6% in the previous 12 months. Lifetime alcohol misuse was highly prevalent (14.3%), while for the last 12 months it was considerably less (3.7%).

Those aged 18–24 had a higher prevalence of substance use disorder. A trend toward a higher risk of mood, anxiety and substance use disorder and adult attention-deficit hyperactivity disorder (ADHD) was found with lower educational level. In general, those living with a partner had a lower risk of mental disorders than those living alone. Unemployed/disabled subjects had a much higher risk for all disorder categories than those in paid employment. Housewives/house-husbands did not differ from those in paid employment. Gender differences were consistent across the different age groups, except for substance use disorder among those aged 25–34 and 35–44, where the gender imbalance was much higher than that in the youngest and oldest age groups. The estimated prevalence of substance use disorder in the previous 12 months in NEMESIS-1 (de Graaf et al., 2000) and the direct measure in NEMESIS-2 (de Graaf et al., 2012) did not differ significantly.

When it comes to the methods of use, injecting substances appears to be very unusual among African minorities, which can be derived from their low attendance at needle and syringe exchange programmes (Rassool, 2006; Sangster et al., 2002). South Asians and African-Caribbeans do seem to inject heroin and steroids. The aversion to intravenous use among Chinese and Vietnamese individuals is mainly dictated by a belief that it is more likely to lead to dependency, a fear of losing control, a fear of needles and human immunodeficiency virus (HIV) infection, and because of the stigma of intravenous use (Nemoto et al., 1999). According to this research, the use of crack and the aversion to its intravenous use occurs more often among Asians who moved to America after birth than among Asians born in America. A qualitative study in London on women from Bangladesh also reports that these women reject injecting of substances (Cottew et al., 2005).

In Belgium only the current (as opposed to the former, or dual) nationality of clients with a migration and/or ethnic background is registered in substance abuse treatment centres (Antoin et al., 2012). Consequently, very few statistical data are available on substance use and

treatment use in people with a migration background. Moreover, the existing statistics are hard to interpret and thus provide few to no insights into substance use among these minorities in Belgium. Derluyn et al. (2008) report that there is a high heterogeneity in the nature of substances used in people with a migration background.

Attendance at substance abuse treatment might give us a better insight into the prevalence of problem substance use in people with a migration background. The quantitative analysis of substance abuse treatment services in Antwerp by Derluyn et al. (2008) concludes that about 25% of service users are non-Belgian. This number is similar to the proportion of non-Belgians in the general population, which could lead to the conclusion that the target group is not under-represented in substance misuse services. These researchers do note a large difference in the profile of these clients when compared to Belgians, most notable that they have a lower socio-economic status. Sacré et al. (2010) confirm this statement in their study of 26 non-Belgian injection heroin users. These individuals are more vulnerable when it comes to their educational, housing and economic situation. The respondents in this study were interviewed in Charleroi and Liège and were mostly males of North African (50%), Eastern and European origin. It is significant that this study also mentions that in some cases heroin and cocaine trafficking is linked to human trafficking, which makes certain groups of migrants (e.g. refugees) more vulnerable to the use of these substances. In conclusion, we mention the study of Blomme (2016) who studied non-Belgians' attendance at treatment centres during the period 2011–2013. She concludes that non-Belgians are not under-represented in heroin substitution treatment, but are under-represented in therapeutic communities and in crisis care. Furthermore, the growing number of non-Belgians from European Union countries in the general population is under-represented at all levels of treatment.

In what follows we intend to deepen the scope of existing research by distinguishing between individual, service-related and other social mechanisms that may influence the nature of substance and service use among people with a migration background. At the social level we introduce the concepts of ethnic conformity pressure, urban contexts, social capital and ethnic density. At the individual level we review people's experiences of ethnic identity, acculturative stress and discrimination. An analysis of the service level is not within the scope of the current research, but we will introduce some promising practices.

2.2 Social mechanisms

Mechanism-based research focuses on the properties, activities, relations and interests of entities that produce effects in a certain situation. Contrary to the covering-law approach, it presupposes that higher-level mechanisms (“disproportionately low number of people with a migration background in treatment services”) originate in lower level mechanisms (e.g. “high degrees of social closure in ethnic groups because of perceived discrimination, which results in a knowledge gap about treatment options”).

Broadening the intersectional approach, it hypothesises that the causal relation between A and B can only be explained by considering A and B not as separate entities but as agents, properties, actions and relations in a time-related framework. Mechanism-based theory is based in opening the black box behind a macro-level observation. It is concerned with how situational mechanisms of social structures constrain individual actions and cultural environments (1), describing action mechanisms linking individuals’ desires, beliefs, etc. to their actions (2) and specifying the transformational mechanisms through which people create (un)intended social outcomes (3). This is what shapes the macro-level association in mechanism-based theory (Hedström et al., 2010).

The position of migrants in society is, to a large extent, defined by the degree of socio-economic inclusion, levels of xenophobia, political decision making and the discourse of the receiving society. Therefore, when studying the nature of substance use in people with a migration background we must also study the social mechanisms underlying problem substance use and/or access to health care from this collective perspective. Migration can, for example, result in poor living conditions, economic and intellectual poverty, unemployment, limited access to education, disruption of social and familial structures and discrimination. Several studies have demonstrated that people with a migration background are over-represented in lower socio-economic classes, which might result in higher unemployment rates, more poverty and worse housing, all elements associated with poor mental health (Lindert et al., 2008; Negi, 2011).

These socio-economic factors can contribute to substance use (Saloner et al., 2013). Various authors add that people with a migration background are often confronted with combined sources of acculturation stress, lack of familial support, racism and discrimination. These can all be (joint) causes of (higher) substance use (Panunzi-Roger, 2005).

Reid (2001) highlight the following risk factors that increase the vulnerability for substance use among people with a migration background: high unemployment, poor knowledge of the host language, limited access to education and low level of education, intergenerational conflicts, acculturation and peer pressure. In our analysis we will focus on the interplay of these social and individual factors and complement them with ethnic conformity pressure, the urban context, ethnic density and social capital.

In what follows we will study how these documented determinants and risk factors are intertwined and interact with each other within the framework of social mechanisms. We therefore propose six sensitising concepts – ethnic conformity pressure, social capital, urban context, ethnic density, acculturative stress and discrimination, ethnic identity – that may be of significance in opening the black boxes of the social mechanisms informing substance and treatment use. Furthermore, we will be alert to new concepts arising during our contacts with and fieldwork in the communities.

2.2.1 Ethnic conformity pressure

Members of ethnic groups sometimes choose opportunistically between the norms, values and practices of their ethnic groups and those of the host society, or they construct a flexible combination of both. They are confronted with a choice between two cultures, while these cultures may conflict in specific situations. To preserve their ethnic background and remain specific as a group, migrant communities often try to maintain ethno-cultural boundaries by exerting ethnic conformity pressure – i.e., pressure not to assimilate too much, but to conform to those norms, values and cultural practices that are deemed central to the ethnic group's identity (Van Kerckem et al., 2014: 277).

In their research on the Turkish community in Ghent, Van Kerckem et al. (2014) suggest that ethnic conformity pressure shapes the behaviour of ethnic group members, and associate this pressure with the maintenance of ethnic boundaries and with familial and ethnic solidarity. This pressure is exerted by other group members and potentially shapes the individual's behaviour, and is expressed through direct discourse and indirectly through social control and sanctions when norms and values are deviated from. In groups with high levels of social interaction social control works through gossip, ridicule and social sanctions, and can lead to blame and expulsion from the community.

In ethnic groups, this ethnic conformity pressure is differentiated by gender; women are generally more pressured, because they are considered as “the designated keepers of the culture”, in charge of the cultural line, the maintenance of an ethnic boundary and ethnic symbols (Van Kerckem et al., 2014). In an interactionist approach, Van Kerckem et al. (2014) consider individuals to be rational and able to weigh the costs and benefits of mainstream or ethnic behaviour. Thus, according to Van Kerckem et al. (2014), it is important to focus on how individuals negotiate, trace and reinterpret symbolic boundaries, and how they deal with the mechanisms of boundary maintenance.

The concept of ethnic conformity pressure and the creation and re-creation of ethnic boundaries¹ may influence views on substance use, individual expressions of substance dependence and treatment strategies. Furthermore, investigating these concepts enables us to further explore the concept of double isolation and alternative treatment strategies as postulated by Derluyn et al. (2008).

2.2.2 Social capital

Social capital is defined as “the resources embedded in a social structure which are accessed and/or mobilised in purposive actions” (Lin, 2001 in Kim et al., 2006). Recent work has mostly been inspired by Putnam (1993) who defined the concept as “those features of social organisation, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated actions”. It taps those “features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit” (Putnam, 1995: 66). Putnam (2002) later refined social capital by distinguishing between networks connecting people who are unlike one another (bridging) and people who are like one another in important respects (bonding).

¹ Zolberg and Woon (1999) consider three types of ethnic boundary change: “boundary blurring”, “boundary shifting” and “boundary crossing”. Boundary crossing refers to the individual-level process of moving from one group to another, without any real change to the boundary itself. Boundary blurring implies a process in which the social profile of a boundary becomes less distinct, where “the clarity of the social distinction involved has become clouded, and individuals' location with respect to the boundary may appear indeterminate” (2005). Boundary shifting, finally, involves “the relocation of a boundary so that populations once situated on one side are now included on the other” (Van Kerckem et al., 2014: 282; Wimmer, 2013).

Analysis of disadvantaged communities has found that bonding capital has a protective effect through risk management and solidarity functions (Kozel & Parker, 1998 in Woolcock et al., 2000). However, most research measures the impact of bonding versus bridging capital. Bridging capital, in this perspective, would outperform bonding capital when related to self-rated health (Kim et al., 2006), positive civic values (Geys et al., 2010) and subjective well-being (Hooghe et al., 2010).

More recently, researchers have used bonding and bridging social capital to specifically study increasingly diverse societies in many aspects, such as the relation between social capital and social cohesion (Chan et al., 2006; Laurence, 2009). However, the concepts of bonding and bridging capital are currently suffering a serious conceptual inflation due to their politicisation – bonding is negative, bridging is positive (Cheong et al., 2007), and due to the lack of conceptual clarity regarding the unit of analysis (individual, community, society at large), its consequent use as an independent, dependent or mediating variable, and its causal or consequential effect on communities and individuals.

Research by Geys & Murdoch (2010) and Laurence (2009) offers insightful clarification of the issues, although they draw very different conclusions. Geys & Murdoch (2010) study the way that bonding and bridging capital tap into each other and into external and internal dimensions of networks. This integrated analysis offers empirical support for the fact that membership in associations that are both bridging in the network itself (e.g. community organisations) and outside it have the strongest relation with acceptance of non-conformist forms of behaviour (in the case of the United Kingdom and Flanders). This is their answer to the idea that two different ways to operationalise social capital coexist, one based on interconnectedness between networks, and one based on within-network heterogeneity.

Laurence (2009) departs from a similar reading of the current study of social capital, but offers a different answer. In studying the relation between social capital and inter-ethnic relations, he concludes that it is not social capital that most strongly correlates with tolerance and positive civic values, but the factor of disadvantage. He suggests that simply using social capital for measuring social cohesion can create (and has created) noticeably negative pictures of the relationship between diversity and social cohesion. While diversity does play a role in weakening social capital, there are significant benefits to the weakening of in-group boundaries that encourage strengthening other social identities superordinate identities. Furthermore, disadvantage has a much stronger eroding effect than diversity on social capital, and is associated with increasing tolerance. Diversity in fact improves tolerance when disadvantage is left out.

Cloud & Granfield (2008) have introduced the concept of “recovery capital” in the context of substance abuse treatment. Based on the definition of social capital, they define recovery capital as the internal and external resources that can be drawn upon to initiate and sustain recovery from alcohol and other drug problems. Recovery in that sense can be subdivided in three categories, namely personal, social and societal recovery capital. The idea behind it is that individuals with a larger compositional recovery capital would be more likely to recover from substance misuse problems.

The interaction and possible relation between, on the one hand, health and substance use and, on the other, embeddedness in bonding and bridging networks, and disposing of recovery capital, are useful in understanding mechanisms imputing substance use and creating barriers to treatment services at society and community levels, and when studying the hypothesis that interventions and policies that leverage community bonding and bridging social capital might serve as a means of population health improvement (Kim et al., 2006; Negi, 2011). We also wish to analyse how social capital, with its protective factors, interrelates with substance use and access to general health care and treatment facilities. Furthermore, social and recovery

capital should be considered when assessing resources and resistance to prevention interventions (Burkhart et al., 2011).

2.2.3 The urban context

According to Caponio (2006), cities are the place where the first contact between migrants and the members of the host society take place. Since the Antiquity, cities have been where people go in search of better living conditions and to escape tyrannical political regimes (Giband, 2011). Relationships between space and ethnicity are becoming increasingly complex due to the major transformations of contemporary cities (Leloup & Radice, 2008). Links between nation and territory, community and neighbourhood, region and local tradition are changing because of migration, mobility, globalisation and new, widespread communication technologies.

In early urban sociology the city was associated with anonymity and the end of the community (Tonkiss, 2005). Louis Wirth (in Tonkiss, 2005: 15) defines the city by its size, its density and its social heterogeneity, and suggests that physical proximity coexists with social distance. In 1967 Wirth wrote, “processes of segregation establish moral distances which make of the city a mosaic of little worlds which touch but do not interpenetrate. This makes it possible for individuals to pass quickly and easily from one moral milieu to another, and encourages the fascinating but dangerous experiment of living at the same time in several different contiguous, but otherwise highly separated worlds” (Wirth, in Tonkiss, 2005: 40–41).

The urban Chicago School of sociology focuses on urban segregation and social differentiation in terms of racial relations within an evolving pattern of competition, reciprocal adaptation and assimilation. This model of ethnically homogeneous neighbourhoods located near the city centre is progressively being replaced by variegated spaces including multi-ethnic neighbourhoods and peripheral areas (Leloup & Radice, 2008: 4). Indeed, neighbourhoods are the territory of ethnic and social diversity (Poirier, 2008), but sociability is also developing through an a-spatial base. The neighbourhood is not the only place of living, however; an individual can identify with several places in relation to the different dimensions of his or her experience.

The use and sale of (illegal) substances have had important transformative effects on those who live in multi-ethnic neighbourhoods (Kokoreff, 2010). Cities are central places for the accumulation of wealth, but they are also areas of social inequality. Cities concentrate social problems induced by the processes of marginalisation, social exclusion and many other urban social problems, such as racial tensions, crime and substance use related problems. In addition, cities provide the contextual conditions and the infrastructure necessary for the functioning of the drug market (Kübler et al., 2001).

The study of the urban framework is important for our research in several ways. First of all, the physical living conditions and locations of our respondents may influence their perception of substance use and access to treatment services. Furthermore, this perception could differ substantially from those living outside urban neighbourhoods or cities. We intend to study the role of the urban context in social mechanisms underlying substance use and access to treatment facilities.

2.2.4 Ethnic density

Ethnic density is defined as the proportion of co-ethnics in a certain ward or neighbourhood (Bécares et al., 2009). High ethnic density has been associated with decreased interpersonal discrimination and increased social support through engaging with people with different

migration backgrounds and enhanced social cohesion (Becares et al., 2009; Bhugra et al., 2005). Furthermore, lower neighbourhood socio-economic status in concert with fewer individuals from one's racial group is associated with increased reports of discrimination (Dailey et al., 2010 in Molina et al., 2012). Poorer health, such as higher levels of stress, anxiety and detrimental health-related behaviour, has in turn been attributed to, among others, interpersonal racism and discrimination (Karlsen et al., 2002; Williams et al., 2001). Epidemiological research has therefore studied ethnic density as a protective moderating effect in health (Karlsen et al., 2002).

Although some studies have found no significant effect of ethnic density on health, more recent studies do affirm this effect. Veling et al. (2008) have identified a significantly increased incidence of psychotic disorder and schizophrenia among people with migrant backgrounds living in low ethnic density areas in Den Haag. Low ethnic density was identified as an element for elevated risk in these first and second generation immigrants for psychotic and schizophrenic disorders.

Bécares et al. (2011) document the greater adherence to protective social norms in areas of high co-ethnic density in the United Kingdom. They study drinking patterns through a combined study of UK Department of Health surveys from 1999 to 2004 and the UK Census, which identifies the spatial concentration of people with a migration background. Respondents living in non-white areas reported decreased odds of being current drinkers, when compared to people living in white areas. This study is the first one to link ethnic density to alcohol use in the United Kingdom.

The relationship between discrimination and health has been studied extensively (Chae et al., 2008). The link between health and ethnic density as a moderating factor is less well documented. In their quantitative studies, Veling et al. (2008) and Bécares et al. (2011) have suggested that ethnic density may be a moderating factor in health. They do, however, also highlight some limitations that are particularly important for our qualitative research. The role of social selection (Veling et al., 2008: 6) or gentrification and individual levels of acculturation (Bécares et al., 2011: 24) may also be attributed a mediating role in the study of ethnic density. Furthermore, this research is based on respectively self-reported measures of alcohol use (Bécares et al., 2011) and DSM-IV definitions of psychotic disorder and schizophrenia (Veling et al., 2008). Both research teams recognise that these respective denominations are limitations to their studies because they may cause biased outcomes and cross-cultural validity was lacking.

Ethnic density often coincides with ethnic segregation in poor neighbourhoods (Verhaeghe, Vanderbracht, et al., 2012), which are often disadvantaged compared to neighbourhoods with low density or neighbourhoods with high ethnic white density (Laurence, 2009). Consequently, it should be noted that the deprivation of a community has a strong relationship with lower self-reported well-being (Hooghe & Vanhoutte, 2010). In this context, we should be cautious about reverse causation. Jamouille (2010), for example, notes in her qualitative study of Brussels neighbourhoods that higher ethnic density often coincides with high levels of perceived discrimination that in turn results in higher ethnic conformity pressure.

To the best of our knowledge, no studies relating neighbourhood ethnic density to health and substance use have been conducted in the Belgian context so far, although the protective ethnic density effect does demonstrate similarities to the characteristics and processes of ethnic conformity pressure as studied in the urban context by Van Kerckem et al. (2013) (see section 2.2.3).

2.2.5 Acculturative stress and discrimination

Although the use and misuse of drugs is not restricted to any sector of society, its high prevalence and associated social problems are particularly marked in areas and localities marked by social exclusion. We could therefore say that minority [ethnic] drug users are facing a position of double jeopardy: they carry the stigmata of racial exclusion and drug use.
(Khan et al., 2000: 9)

Some research directly links the migration process to acculturation stress (Berry, 1994; Berry et al., 2007). This stress, in turn, can negatively influence physical and mental health (Haasen et al., 2004; Lindert et al., 2008; Sam et al., 1995). Stress caused by acculturation could therefore lead to (elevated) substance use, serving as a coping mechanism (De La Rosa et al., 2000; Vega et al., 1998).

Then again, substance use can cause a more difficult acculturation process, in turn raising the accompanying stress. German research among migrants from the former Soviet Union shows that substance dependence among migrants can seriously interfere with the process of acculturation in the host country (Grüsser et al., 2005). On the other hand, multiple studies on Hispanic women report that the stress connected with acculturation and the changes in the position of men and women and the relationship between them, raises the risk of alcohol and substance use (Amaro et al., 2006; Finch et al., 2001; Vega et al., 1998). However, the role of acculturation in the origination of substance use among people with a migration background is not always clear (Vega et al., 1998).

Acculturation is defined as “complex processes and cultural contacts through which societies or social groups assimilate or are obliged to adopt the features from other societies” (Berry, 1994). Improvements in acculturation research have been made by giving a more specific definition to the concept of acculturation by adding variables such as language skills, birthplace, educational level, socio-economic status, relationship with peers, etc.

Several hypotheses can be distinguished when it comes to associating acculturation and substance use. The assimilationist model demonstrates that migrants’ substance use tends to progressively be similar to those of the members of the host society. This model is exemplified by the fact that higher levels of acculturation in Hispanic American youth cause greater normative approval of substance use and higher rates of actual substance use (Epstein et al. in Kulis et al., 2009). Furthermore, acculturation may produce an acculturation gap between parents and children that undermines parental control over risk behaviour such as substance use (Escobar in Kulis et al., 2009).

A third model is based on the fact that acculturation is a stressful process and considers substance use as a coping mechanism (Gibbons et al., 2012). Lastly, higher acculturation has been associated with a heightened awareness of disadvantaged ethnic minority status, triggering coping mechanisms such as substance use (Vega & Gil in Kulis et al., 2009). Nieri et al. (2005), Ebin et al. (2001) and Finch et al. (2001) have concluded that higher acculturation (see infra) results in higher prevalence of substance use, while lower acculturation is recognised as a protective factor (in Latino adults). Kulis et al. (2009) contrarily have found no evidence for this conclusion and point out that less acculturated (see infra) Latino youth perceive higher levels of ethnic discrimination and might consequently be more prone to substance use. It has previously been assumed that acculturation inevitably involves social and psychological problems, but recent studies report mixed results in regard to acculturation and mental health (Missinne et al., 2012).

Recent research rules out acculturative stress as the prominent and decisive risk factor for substance use. Kulis et al. (2009) have compared the relative impact of both acculturative stress and perceived discrimination, and conclude that the latter factor is far more influential.

The problem, though, is the fact that in most research discrimination is considered an aspect of acculturative stress and not measured separately even though there is no conceptual basis for this hierarchy. Recent studies on discrimination and substance use can be subdivided into studies that focus on individually perceived discrimination identifying mediating factors such as self-control (Gibbons et al., 2012) and coping mechanisms, and those that explore the impact of structural discrimination on health outcomes (Krieger, 2012).

Within the framework of a critical ecosocial approach (Krieger, 2012) to health and discrimination, we will explore how acculturative stress, structural and perceived discrimination interact and relate to substance use in the studied populations. We will describe the degree to which participants in our research feel exposed to perceived discrimination and how this relates to their ethnic identity and to the nature and patterns of their substance use.

2.2.6 Ethnic identity

Ethnic identity refers to a sense of belonging to an ethnic group, the pride of belonging and the degree of involvement (Chédebois et al., 2009). In terms of the identification process of an individual, it is important to examine their social ties. Identification is closely related to social ties, i.e. not only those between the individual and the ethnic group, but also those between the individual and those perceived of as 'natives'. De Vroome et al. (2011) demonstrate that having social ties with these 'native' people is positively related to national self-identification.

The development of one's identity must be seen along similar lines. The younger generation of people with a migration background learn how to deal with their "ethnic identity" in a new way, as part of the acculturation process of an individual. This can be very complex because of their life "in" and "between" two cultures. Further, certain features of the communities involved may additionally hinder the development of the identity (Rastogi et al., 2006).

When it comes to measuring ethnic identity, it is important to introduce the concept of collective identity. Ashmore et al. (2004) and numerous other researchers consider collective identity as a multidimensional concept (Ashmore et al., 2001; Deaux, 2013; Jackson et al., 1997; Phinney, 1992). The most basic element of collective identity is self-categorisation (Ashmore et al., 2004). In understanding ethnic identity we have based our research on respondents' self-categorisation (Phinney et al., 2007). In that sense, measurement of ethnic identity must begin with verifying that the individuals studied in fact self-identify as members of a particular group. This can be done by using open-ended questions/statements, for example by having the respondent complete sentences such as: "In terms of my ethnic group, I consider myself to be...". In this perspective, Phinney (1992) created the Multigroup Ethnic Identity Measure (MEIM) (see Annex I: Interview guide).

Research linking ethnic identity to substance use is quite contradictory (Taïeb et al., 2008). Individuals with low self-identification towards both the receiving culture and the "home" culture would be more vulnerable to substance use disorders (Oetting, 1994). A second hypothesis is that a low level of acculturation combined with a high level of ethnic self-identification serves as a protective factor for substance use disorders. A third hypothesis is that low ethnic self-identification may result in higher identification with deviant subcultures (Beauvais et al., 2002).

2.3 Barriers to care and treatment

2.3.1 Differences in care trajectories

International research points out the fact that care trajectories in substance abuse treatment are quite different in people with a migration background when compared to the general

population (Perron et al., 2009; Polanco-Roman et al., 2014). Professionals in Flemish in-patient and out-patient (Derluyn et al., 2008) substance abuse treatment centres have themselves noticed the absence of African clients, variations in the number of Eastern European clients, and the under-representation of clients with Turkish and Moroccan roots. For example, during the exploratory talks for the current research a stakeholder of a Flemish heroin substitution centre (personal communication, 14 July 2015) expressed concerns about accessibility for Congolese, Bulgarian and Slovakian populations. The stakeholder also attested that the centre's reach of users with Turkish and Roma roots and undocumented migrants had improved during the last couple of years.

Lodewyckx et al. (2005) studied the differences between care trajectories among youngsters with native and immigrant backgrounds (regarding mental or behavioural problems). They conclude that youngsters with an immigrant background find their way to treatment centres at a very late stage in their user careers. Earlier intervention would logically reduce the risk for escalation of the problem at hand.

Equal access to health care is a fundamental human right. Within this human rights perspective, users with a migration background seem to be confronted with various barriers when using those services (Scheppers et al., 2006). These barriers can be divided into different clusters. We use the threefold classification of Scheppers et al. (2006):² barriers at the individual, provider and societal level. This cluster stems from a socio-ecological model that provides a community understanding of health and offers an overarching framework for examining individual, organisational and social factors in mental health and substance abuse treatment services (Fleyry & Lee in Shattell et al., 2008). We agree with Scheppers et al. (2006) that this ecological approach should be complemented by including potential barriers at the system level. This approach is in line with Martiniello's approach to unequal social outcomes in people with a migration background at micro, meso and macro level (see section 2.2).

2.3.2 Barriers at the individual level

Within the category of individual barriers, we discern three barriers: cultural perspectives, religious perspectives and collectivist perspectives on the individual within the family. However, individual barriers are often intertwined with structural barriers. Also, there is a lack of *knowledge about the diversity of substance abuse treatment* among some people with a migration background. Some minorities are less informed about the existing diversity of care services, and about where to go with a specific health problem.

Among some ethnic communities, (illicit) substance use is strongly stigmatised. A feeling of shame or the fear of being stigmatised by their own community may prevent substance users from seeking help and recognising the problem (Ciftci et al., 2013; Clement et al., 2015; Sacré et al., 2010). Another barrier among people with a migration background is the fact that individuals may be *less conscious* of the gravity of the substance use related problem. Even when these individuals are conscious of the problem, actually *recognising the problem* is often too big a step (Derluyn et al., 2008).

Another barrier within the cluster of individual barriers may consist of a different cultural representation of the problem of substance addiction. This problem is twofold. Individuals with a migration background may adhere to a purely medical approach to substance use (Derluyn et al., 2008). Furthermore, different cultures have different concepts of health and disease (Lindert et al., 2008). This often creates cautiousness towards Western, formal addiction care services and Western therapy based in empowerment and self-reflection.

² Equally used by Derluyn et al. (2008).

Furthermore, substance users who describe themselves as having a migration background seem to have a greater inclination to rely on religious or spiritual explanations for their addiction problems. They turn, for instance, to spiritual healers or shamans (Derluyn et al., 2008) to resolve substance-related problems. Some scholars argue that this inclination is similar to native populations resorting to “alternative treatment” (Knipscheer et al., 2005).

2.3.3 Barriers at the provider level

Several barriers can be identified at the organisational level of treatment and general health care services. First, Fountain et al. (2004) determine a *lack of cultural sensitiveness* or “cultural awareness” within care services. If professionals and their clients share similar ethnic backgrounds, the sustainability of treatment may be influenced in a positive manner (Ellis, 1999 in Derluyn et al., 2008). Some research goes beyond the concept of cultural sensitiveness and points to a *lack of competence or willingness* by administrative, medical, and social actors to adequately inform and reach people with a migration background (Suijkerbuijck, 2014).

Furthermore, the **lack of cultural responsiveness** of the professional can be a reason why people with a migration background are under-represented in treatment services (Derluyn et al., 2008; Finn Ma Mat, 1994). An important element is the way the client perceives the health professional’s empathy, because this influences clients’ involvement (Fiorentine et al., 1999 in Derluyn et al., 2008). Another determinant is *the level of transcultural competence* of professionals. This competence takes account of the socio-cultural context and the familial context of the client. The presumptions of professionals are of vital importance to the success of treatment. Stereotyped images and missing the context of marginalisation, discrimination and poverty could lead to lower treatment completion rates (Quintero in Alegria et al., 2011).

At the organisational level, we can also distinguish a practical barrier. **Communication and language** are significant barriers to accessing and undertaking treatment. A lack of multilingual staff in addiction care services and the non-availability of interpreters can be seen as important motives to quit treatment (Derluyn et al., 2008). However, the use of an interpreter is not always the solution for overcoming the language barrier, as the intervention of an interpreter can also create distrust both in the client and in professionals (De Vylder, 2012).

2.3.4 Barriers at the system and societal level

Stigmatisation towards substance users occurs not only at the level of ethnic communities, but also among the authorities and society of the host country (Jung, 2004). People with a migration background might suffer *double stigma*, meaning that they suffer from being stigmatised both because of their ethnic identity and because of their substance use (Gary, 2005). This stigma has proven to have a negative effect on help-seeking behaviour, especially in ethnic minorities (Clement et al., 2015).

The “nature” of substance abuse treatment and the medical paradigm (Scheppers et al., 2006) can be seen as another potential barrier (Derluyn et al., 2008). Users with a migration background may feel uncomfortable or even threatened by the Western values, professional attitudes and scientific knowledge on which care services are based, for instance the concept of (medical) confidentiality (De Vylder, 2012).

Moreover, in many cultures, unlike in the West, substance use related problems or dependence are not seen as an illness (Derluyn et al., 2008; Muys, 2010) but as a criminal act. This means that the taboo surrounding substance use related problems is likely to be significantly greater in those countries than in Western countries.

Further, US based research mentions that health care policies and regulations at the city, state and federal level may result in access disparities (Alegria et al., 2011). Our personal communications with professionals in health care and substance abuse treatment centres confirm that budget cuts often result in limiting outreach work and suspending projects that promote broader access and diversity in treatment, health care and other relevant social facilities.

Many scholars (Amaro et al., 2006; Marmot et al., 2016) argue that low socio-economic status is a negative predictor of treatment results in the addiction care services. Furthermore, it is well established that the poor living conditions of substance users can result in socio-economic problems and a lack of attention towards health-related problems (Piérart et al., 2008). *Judicial status* is another barrier at the individual level. The accessibility to general health care and treatment services is often an extra problem for those individuals without permanent resident permits (Haker et al., 2010; Shattell et al., 2008) in that they cannot make use of the full spectrum of (mental) health treatment services.

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2.4 Overall assessment of the state of the art

In our review of the existing literature we depart from the idea that ethnicity and migration are dynamic concepts and therefore somewhat problematic when used as units of analysis. Two main research traditions can be distinguished: research that studies bounded ethnic groups; and research that refutes this unity of community, culture and identity, and therefore departs from individual variables in relation to substance use. The difference between these traditions often results in contradictory outcomes when the relation between ethnicity and substance use is studied. Nevertheless, lower health statuses and substance use have proven to be linked to lower socio-economic statuses and discrimination (Marmot et al., 2005; Otiniano Verissimo et al., 2014; Smedley et al., 2003; Warnecke et al., 2008). Furthermore, many individuals self-categorised as having a migration background often have lower socio-economic statuses (Manço, 2004; Van Kerckem et al., 2013). Additionally, these individuals are under-represented in substance abuse treatment facilities (Blomme, 2016; Verdurmen et al., 2004; Vandavelde et al., 2003).

Epidemiological prevalence studies offer insights into substance preference, prevalence and methods of use in specific people with a migration background. These studies allow us to identify the influence of accessibility of prescribed medication on the choice of substances (Argeriou, 1997), the influence of the country of origin on prevalence (Ramsey et al., 2001 in Rassool, 2006) and differences in prevalence between generations (Hjern, 2004) in specific ethnic minorities. Nevertheless, most of this epidemiological research remains problematic because its basic assumption is a distinction between ethnic groups (Giritli Nygren et al., 2014; Talley et al., 2014). Consequently, other explanatory factors, such as discrimination, remain subordinate in studying the impact of the ethnicity factor (Kulis et al., 2009).

We strongly argue for the need to diversify the concept of ethnicity at three levels, i.e. individual identification, ethnic mobilisation and social positioning (Martiniello, 2013). Consequently, we link substance use to the production and reconstruction of ethnic boundaries (Wimmer, 2013), and stress the importance of including the analysis of non-ethnic social mechanisms, and distinguishing ethnic processes from individual processes in social mechanisms. We will focus our qualitative research on the social dimensions of the urban context, ethnic density, (ethnic) conformity pressure and social capital. At the individual level, we will focus on acculturative stress, discrimination and the formation of ethnic identities.

We will explore how these social mechanisms influence the nature and patterns of substance use and access to treatment facilities. Recognising the complexity of the concept of ethnicity, however, impels us to create a new framework for taking a variety of non-ethnic factors into account, to define and be aware of the heterogeneity within and between the people with a migration background who we studied, and to place the aspect of ethnicity and migration in a wider context of non-ethnic influences at the micro, meso and macro levels.

We have reviewed scientific and grey literature, and have supplemented this review with personal communications with key figures to address the barriers that individuals with a migrant or ethnic background experience. We have clustered these barriers into individual, societal, and service-related barriers.

In our qualitative fieldwork we tested these sensitising concepts in the narratives of community members and users, and complemented them with new concepts that emanate from our fieldwork.

The concepts that we detail in this review – ethnic conformity pressure, social capital, the urban context, ethnic density, acculturative stress, discrimination and ethnic identity formation – have proven to be productive analytical concepts in the study of ethnicity and health. Our research design does, however, imply that we work both inductively and deductively in this exploratory

study, that we do not depart only from specific hypotheses, but that we are also open to new explanatory factors or contextual themes that emanated from the research context, the community researchers, the stakeholders, other field workers and community researchers.

Because of the difficulties related to conducting research in the areas outlined above, we have decided to work within a community-based participatory research design. We aim to improve the understanding of service planners and providers, build community capacity and, most importantly, create a bridge between academic knowledge, policy and practice. This research design will be described in depth in what follows.

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3 COMMUNITY-BASED PARTICIPATORY RESEARCH

Community-based participatory research (CBPR) is a research and engagement model developed to tackle health disparities in disadvantaged groups by installing equitable partnerships between academia and community-based partners (Belone et al., 2014; Bogart & Uyeda, 2009; Green et al., 1995; Israel et al., 2010; Israel et al., 2001; Krieger, 2014). It is a conceptual model for bridging evidence with policy-making (Cacari-Stone et al., 2014; Domenig et al., 2007; Minkler et al., 2008). When applying CBPR to the case of substance use in people with a migration background, the underlying rationale is not only to study substance and treatment use, but also to increase the understanding of service planners, commissioners and providers about segments of the population they serve (Domenig et al., 2007; Fountain et al., 2004). Furthermore, community involvement builds upon community capacity, and increases the likelihood of future sustainable interventions through existing social organisations and community structures (Bogart & Uyeda, 2009; Wallerstein et al., 2010). This way, CBPR also enables health disparities to be tackled at the fundamental levels of distributive and procedural injustice (Cacari-Stone et al., 2014). The engagement model is thus aimed at equality of access, equality of experience and equality of outcomes (Fountain & Hicks, 2010).

In what follows we will elaborate upon (1) the history and goals of the research design, (2) the concept of empowerment in this research design, (3) the application of CBPR to our four case studies and collaboration between a) project assistants, b) community organisations, c) community researchers and d) community advisory boards. We conclude by pointing out some of the pitfalls we encountered during the implementation of this model.

3.1 History and goals of the research design

Participatory research is an umbrella term for various research methods including CBPR.³ It can be traced back to Lewin's utilisation-focused action research (1948), Paulo Freire's emancipatory research (1968), and the more recent self-determination and sovereignty movements of indigenous peoples and ethnic minorities in the USA, New Zealand, Canada (Cargo et al., 2008) and the United Kingdom (Fountain & Hicks, 2010). Participatory research attempts to form partnerships between academics and those who will utilise and benefit from the results of the research to effect change (Salsberg et al., 2015). Community-based participatory research increases the relevance of the research questions, creates the potential for effective knowledge translation, and leads to a faster uptake of evidence into practice. CBPR, fundamentally (Israel et al., 1998):

- is participatory;
- is cooperative, engaging community members and researchers in a joint process to which each contributes equally;
- is a co-learning process;
- is an empowering process through which participants can increase control of their lives;
- involves system development and local capacity building, and achieves a balance between research and action.

³ Participatory research also includes action research, participatory rural appraisal, empowerment evaluation, participatory action research, community-partnered participatory research, cooperative inquiry, dialectical inquiry, appreciative inquiry, decolonizing methodologies, participatory and democratic evaluation, social reconnaissance, emancipatory research and participatory action research (Cargo & Mercer, 2008: 326).

These principles translate into five practices that characterise CBPR (Salsberg et al., 2015):

- the creation of an advisory board;
- the development of a research agreement;
- the use of group facilitation techniques;
- hiring from the community;
- having frequent meetings.

An extensive literature review on CBPR projects by Cargo & Mercer (2008) reveals that participatory research designs have significantly contributed to closing the gap between scientific standards, and social and cultural validity. Participatory research has proven its value specifically in: (1) illuminating the prevalence rates of health problems; (2) identifying the needs and priorities of diverse communities of interest; and (3) establishing causal associations between behavioural risk factors, social and environmental risk conditions, and the health status of vulnerable populations (Cargo & Mercer, 2008).

Local needs assessments in the tradition of rapid assessment or participatory action research prove to be useful in assessing and addressing specific needs in harm reduction and treatment (Castro et al. in Alegria et al., 2011). These methods have paved the way for grounded and specific interventions that reach populations through the knowledge gained about specific needs in communities and the difficulties in working with these communities. In assessing these needs and tailoring interventions, it should be underlined that not everyone with a migration background has the same needs, and that tailored interventions might not have the same impact on all individual group members (Sloboda et al., 2012).

Using methods of involvement, consultation, participation and engagement of people with a migration background (Fountain & Hicks, 2010) and not only key figures (Fountain et al., 2004) offers a useful insight into specific needs, supports capacity building and increases knowledge about and consciousness of substance use.

3.2 Empowerment

We consider that the participative aspect of our research not only allows us to collect data and easily reach substance users with a migration background; it also provides a way of increasing expertise in those communities. This concept of empowerment first arose in Anglo-Saxon literature, where the ideas of community and individual agency (capacity of doing) are strongly embedded in social values and leave little space for state intervention in the social sector. In the European and specifically the Belgian context, in contrast, the intervention of the state in the social sector is considerably greater. However, the notions of empowerment and voluntary participation were recently reintroduced both by both the state and social actors within the context of financial crises. We will elaborate upon the consequences of this evolution in our description of the CBPR process.

The concept of empowerment has been used in very different contexts since the 1970s, including the feminist movements in the USA and South Asia, popular education movements and black movements to name but a few (Biewener et al., 2014). For US battered women's associations empowerment focuses on egalitarian, participatory and local processes in which women develop social awareness (Biewener & Bacqué, 2014) to strengthen their internal strength and gain the capacity to individually and collectively act in a perspective of social change.

More recently, the concept of empowerment has been added to the international vocabulary of expertise and public policy of international organisations such as the United Nations and the World Bank (Biewener & Bacqué, 2014). The notion highlights the relationship between

knowledge and power within a knowledge society – in other words, acting consciously and rationally for community organisations presupposes being knowledgeable about community issues, both to represent and to advocate as the target of public policies. In the context of health research, empowerment and agency have been quoted as resolving the mystery of the health gradient by Syme (2004). Syme suggests that poverty and lower education cannot be the only determinants of worse health, and that control over one’s destiny – agency – may have a greater impact on health. In this line of thinking, Piérart et al. (2008) state that by diagnosing a health situation within a deprived community in close collaboration with the community itself, not only does the community form the basis for resolution of the situation, but the resolution process has already begun by tackling one of the possible determinants of unequal health statuses – empowerment and agency.

Scholars have highlighted the fact that a conceptual framework is still missing to consolidate the benefit of this type of research to academics and communities. Consequently, no association can be made between conducting this type of research and empowerment (Cargo & Mercer, 2008). The research of Cacari-Stone et al. (2014) is noteworthy in measuring the degree to which CBPR designs lead knowledge sharing between research and policy.

The most recent *Reliability Tested Guidelines for Participatory Research* (Cargo & Mercer, 2008) are an extended version of Green et al.’s (1995) five review criteria intended for research partners to evaluate and gain perspective in designing, implementing and evaluating community-based participatory research projects. However, these guidelines do not address issues of power dynamics, centralised power and equity of resources, nor the issue of adding or replacing new members through the project (Salsberg et al., 2015).

Taking into account that clarity concerning the scope of our design is paramount, we chose to limit our implementation and evaluation criteria to those outlined in table 1 during the project design, implementation and evaluation. We will use these criteria in describing our CBPR process.

Table 1: Criteria for CBPR evaluation (Green et al. 1995)

<p>1. Participants and the nature of their involvement</p> <ul style="list-style-type: none"> ✓ Is the community of interest clearly described or defined? ✓ Do members have concern or experience with the issue? ✓ Are interested members provided with opportunities to participate in the process? ✓ Has attention been given to establishing an understanding of the researchers’ commitment to the issue? <p>2. Origin of the research question</p> <ul style="list-style-type: none"> ✓ Did the impetus for the research come from the community? ✓ Is an effort to research the issue supported by the members? <p>3. Purpose of the research</p> <ul style="list-style-type: none"> ✓ Can the research facilitate learning among participants about individual and collective resources for self-determination? ✓ Is the purpose of the research to empower the community to address determinants of health? <p>4. Process and methodological implications</p> <ul style="list-style-type: none"> ✓ Does the research process apply the knowledge of community participants in the phases of planning, implementing and evaluating? ✓ Does the process allow for learning about research methods (community participants)? ✓ Does the process allow for learning about the community’s health issues (researchers)? ✓ Are community participants involved in analytics issues: interpretation, synthesis, verification of conclusions? <p>5. Nature of the research outcomes</p> <ul style="list-style-type: none"> ✓ Do community participants benefit from the research outcomes? ✓ Is there an agreement about the ownership of the research data? ✓ Is there an agreement about the dissemination of the research results?

3.3 The CBPR model in this study

The simultaneous and multifaceted engagement of supported and adequately resourced communities and relevant agencies around an issue, or set of issues, in order to raise awareness, assess and articulate need and achieve sustained and equitable provision of appropriate services.
(Fountain et al., 2004)

The Centre for Ethnicity and Health (UK) has developed a CBPR model based on the following key principles (Domenig et al., 2007) that are in line with the accepted principles in CBPR literature (Cacari-Stone et al., 2014; Israel et al., 2010; Israel et al., 1998, 2001; Lantz et al., 2001):

- raising the awareness of community members;
- reducing the community's stigma;
- capacity building within the community;
- increasing the trust of the community;
- involving local service planners.

These principles were part of a research project on substance use by ethnic minorities in the United Kingdom (Fountain & Hicks, 2010). This model was the blueprint for our research design. Rather than employing “external” people to conduct research, this approach involved forming a relationship with relevant “host” organisations (community organisations) that have helped us to recruit a team of researchers from the community, and to provide training to support the work. Four researchers (project assistants) from the universities involved provided ongoing support and mentoring to these community researchers (see infra). Training was provided to build the capacity of the community researchers alongside help with managing the project and quality assurance.

The four sub-studies each consisted of:

- an academic project assistant (see § 4.3.1);
- a community organisation (see § 4.3.2);
- at least 10 community researchers (see § 4.3.3);
- a community advisory board (see § 4.3.4).

Although we used the Centre for Ethnicity and Health's model as a blueprint for our research design, the execution of the projects differs substantially. First and most importantly, the scale of the projects differ: the UK project reached over 2,000 substance users in 30 ethnic groups in 47 geographical locations (Fountain et al., 2004), whereas the Belgian project reached 247 substance users in four ethnic communities in three urban areas. Second, the United Kingdom and Belgium differ substantially in their societal organisation and mobilisation of ethnic minorities. The United Kingdom has long-established community organisations as the backbone of the British model of multiculturalism (Vertovec, 2007: 28), whereas ethnic organisations in Belgium and more specifically in Flanders are less structurally embedded, less organised and are not recognised as liaison points between specific ethnic minorities and local or other governments.

3.3.1 The project assistants

The four project assistants, scientific staff members that work at Ghent University (three) and Université Libre de Bruxelles (one), were responsible for monitoring the project, and each one was responsible for one of the populations. Their main tasks were: the scoping literature review; organising information sessions and training and following up the community

researchers; monitoring the community researchers; and organising meetings of the community advisory board. The project assistants also sought out new respondents when community researchers were struggling to reach any participants or certain sub populations. This was the case in all sub-studies (see *infra*).

Two of the case studies were Ghent-based (the Turkish and the Eastern European communities) while the third target group could not be linked to a particular region (asylum applicants, refugees and undocumented migrants). Consequently, some of the work was carried out jointly, such as the regular dissemination of the call for participants, organising an information evening and the joint community advisory board for the Turkish and Eastern European communities (see *infra*).

The project assistants presented the project: at a heroin substitution centre in Ghent; during three municipal welfare meetings in Ghent (*Welzijnsoverleg*: Tolhuis, Brugse Poort, Bloemekeswijk, Sluizeken-Ham); at a neighbourhood team meeting in Ghent (Brugse Poort); at an out-client centre for dual diagnosed clients (Villa Voortman); to staff members of Flemish refugee centres (*Wingene*); and at a youth organisation in Ghent (NPO Jong). The project assistants conducted exploratory interviews with staff members of in-client, out-client and outreach substance abuse treatment centres, municipal health centres (*wijkgezondheidscentra*), youth organisations, other municipal services and key figures in the respective communities. The goal of these preliminary talks was to gain insight into the phenomenon of substance use in the four populations and during the writing of the literature review. These contacts were also made to create a network for dissemination.

3.4 Community organisations

Ethnic minority civil society organisations were considered to be important stakeholders in this project. Early on in the project we noticed that this pillar of the CBPR model could not easily be established in the Belgian context. This is mainly due to the fact that the CBPR model was developed and refined in the United States and United Kingdom. In these Anglo-Saxon countries the multicultural societal model consists of the recognition of ethnic groups through the establishment of subsidised ethnic organisations parallel to other “native” socio-cultural organisations. These organisations also exist in Belgium, but enjoy less funding. Furthermore, community and neighbourhood-based (mental) health care systems are well developed in Anglo-Saxon countries, whereas – despite recent efforts and reforms – they are more centralised in the Belgian context. Lastly, both the socio-cultural and the mental health care sectors in Flanders are undergoing far-reaching governmental reforms,⁴ putting pressure on their organisational structures.

The first stage of the project was essentially focused on finding support in ethnic communities and finding suitable community organisations. In each of the four communities we identified community organisations through personal contacts, stakeholders, professionals from treatment and prevention services, and specialist networks, academics and professionals with expertise on people with a migration background. Once the partnership with community organisations was established they received a small financial recompense for their collaboration.

We applied the following criteria in selecting the respective community organisations:

- an ethnic and/or cultural minority-based organisation or a community-based organisation that demonstrates that it undertakes a substantial amount of work with, or on behalf of, the ethnic and/or cultural minority;

⁴ New Flemish decrees for both socio-cultural work and mental health care, indicating a restructuring of the municipal, provincial and community organisation of these sectors.

- able to identify at least 10 volunteers from within their community who would be willing to be trained, and supported to conduct interviews;
- able to access members from people with a migration background;
- able to secure the support of, and engage with, key service planners and providers.

A symbolic commitment agreement was signed in May 2015 by the Institute for Social Drug Research (Ghent University) and the participating organisations, reflecting their mutual commitment to the project.

3.4.1 The Turkish community

Over 100 organisations run by people with a Turkish migration background support their own community in Ghent. These organisations are usually run by a single individual on a voluntary basis. They bring Turkish people together for leisure and socio-cultural activities. Many of these organisations initially brought people together who originated from the same region in Turkey. Also, some of these organisations are indirectly linked to political or religious movements. They offer services that people of Turkish origin initially could not find in “regular” municipal or governmental services (e.g. educational support, language lessons, administrative support, etc.). Over the years several federations were installed to strengthen these and other ethnic organisations. VOEM, the Turkish Union, CDF (Federation for Progressive Associations) and FZO-VL (Federation of Community Organisations Flanders) are examples of these federations with multiple paid staff in Brussels and Flanders.

Because these federations reach a large number of organisations and individuals of Turkish origin, we chose to work with two of them instead of partnering directly with individual community organisations. Because of personal and well-established professional contact we partnered with CDF and FZO-VL. These organisations focus on a broad range of political and religious ideologies to reach people from various regions of Turkey. They unify 16 and 15 Turkish community organisations respectively.

We chose those two federations to minimise the risk of participants dropping out the project and to reach the widest possible audience, both for finding community researchers and for finding research participants. The community organisations have actively collaborated in finding community researchers and later on in the organisation of a meeting with potential community researchers, and its delegates participated in the four meetings of the community advisory board. The premises of these two organisations were used alternately for the training of community researchers and peer interventions.

3.4.2 The Eastern European communities

The Eastern European communities in Ghent stems from a fairly recent migration flux (see infra). Therefore it is not as organised as, for example, Turkish and African communities in the city. Of the 82 recently recognised community organisations in Ghent, no more than 10 organisations represent the Eastern European communities and individuals.

In 2012 the Bulgarian Cultural Centre, a non-profit organisation (NPO) (a member of FZO-VL, the Turkish community organisations), was officially opened. Its main goal is to advise people of Bulgarian origin of all ages and to offer tutoring for students, Bulgarian and Belgian language classes, etc., so that their integration in the community of Ghent is optimised. In 2013 the NPO De Magische Stem was founded by a small group of Bulgarians in Ghent. It is a Bulgarian cultural organisation that wants to improve the image of the Bulgarian community, emphasising the wide variety of Bulgarian migrants. The organisation aims to provide a platform for the creative, working and enterprising Bulgarian people who want to keep Bulgarian culture alive and pass it on to their children. Further, it wants to support charity in Bulgaria by organising charity events in Ghent and the surrounding area.

Therefore we chose to work with an organisation that could most help us to reach an Eastern European subgroup, namely Bulgarian Roma. The NPO Opre Roma is a one-person community organisation run by volunteers. The main aim of this organisation is to tackle the issues the Bulgarian community is dealing with and to spread positive signals to the whole community. They want to fight the persistent prejudices and be a point of contact for the community and the local authorities.

Opre Roma focuses on the current situation of Roma in Belgium, more specifically in Ghent. It wants to widen the policy scope relating to Roma from one that deals with separate “problems” or issues, to a more encompassing “theme” approach. It aims to provide honest and accurate information on the culture and situation of Roma people. With that in mind, volunteers organise informative, cultural and sports activities for Roma and non-Roma people. Opre Roma is recognised by the Ministry of Welfare and is the only named NPO working with Roma in Ghent. There are no other significant community organisations within the Eastern European communities in Ghent.

All of these organisations are driven by volunteers and are fully dependent on funding. We contacted every organisation more than once. Some we could get hold of, others we couldn't reach or they weren't willing to cooperate as community organisation. Opre Roma was willing to participate and to act as the community organisation of this sub-study.

3.4.3 Asylum applicants, refugees and undocumented migrants

During our search for community organisations we also sent out a call to experts and policy-makers who focus on asylum applicants, refugees or undocumented migrants, and to professionals who work for organisations in the field. Eventually we established links with two community organisations. The first of these is the NPO Free Clinic, located in Antwerp. Free Clinic offers out-client services to people who use illegal drugs and have a serious addiction problem. It operates within a harm reduction perspective and helps users with addiction problems. Many undocumented migrants find their way to these low-threshold services.

The second community organisation is the Mind-Spring project (embedded in Agentschap Integratie & Inburgering), located in East Flanders, Ghent. Mind-Spring is a psycho-educational programme for asylum applicants and refugees. The programme is guided by qualified trainers who have had experiences that are characteristic of refugees and asylum applicants.

The NPO Free Clinic reaches undocumented migrants; the Mind-Spring project reaches asylum applicants and refugees. The organisations actively collaborated in finding community researchers and in participating in the meetings of the community advisory board. The Free Clinic premises were used for training community researchers and other meetings.

3.4.4 The Congolese community

Finding a suitable community organisation to conduct the research in the Congolese community in Brussels turned out to be quite difficult, because of the weak professionalisation of the Congolese associative structure in Belgium (Demart, 2013; Manço et al., 2013; Rea et al., 2006). Although there are more than 600 Congolese associations (Godin et al., 2015), only a few of them are really working and receiving public subsidies. The current situation of the Congolese associations reflects the social exclusion and ethnic discrimination faced by the Congolese community in Belgium.

When searching for a community partner, many of the key figures with Congolese origins (priests, doctors, and Belgian officials) directed our interest to organisations such as Observatoire Bayaya, l'amicale Lipopo, Change and Mémoires coloniales, and to associated

organisations (Maison Africaine, Free Clinic) and public agents (Service de prévention de la Commune d'Ixelles, Stewards de rue de la Commune d'Ixelles, et Police d'Ixelles) acting in the neighbourhood of Matongé, which is the meeting point of the Congolese community in Belgium even though not many live there (Schoonvaere, 2013). Some organisations expected more financial reimbursement for the partnership than we were able to offer, others considered that their work was too different from the subject of the research.

Eventually a partnership was officialised with the organisation Change in Congo. Since this partnership was initiated when data collection had already started in the other case studies, the relationship with the organisation was not easy: the process of agreement for the partnership was long and slow at the beginning, and most communication was about their financial recompense for the project. Despite these difficulties, the partner organisation did help promote the project to find respondents and community researchers. The project assistant announced the search for community researchers four times on a Congolese radio station. But the majority of the community researchers were found thanks to a student job advertisement on the website of the Université Libre de Bruxelles and Infor Jeunes. During the research process, contacts with other Congolese representatives and associations (le Manguier à Fleurs, Carrefours Jeunes Africains) helped us find Congolese drug or alcohol users.

3.5 The community researchers and participants

Initially, each project assistant aimed to reach a minimum of 10 community researchers per sub-study via the community organisations. Potential community researchers were invited for a personal interview with the project assistants and were screened on their communication skills, potential research skills, empathic attitude and social engagement.

Once recruited, the community researchers in each sub-study were asked to attend a nine-hour training session on how to conduct in-depth semi-structured interviews on issues surrounding drug use in people with a migration background. The training particularly emphasised qualitative techniques, basic awareness of drugs with an emphasis on drug types and effects, Belgian legislation, and the study's conceptual framework, aims and design. During these training sessions we also discussed ethical dilemmas, research methods and interview skills. In addition, we discussed how to deal with requests for help, and questions about anonymity, and how to approach the sensitive subject of substance use. Participants who had finished the entire training were awarded a certificate in community research and drugs by Ghent University and Université Libre de Bruxelles. They also received a financial payment for their voluntary work in the research project, namely conducting semi-structured interviews with substance users. The research team developed an interview guide that was discussed at the end of the training with the community researchers of each sub-study separately (see Annex I). This guide was adjusted based on the community researchers' feedback.

3.5.1 The Turkish community

In the search for community researchers we used an information leaflet and contacted the community organisations and other organisations in the socio-cultural field. Posters about an information session in Ghent were distributed to community centres and small Turkish entrepreneurs in the city centre, the Brugse Poort and Dampoort neighbourhoods (see Annex II: Boroughs in Ghent municipality). During the information session we met about 30 people who wanted to volunteer as a community researcher. Seventeen of them eventually participated in the nine-hour training programme, which was organised on three different occasions.

Thirteen of the 17 community researchers conducted a total of 57 interviews over a period of seven months (May to November 2015). Four interviewers did not conduct any interviews. Eight of the interviews turned out to be invalid.⁵ The project assistant conducted 13 interviews with an audience that could not be reached by the community researchers, more specifically heroin and methadone users.

Eight intervision (colleague supervision) sessions were organised during the period of data collection, and the project assistant visited the community researchers at their homes about four times for supervision. Specific questions, doubts and difficulties were discussed. These sessions also allowed the project assistant to establish a relationship with the community researchers, to keep abreast of their motivation, the quality and quantity of the interviews and the type of participants.

The group of research participants was largely influenced by the profiles of the community researchers; table 2 summarises the researchers' characteristics.

Table 2: Characteristics of the Turkish community researchers

Age	Average: 37, youngest: 19, oldest: 54
Gender	7 women, 6 men
Education	7 highly educated, 6 attained secondary education ⁶
Profession	6 in permanent employment, 2 in temporary employment, 3 unemployed, 2 students
Motivation	7 professional and personal motivation, 3 experience with use in the family, 3 want to empower the Turkish community in dealing with substance use
Generation	10 second generation, 2 third generation, 1 first generation ⁷
Origin	Emirdag, Eskisehir, Izmir, Posof, Black Sea
Place of residence	Boroughs of Ghent (5), Ghent: Brugse Poort (2), Ghent: centre (2), Ghent: Tolpoort (1), Ghent: Bloemekeswijk (1), Ghent: port (1), outside Ghent (1)

3.5.2 The Eastern European communities

The goal was to find ten motivated community researchers who would each carry out ten interviews with users of Bulgarian or Slovakian origin. During the information session we met about eight people who wanted to volunteer as a community researcher. Seven of these participated in a nine-hour training session in Dutch that was organised on two different occasions. We met another three interested people as the project progressed. Two of them were trained at a six-hour training session in English and one was trained at a one-day training session in Dutch. This report was also presented to the community researchers, and their feedback was incorporated. The advantages and disadvantages of working with community researchers are described in chapter 6 of this report, as they are very similar in the four sub-studies.

Eight of the ten community researchers conducted a total of 63 interviews over a period of seven months (May to December). Two trained community researchers did not conduct any interviews. One interview turned out to be unusable.⁸ The project assistant conducted three interviews with an audience that wasn't reached by the community researchers, more

⁵ One of the community researchers lost three audio files because his recording device broke down. Five interviews could not be analysed due to a variety of reasons: the quality of the audio file for one interview was too low; one participant retracted his permission for the use of the interview afterwards; one interview was not transcribed in time; one interview was not recorded; one participant was interviewed twice, by two different community researchers.

⁶ We defined low education as not having completed secondary education; and highly educated as having completed higher education (bachelor's or master's degree).

⁷ See 4.2.4 "Generations" in chapter 4 for a definition of these generations.

⁸ One interview was not transcribed in time.

specifically heroin and methadone users. During the period of data collection three intervision sessions were organised and each community researcher had about three supervisions at various places (e.g. their home, the office of the project assistant, a cafeteria). During these meetings specific feedback was given on their interviews, and questions, doubts and difficulties were discussed. These sessions also allowed the project assistant to build up a relationship with the community researchers to keep abreast of their motivation, the quality and quantity of the interviews and the type of participants.

The group of research participants was largely influenced by the profiles of the community researchers; table 3 summarises the researchers' characteristics.

Table 3: Characteristics of the reserchers from the Eastern European communities

Age	Average: 31, youngest: 26, oldest: 36
Gender	6 women, 2 men
Education	7 highly educated, 1 attained secondary education
Profession	3 in permanent employment, 4 in alternative temporary employment and unemployed, 1 part-time student/part-time permanent employment
Motivation	5 professional and personal motivation, 3 financial motivation
Generation	8 first generation ⁹
Origin	6 from Bulgaria, 2 from Slovakia
Place of residence	Eeklo (2), Ghent: Ledeborg (1), Ghent: Sint-Amandsberg (1), Ghent: Elisabethbegijnhof-Papegaai (1), Ghent: Macharius-Heirnis (1), Ghent: Rabot-Blaisantvest (1), Ghent: Muide-Meulestede (1)

3.5.3 Asylum applicants, refugees and undocumented migrants

To identify community researchers for this research group we used an information leaflet and sent out a call to our community organisations. The goal was to find 10 motivated community researchers who would each conduct 10 interviews with asylum applicants, refugees or undocumented migrants who use substances. An information session was organised and three different nine-hour training sessions were organised in May and June – two in Dutch and one in English. An extra training session in French was given for two French-speaking community researchers. Finally, one more training session in Dutch was given in September. In total, 14 community researchers were trained.

Eleven of the 14 community researchers conducted a total of 71 interviews over a period of seven months (May to November). During the period of the data collection, seven intervision sessions were organised and the project assistant supervised the community researchers through telephone calls, individual meetings and emails. During these meetings specific questions, doubts and difficulties were discussed. These sessions also allowed the project assistant to establish a relationship with the community researchers, to keep abreast of their motivation, the quality and quantity of the interviews and the type of participants and to give them the support and feedback they needed to succeed in their task as a community researcher.

The group of research participants is largely influenced by the profiles of the community researchers; table 4 summarises the researchers' characteristics.

⁹ See 4.2.4 "Generations" in chapter 4 for a definition of these generations.

Table 4: Characteristics of the community researchers in the target group of asylum applicants, refugees and undocumented migrants

Age	Average: 39, youngest: 26, oldest: 57
Gender	2 women, 9 men
Education	7 highly educated, 1 attained secondary education, 3 unknown
Profession	3 in employment, 5 unemployed, 3 students
Origin	3 from Afghanistan, 2 from Iraq, 1 from Rwanda, Ghana (1), 1 from Morocco, 1 from Syria, 1 from Iran, 1 from the United Kingdom
Place of residence	Ghent (3), Antwerp (2), Gentbrugge (1), Dendermonde (1), Deinze (1), Anderlecht (1), Vilvoorde (1), Genk (1)
Type of residence permit	8 definitive residence document, 8 undocumented migrants

3.5.4 The Congolese community

The Congolese community researchers were recruited through various channels. Posters were distributed via student houses and community organisations, the project assistant advertised the project on four radio shows (Radio Panik, RADIO Air Libre, Radio Campus), in a treatment centre and at the student job website of Université Libre de Bruxelles. This last source resulted in most of the community researchers, while the other sources only resulted in six community researchers. Twenty-two community researchers were found via the student job site and trained during a one-day training session. Since most community researchers were students and the training was organised on campus, there was not a lot of interaction or debate about the research questions or the interview guide. Unfortunately, only seven of these student community researchers conducted interviews.

Maintaining regular contacts with the community researchers for this group was quite hard. At the start of the data collection period (June 2015–January 2016) some of the community researchers became demotivated, first because of technical research issues (the financial payment that had been promised to the respondents could not be handed over at the time of the interview), and second because of the weak level of awareness of drug and alcohol use among these community researchers. During the training in June 2015 it was obvious that the majority of these community researchers knew little about drug and alcohol use.

The community researchers were unable to find users within their own circles. This is related to a high level of suspicion and paranoia in the Congolese community when someone is interested in socially taboo topics. There is a fear of reinforcing the bad image of the Congolese community and its poor reputation. This kind of reaction is typical of people who have had bad experiences with police officers and authoritarian structures.

The female community researchers were the most productive. However, by the end of the data collections period, despite the efforts of the project assistant to find users, all the community researchers were inactive. At this moment, the project assistant started conducting interviews herself together with an intern of sub-Saharan origin.

3.6 Community advisory boards

Each project assistant mobilised a large group of stakeholders, in collaboration with the community organisation. These stakeholders included target group representatives, commissioners of drug services at regional and local level, and a range of other agencies including health, housing, outreach workers and local academic institutions. In each sub-study these stakeholders were invited to participate in a community advisory board, which met every two to three months and had a decisive input into each key moment of the project. These community advisory boards were a valuable way of obtaining feedback on the progress of the

sub-studies, and of involving those who have a vested interest in the results of the research and could ensure the sustainability of the work.

3.6.1 The Turkish and Eastern European communities

The community advisory board for the Turkish community consisted of a delegate from FZO-VL and CDF (the Turkish community organisations), a representative of the NPO InGent, a staff member of the NPO Jong, the municipal drug officer, a staff member of the municipal outreach service, the president of Moslim Adviespunt and NPO Avroes, the coordinator of the Institute for Social Drug Research, the project assistant and a member of the Centre for Turkish Studies of Ghent University. After the first meeting the group was supplemented with an experience expert and a staff member of the municipal Integration Service.

For practical and contextual reasons we decided to combine the community advisory boards for the Turkish and the Eastern European communities in Ghent. It offered the project assistants the advantage of comparing challenges and successes in the work with the two populations and to adjust the research process accordingly. It also reduced the amount of time spent attending them by members of the community advisory boards employed in municipal services.

The community advisory board was therefore extended to include a representative of the Roma organisation Opre Roma. Following a presentation of the project to a group of local welfare practitioners (*Welzijnsoverleg*) we were advised to include the coordinator of a homeless shelter (Huize Triest) that houses many Bulgarian and Slovakian residents.

The main goal of these two-monthly meetings was to systematically verify and adapt the research goals to the needs of the populations and professionals in addiction care and the socio-cultural field. Moreover, the members of the community advisory board were regularly contacted on an individual basis about specific questions. The following items were discussed at length in the community advisory board:

- the timing of the project;
- the content of the training provided to community researchers;
- the interview guide;
- supplementing the participant pool;
- reporting and disseminating the research results;
- keeping the subject of this research on the municipal policy agenda.

This report was also presented to the community advisory board, and their feedback was incorporated in the text. The board' mainly reflected an interest in successful referral systems, which resulted in a small sub-chapter about this topic in chapter 4.4. The community advisory board's concerns were included in our recommendations (chapter 9). Furthermore, the work plan of the project was discussed with the community researchers. The project planning was adapted because of the fact that many people with Turkish roots go to Turkey during the summer holidays. We decided to prolong the period of data collection by two months. The research outcomes were also discussed with all actors in the project (see supra) and their feedback was incorporated in this report. This report, and the expertise created in the community organisations and community researchers, will enable the research design to be refined and introduced in other fields of research or in new research on local need assessments. The dissemination of the research outcomes was also conducted in close collaboration with all the actors in the project.

3.6.2 Asylum applicants, refugees and undocumented migrants

The community advisory board for this research group consisted of a delegate from each of the two community organisations (Free Clinic and the Mind-Spring project), a representative

of Fedasil, a retired professional from the Red Cross asylum centre in Wingene, a representative of Stedelijk Opvanginitiatief (SOI) for asylum applicants in Ghent, a representative of the heroin substitution centre in Ghent, a researcher from the International Centre for Reproductive Health (ICRH), a physician from the Fedasil asylum centre in Poelkapelle, the project assistant from the Turkish sub-study, the project assistant and the promoter of the sub-study for asylum applicants, refugees and undocumented migrants.

The main goal of these meetings was to systematically verify and adapt the research goals to the needs of the target group and professionals in addiction care and organisations in this field. The following items were discussed at length in this community advisory board:

- input from professionals/experts (sharing expertise);
- building bridges between different organisations;
- reporting and disseminating the research results;
- converting the research results into action.

This report was also presented to the community advisory board and its feedback was incorporated in the text. For example, this board advised us to subdivide user groups into users that started using substance/s in their home countries, during their migration or in Belgium.

3.6.3 The Congolese community

The creation of a community advisory board for the Congolese community was not really successful. The first meeting was set late in the data collection period (instead of before the data collection period or the training of the community researchers). This community advisory board included researchers, local associations, user services and community researchers but only a few of them actually attended the meeting, and none of the community researchers were present.

Many people were contacted as potential members of the community advisory board: Congolese doctors, pastors, musicians, associates, police officers in Matongé, prevention workers and a mother who belongs to a Congolese Uccle-based association for drug prevention among Congolese youngsters. This association received funds, collaborated with the police, and diffused its know-how and methodology even in Canada, but recently it was judged to be unprofessional and it no longer receives subsidies. The discussions we held with the people who attended this community advisory board were extremely interesting and highlighted the link between prevention and policing services.

3.7 Data collection: interviews

Upon completion of the training workshops, community researchers were asked by the project assistant to consider the various points from which they could begin to access members from their community to participate in the research. In collaboration with the community organisation and the community advisory board, they contributed to the wording of the interview guide. The project assistant prepared an introduction that explained the nature and purpose of the research, and stressed that interviews were confidential and reported anonymously. This document was discussed with the community researchers and adapted accordingly.

The interviews focused on several themes from international literature that appeared to be relevant (Fountain et al., 2004), namely: ethnic identity, structural and perceived discrimination, ethnic density, social capital, ethnic conformity pressure, and the individual, organisational and structural barriers to substance abuse treatment care.

Community researchers were asked to conduct 10 to 12 interviews (in order to reach a preliminary goal of about 100 interviews per sub-study) with participants meeting the following inclusion criteria: they described themselves as belonging to the particular community or target group under study; they were between 15 and 65 years old, and had experience of illegal substance use or episodes of excessive drinking in the last year. Respondents were recruited using respondent driven sampling, a recruitment strategy specifically designed to research hidden networks of at-risk populations in precarious situations (Heckathorn, 2011). The participants were encouraged to identify and access a sample of the community under study, as representative as possible, but we did expect that some community researchers would experience difficulty in accessing participants outside their own peer groups (Salganik & Heckathorn, 2004; Schonlau & Liebau, 2012). Because of the risk of not reaching certain subgroups via this “insider” sampling technique (Simon et al., 2010), we supplemented it with purposive sampling.

During the fieldwork, it turned out that the initial aim of reaching 100 interviews per sub-study was overly ambitious, and it had to be scaled down. Instead of artificially striving to reach this initial goal and losing quality in the process of making short cuts, we decided to stick to a similar in-depth procedure throughout the data collection phase, which resulted in a smaller number of respondents. Over the course of six months we conducted 71 semi-structured interviews with members of the Eastern European communities in Ghent, 71 with undocumented migrants in Flanders, 70 with members of the Turkish community in Ghent and 54 with members of the Congolese community in Brussels. Most of these interviews were conducted by the community researchers. Some of the interviews were conducted by the project assistants (n=19); these interviews were mostly with problem heroin users and hard-to-reach Congolese users. In the end only 247 interviews were analysed (see infra).

About half of the interviews were carried out in mother-tongue languages, and some in Dutch, English or French. These interviews were audio recorded. Researchers were asked to conduct interviews in settings where the interviewees felt comfortable and the safety of both parties could be ensured. Information about the study aims and confidentiality was given to all participants prior to the interview (Salganik et al., 2004). Community researchers were asked to inform their project assistants when participants made specific requests for help during the interviews. The researchers were largely supported by the project assistants guiding the sub-studies. This guidance mainly consisted of peer group sessions and individual assistance.

All interview tapes were transcribed as soon as possible after the interview (Silverman, 2013). This allowed the project assistants to examine the data in detail, and remain aware of data collection saturation. Where translation of interview recordings was needed, this was done by the community researchers and in some cases by the project assistants.

3.8 Data analysis and dissemination

The period of data analysis took about seven months. Interviews were considered valid when we received the audio transcripts (including oral informed consent), the interview guide with (anonymised) personal information about the participants and ad verbatim transcripts. These research proceedings were approved by the Ethical Committee of the Ghent University Faculty of Law. Most of the interviews were transcribed by the community researchers and some by the project assistants.

After having received the first interviews of the community researchers, the interview guide was slightly modified and simplified. This was mainly because most community researchers had interpreted the interview guide as a questionnaire. They read out the questions literally, which prevented the participants from speaking openly about the topics. This in turn led to difficulty in obtaining rich, in-depth data.

A first phase of grounded coding in the qualitative data software Nvivo 9 was conducted by one of the project assistants following interviews with participants from the Turkish community in Ghent, during the data collection period. An initial coding list was used during this first phase, notwithstanding the fact that new, emerging themes were identified (Hesse-Biber et al., 2010). This procedure was carried out in all interviews with Turkish participants and resulted in a proposal on the main coding categories and procedures for all the sub-studies. Each project assistant applied this coding list to some interviews in each target group. This way, the coding list was further refined and categories specific to a target group were identified. After checking for inter-code agreement by having one interview in each target group analysed by all project assistants, each assistant adapted the coding list to match the respective populations.

A report was created for each sub-study/target group based on the analysis of the interviews, field notes, reports of meetings with the community advisory board and community researchers and literature on the target group. This report was presented to the respective community advisory boards and to the community researchers. Their feedback and deliberations were included in the current report. The members of the community advisory boards for the Turkish and Eastern European communities, for example, asked us to refine the recommendations and to put the emphasis on referral systems in substance abuse treatment care.

The preliminary results for each of the sub-studies were discussed in a one-day small-scale seminar with the community researchers, the project assistants (the academic staff), the project manager and other representatives from the community organisation, and the community advisory board (stakeholders), and we jointly agreed on the final conclusions and on the policy, practice and research implications of the findings. In these seminars we also discussed how the findings and recommendations could be disseminated and promoted (among the communities under study, among the community researchers' networks, and to policy-makers, relevant professionals, organisations, civil society and academics).

3.9 Difficulties in CBPR

Collecting data about people with a migration background is often difficult for WEIRD¹⁰ academics (Van buren, 2010). We anticipated these risks primarily by means of the proper CBPR design and by working with community researchers. However, this design does not eliminate all possible difficulties. Some of them are specific to the target group, others to the researchers and still others to the research context and setting.

3.9.1 The participants

¹⁰ Western, educated, and from industrialised, rich and democratic countries (Henrich et al., 2010).

As mentioned above (section 3.7) participants were recruited using respondent driven sampling, a recruitment strategy specifically designed to research hidden networks of at-risk populations in precarious situations (Heckathorn, 2011). The construction of the waves was decided upon by the community researchers themselves. Participants were given a EUR 30 gift voucher for a supermarket as an incentive for participation. Community researchers did have some difficulty accessing interviewees outside their own peer groups (Salganik & Heckathorn, 2004; Schonlau et al., 2012). In the Turkish community, for example, the researchers were unable to reach heroin or cocaine users, although this sub-target group exists. As a result, project assistants had to supplement the sample through purposive sampling (see case studies) for these populations.

All experienced researchers realise that it is sometimes hard to meet participants and carry out an interview. It entails remaining in close contact, arranging a fixed appointment at a proper date, hour and location. Furthermore, the target group of substance users is a particularly hard population to reach. These difficulties were discussed with all community researchers during their training. Despite this, many of the community researchers became demotivated after several experiences of not being able to carry out an interview because of a problem in communication. There was an extra difficulty in the group of undocumented migrants, because they do not have a fixed place of residence. In addition, some participants didn't have a mobile phone, which made it hard to communicate with them and make an appointment

The search for asylum applicants who were substance users was another difficult mission for community researchers. While it remains difficult to convince any substance users to be interviewed, it was even harder to convince them if they were also asylum applicants. They were often very suspicious, especially of talking about their substance use. They found it hard to believe that talking about their substance use to the researcher would not have consequences for their asylum application. The word "interview" also had the connotation of the official interview with governmental officers for received residence document. These factors made it particularly hard for the community researchers to find substance-using asylum applicants willing to be interviewed. Moreover, none of the active community researchers were asylum applicants during the period of the research project, and this was probably another potential reason why we did not reach many asylum applicants.

Another difficulty that affected different community researchers – whether they had a background as an (ex)substance user or not – was the fact that some respondents were under the influence of a substance while the interview took place. Some interviews took place regardless of this, others were cancelled or delayed to another time.

The fact that the participants belong to an ethnic minority was an extra difficulty for the data collection. Ethnographic researchers such as Deutsch (2008) and Hagendorn (2008) point out that people with an ethnic background, particularly those involved in gangs or substance use, are very sensitive about how they are perceived by others and are easily hurt by discrimination or stigmatisation. This resulted in many of the respondents using "politically correct" explanations for their substance use to avoid stigmatisation. Furthermore, some of the community researchers did not succeed in putting their own normative systems and beliefs aside while interviewing, which of course influenced the scope of the answer of the participants.

Finally, for some respondents, the question of financial reimbursement was the main incentive to agree to do an interview. Some interviewees asked for financial compensation before the community researchers had time to explain the goal and the process of the research, and some respondents considered that the gift voucher (EUR 30) wasn't enough money.

3.9.2 Positionality of co-ethnic community researchers

Having interviews conducted by people from the same ethnic background as respondents (co-ethnics) has several advantages; nevertheless, most of these advantages also come with considerable disadvantages and ethical issues. First, co-ethnics have easier access to co-

ethnic participants, but some participants feel more at ease talking to someone neutral who can guarantee not to spread information within the respective communities. In close communities, such as the Turkish community in Ghent, the subject of privacy and confidentiality cannot be guaranteed by semi-professional community researchers (Simon & Mosavel, 2010).

Co-ethnic researchers who do not use substances have also been found to have limited access to users within their communities. As a part of the respective communities, co-ethnic researchers cannot guarantee they are value-free when it comes to the taboo subject of substance use. In other words, when community researchers unconsciously uphold this taboo and possibly stigmatise substance users this has a large influence on their ability to find participants and have an open conversation about substance use. This is particularly true for the Turkish and Congolese community researchers.

Secondly, co-ethnics have the advantage of conducting the interview in the interviewee's mother tongue, but this in its turn has the disadvantage of a need for back-translation (Mosavel et al., 2005), which seriously jeopardises ad verbatim transcription and rich linguistic description (Winchatz, 2006). Certain sentences in the interviews, for instance, lead us to believe that some concepts or shared beliefs are not explained explicitly during the interview and consequently are not always understandable to the person analysing the data (e.g. "you know how these things go", "you know what they say about that", etc.).

Furthermore, the shared feeling of belonging to a community by researcher and participant easily implies an imbalance in the communication because the researcher is not a substance user, possibly has a better socio-economic status within the community, or conforms more to the community's perceived norms.

Community researchers with a background as an (ex)substance user found it easier to find respondents in their network (cf. the method of respondent driven sampling), while community researchers who were not familiar with substance use experienced more difficulties. However, the community researchers who know substance users in their network encountered another difficulty. The peers they interviewed were not always honest in their answers, or the community researchers received very short answers from their peers – they stated. Perhaps the relationship between the community researcher and the respondent was too close in this situation. So, probably, the advantage of the CBPR design became a disadvantage with respect to this issue.

These considerations bring us to the very core of ethnographic fieldwork. Whereas ethnographers in classic anthropological studies have generally defended the idea of getting as much in touch with participants as possible while safeguarding an outsider research position (see, for example, Malinowski), current ethnographic researchers question the degree to which these insider–outsider and in-group–out-group perspectives influence the quality of data. Being both an insider and an outsider has its advantages in specific research contexts. Bucerius (2013) for example, a young female German researcher, has been capable of getting quite close into the lives and beliefs of a set of male Turkish German drug dealers. Berliner (2008), in his turn, doubts if his being male jeopardises data collection in female samples. Each research setting should be assessed specifically for the influences of the researcher on the participants. In some cases over-identification, value conflict, behavioural norms or power relations will jeopardise quality and objectivity while in other settings these issues will be of no value or could turn into advantages. To nuance the insider–outsider debate Carling et al. (2014) identify five types of "third positions" that deviate from the archetypal insider–outsider dichotomy in migration research: explicit third party, honorary insider, insider by proxy, hybrid insider–outsider and apparent insider. We could describe Bucerius as a "proxy" insider (a researcher who acquires an insider position during fieldwork), whereas the community researchers in this project are better described as apparent insiders because they belong to the same group or ethnic community but do not use substances.

3.9.3 The relationship between community researcher and project assistant

The main task of the project assistant during the data collection period was to keep the community researchers motivated and to guide them in optimising their interview skills and dealing with problems they encountered. In doing so we acknowledge that “researchers need to be aware of their own personal investments, interests, and frustrations”; “accept rather than defend against healthy tensions in fieldwork”; and be attuned to “questions of relationships, position, social complexities, and how to turn resulting tensions into data” (Luttrell in Muhammad et al., 2014: 6). This entails a reflexive research identity among both academic staff and community researchers, and implies the active exploration of how identity and perceived power within identity status may influence data collection and analysis processes.

Each community researcher had his or her own “learning curve” and different preferences on how to deal with these issues. Some were always present in group sessions, others preferred face-to-face supervision and still others avoided contact because they did not feel the need for guidance or because they had lost the motivation to participate in the research. The community researchers received a financial payment per interview they conducted and transcribed. During the process we noticed that a significant number of researchers underestimated the effort needed to transcribe the interviews. Consequently, we instituted a new arrangement for financial remuneration for those who did not want to transcribe the interviews. During the process of data collection we lost track of many of the community researchers in all four populations who had attended the training. The main reason for this drop-out was the community researchers’ underestimation of the time investment, but also the demotivating effect of participants not showing up, being under the influence of substances during the interview or of not finding participants at all.

The contact sessions between community researchers and participants were also meant to keep track of the quality of the interviews and possible saturation of data collection. Because some researchers had a very fast pace while others were rather slow or had changing paces, it was quite hard to keep track of the amount and quality of the interviews during the data collection. When reaching the proposed ending of the data collection process we decided to extend the period because the amount of interviews gathered was not sufficient. This was mainly due to the fact that the data collection period took place during the summer holidays and because community researchers had difficulties in finding participants.

4 SUBSTANCE USE IN THE TURKISH COMMUNITY IN GHENT

4.1 The Turkish community in Ghent

The Turkish community is quite well embedded in the Ghent municipality. In the 1960s firms and by the Belgian government sought to attract foreign workers to overcome a labour shortage. The foreign workers originated from Tunisia, Morocco, Italy, Portugal and Turkey, among other countries. They worked mainly in textile and metal industries, and in abattoirs. The Belgian government put a halt to migration in 1974 because of the decline in the Belgian economy in the 1970s. Most of the Turkish “Ghentians” who moved to Belgium during the 1960s came from Emirdag, Peribeyli and Posof. The group of Turkish and North African foreign workers mainly consisted of men aged between 25 and 40 years (Verhaeghe, 2013: 15). Many of them left their wives and children in Turkey because they expected to return to their home countries. After 1974 the Turkish community kept growing, because men brought their families over through the legal system of family reunion. This migration was supplemented with marital migration, because of a lack of suitable partners in Ghent.

In 2010 about 152,000 people with Turkish or dual nationality were living in Belgium. This group made up about 1.4% of the Belgian population, and thereby became the fifth largest ethnic minority in Belgium (Schoonvaere, 2013). Most people with Turkish origins live in the Brussels region, followed by East Flanders (16%). Migrants from the provinces of Afyon and Eshikishir mostly live in Brussels and Ghent, while people from other regions live more widespread in the regions of Limburg and Antwerp (Schoonvaere, 2013; Van Kerckem et al., 2013).

Between 2001 and 2005 the Turkish-Belgian migration flux was mostly directed towards Ghent (Schoonvaere, 2013: 50). In 2014 about 42.2% of the Ghent population were people with an ethnic background,¹¹ of which about 12.8% were not Belgian nationals (Laban, 2015). This part of the Ghent population consists of 156 different nationalities. A total of 10.5% of the Ghent population are of Turkish origin, of which only 1.7% are Turkish nationals (Laban, 2015). The remainder have both Belgian and Turkish, or only Belgian, nationality.

4.1.1 Spatial distribution in the city of Ghent

The participants in the sample of this study (n=62) mainly originate from the regions of Istanbul, Afyon (Emirdag and Eskisehir) and Ankara. When we asked participants¹² what the Turkish community in Ghent means to them we received a wide array of answers.

We based the general description of the Turkish community in Ghent on the opinion of 56 participants that answered this question. One in six participants state that there are different Turkish communities in Ghent. One in five find the spatial segregation the most characteristic element of the Turkish community.

The participants in this study live quite dispersed in the city. However, it should be noted that some of the participants consciously moved to another neighbourhood to avoid contact with family and acquaintances (see *infra*). Moreover, a large majority of the participants live in the nineteenth century belt of the city¹³. One-fifth live in the suburban periphery of Ghent and one in ten in the city centre. This seems to confirm the research of Verhaeghe (2013) that states that the spatial segregation of the Turkish community in Ghent had been in decline between

¹¹ Their current or first nationality is not Belgian or the first nationality of one of their parents is not Belgian.

¹² For a comprehensive overview of the profile of the participants see section 4.2

¹³ Mainly Tolpoort, Sleepstraat, Dampoort and Brugse Poort (see Annex II: Boroughs in the Ghent municipality).

2001 and 2011. The fact that a substantial proportion of the participants live in the suburban periphery seems to confirm this thesis.¹⁴

4.1.2 Characteristics of the community

“Vandaag de dag betekent de Turkse gemeenschap heel veel. Vroeger was dat zo niet... dan bestond er geen Turkse gemeenschap maar vandaag de dag wel. Er zijn handelaars, winkeliers, kappers, politieagenten, advocaten, dokters, politici,... We zijn langzaam geïntegreerd aan het geraken in de maatschappij hier he. Terwijl dat in de periode van onze ouders niet zo was... Als mijn vader achter eieren ging in de winkel dan moest hij gelijk een kiekeken staan kakelen om uit te leggen wat eieren waren.”
(Fatih, male, 50, heroin and methadone)

“Nowadays the Turkish community has a lot of meaning. It was not like this before... back then, the Turkish community did not exist, but now it does. There are merchants, tradespeople, hairdressers, police officers, lawyers, doctors, politicians... We have gradually integrated into this society. This was not the case during the time of our parents... When my father went to buy eggs in the shop, he had to cackle like a chicken to explain what eggs were.”
(Fatih, male, 50, heroin and methadone)

When we ask about the characteristics of the Turkish community in Ghent, we are often told that Turkish people mostly originate from Emirdag and that this creates a bond. About half of the participants originate from Emirdag but they are not the only ones to make this statement. Additionally, participants note that the shared migration history is a characteristic of the community. Cultural and sociological characteristics are also mentioned. Participants mention Turkish bars, marriages and going to the mosque. Many participants link belonging to the community to social cohesion (“Ghent is small and everybody knows each other” is mentioned at least four times in the interviews) or more pejoratively to social control.

As mentioned before, the feeling of social control has in some cases resulted in individuals moving to other neighbourhoods or even other cities. This practice is confirmed in other studies on the Turkish community in Ghent (Van Kerckem et al., 2014). Other characteristics mentioned are pride, entrepreneurship and identification with the historical Ataturk leadership. All participants mention in one way or another that the Turkish community nowadays is quite divided, be that in terms of generations, religious beliefs or political controversies.

“Heel wat mensen hebben hun visies en gedachten bijgesteld. Zij die eerst korte kleren droegen, dragen nu langere kleren en omgekeerd. Vroeger lette ik daar niet op, maar nu weet ik in welke situaties ik moet opletten. Vroeger nam ik nooit een hoofddoek mee als ik de Koran ging beluisteren bij iemand huis. Ik zei dat ik zo was. Maar naarmate de tijd vorderde, en waarschijnlijk ook door de leeftijd, probeer ik nu toch te letten op mijn kleding.”
(Berna, female, 46, prescribed medication)

“A lot of people have changed their vision and thoughts. Those who wore short clothing at first, now wear longer clothing and vice versa. I didn't really pay attention to it before, but now I know which situations I should pay attention to. I never brought a headdress when I went to someone's house to listen to the Koran. I said that that's who I was. But as time progressed, and probably because of my age as well, I now try to pay more attention to my clothing.”
(Berna, female, 46, prescribed medication)

¹⁴ Mainly Gentbrugge, Sint-Amandsberg, Sint-Denijs, Wondelgem and Oostakker.

4.1.3 Relatedness to the community

When we ask participants about the way they relate to the Turkish community, they never answer completely negatively. However, more than half of the participants state that they have mixed feelings concerning this relationship. In some situations, they feel more or less bound to the community. This ties in with the notion of Lamont and Molnár's (2001) notion of actively refining the symbolic boundaries of the perceived community. When participants answer the question about feeling related to the Turkish community positively, they refer to a feeling of mutual respect and relatedness in the domains of language, migration history and traditions (mostly referring to marriage and death).

One in three participants state that they are "different" from other members of the community. They report that they do not feel part of the community, because they are not from a village, are better educated, have different cultural values (less materialist, more modern, other living habits or other familial circumstances) or because of their (mostly problem) substance use (see *infra*). Some of them also note that they don't seek contact with the community, in order to escape the social control of the community or because they find the community too conservative.

"Er zijn café's, en vzw's waar de Turken naartoe gaan en gans de dag op hun leeg gat zitten. En roddelen achter een ander zijn dingen en ditten en datten. Dus ik hoor daar niet bij. Ik ben een junkie en ze bekijken mij als stront, terwijl dat ze zelf bijvoorbeeld alcoholieker zijn. Ze zitten gans de dag te zuipen en te drinken en ditten en datten, nee ik voel mij daar niet thuis."
(Ekrem, male, 47, heroin)

"There are bars and non-profit organisations that Turks visit and sit on their asses all day. And gossip about someone else's business and this and that. So I don't belong there. I am a junkie and they look at me like I'm dirt, while they themselves are alcoholics, for example. They sit there boozing and drinking and this and that, no, I don't feel at home there."
(Ekrem, male, 47, heroin)

4.1.4 Religion and community

Almost all Turkish Ghent people describe themselves as Muslims. Today, Ghent has about 15 Islamic houses of prayer. In 2002 (Kanmaz, 2007) about two-thirds of the mosques were exploited by the Diyanet, the Turkish state service for religious matters. These mosques are directly supported by the Turkish government, and imams preaching in these mosques are sent from Turkey. Not all Turkish Ghentians agree with this interference of the Turkish state or simply adhere another Islamic branch, such as the ones preached by Milli Görüş, Süleymanci or Fethullah Gulen (Kanmaz, 2007). Furthermore, a small minority is Alevite and Sufi associations also exist. Most mosques are more than what we would expect from Catholic churches, for example, and are not only a place for strict religious activities. A mosque in Belgium is a place where all sorts of activities take place, and it also serves as a community centre (De Gendt, 2014; Kanmaz, 2007). This is also reflected in its architecture: a mosque is often not recognisable as such from the outside, and consists of many rooms to host a wide range of activities, such as guest lectures, religious schooling, educational support and other socio-cultural activities.

4.2 The participants

We stress that the sample of this qualitative study is not representative of the whole Turkish community in Ghent. In total, we interviewed 70 people. In the analysis we include 62 interviews, seven of which were interviews with family members of users. These were family

members of problem alcohol, cannabis and polydrug users. When we report on the use of substances we only use the own description of problem or non-problem use that the participant gives. When we take the opinions of family members into account, we mention this specifically. Participants were mostly contacted because of the use of one specific substance, but during the interviews other products were mentioned in almost all cases. A small number of the participants are ex-users, but most participants do not report on current or former use in a consequent way during the interviews (e.g. at the start of the interview some stated that they had quit using, while during the course of the interview they referred to current use). Therefore, we only make this distinction if the nature of the given information requires it.

4.2.1 Socio-demographic characteristics

Three in four participants are male and one in four is female. About three in four participants mention that the use of the main product is the problem. Four in five participants have not attended higher education, and half of these participants have not completed secondary education. Those who describe their use as problematic belong exclusively to this latter group. Only a small minority (about one in ten) of participants has completed higher education and none of these participants indicate their use as problematic. The majority of the self-described problem users (39) are single (29), of which 6 participants are divorced and live alone and 11 participants live with their parents. The remaining participants are married (8), cohabiting or widowed (2). Half of the group of problem users is unemployed, 9 of which have been categorised as disabled in the social security system.

Table 5 lists the age range of the sample.

Table 5: Age and problem substance use in the Turkish sample (n=55)

Age range	Non-problem drug use	Problem drug use
18–25	8	4
26–35	6	14
36–45	2	14
46–55	–	6
60	–	1

4.2.2 Substance use

“Als gij psychisch problemen hebt, ga jij gemakkelijk geneigd zijn om iets te gebruiken. Begrijp je? Als gij sociale problemen hebt, ga jij gemakkelijker iets misbruiken. Dat kan eten zijn, dat kan middelen zijn, dat kan gokken zijn. Dat kan vrouwen zijn. Het kan van alles zijn.”
(Arda, male, 36, ex-heroin user)

“If you have psychological problems, you will feel more inclined to use something. Do you understand? If you have social problems, you will feel more inclined to misuse something. That can be food, it can be medication, it can be gambling. It can be women. It can be anything.”
(Arda, male, 36, ex-heroin user)

As mentioned above, participants were contacted about their use of one main substance. Participants mention several other substances as well as gambling during the interview. Therefore, the list below does not correspond with the total number of participants. Further, it should be noted that the actual use is probably higher, because participants may, consciously or unconsciously, not mention the use of certain substances. It is notable in this respect that the three main substances participants were contacted about (alcohol, cannabis, heroin) do not match the three main substances mentioned during the interview (alcohol, cannabis, cocaine). The project assistant maintained a good relationship with the heroin substitution centre Gewad, which is why there is an over-representation of heroin and methadone users in the sample. The project assistant started purposive sampling in this group when it became clear that community researchers did not reach this type of user. All other participants were found by the community researchers.

Table 6: Prevalence of substance use in the Turkish sample (n=55)

Substance	Total	Non-problem drug use	Age range	Male	Female	Problem drug use	Age category	Male	Female
Alcohol	27	17	18–42	7	4	10	25–55	8	5
Cannabis	27	16	18–41	12	4	11	21–55	10	4
Cocaine	19	10	25–42	9	1	9	33–55	8	1
Heroin	13	2	28–32	1	1	11	33–55	11	–
Ecstasy	11	9	21–44	8	1	2	33–34	2	–
Methadone	11	4	33–42	4	–	7	35–50	7	–
Sedative (prescribed) medication ¹⁵	7	–	–	–	–	7	19–45	4	3
Speed	6	3	22–35	3	–	3	32–36	3	–
<i>Gambling</i>	5	–	–	–	–	5	35–55	5	–
Antidepressants ¹⁶	4	2	21–33	–	2	2	34–42	–	2
Antipsychotic ¹⁷	4	2	33–41	2	–	2	38–42	1	1
Anabolic steroids	1	–	–	–	–	1	35	1	–
LSD	1	1	22	1	–	–	–	–	–

¹⁵ Mostly benzodiazepines.

¹⁶ The drug was not specified in all cases. Participants mentioned Seroquel and Tranxene.

¹⁷ The drug was not specified in all cases. Most participants spoke of Trazanol, Dominalfort and Cloxipol.

More than half of the participants consume alcohol and about one in five describes this use as problematic. Three interviews with family members were about problem alcohol use. The data corresponds with the available data for the whole Belgian population. Half of the Belgian population above the age of 15 does not use alcohol daily or ever, and one in four Belgians has a tendency to be a problem drinker (Drieskens et al., 2015: 48). The general acceptance of alcohol use in the Turkish community was confirmed by professionals in community and municipal outreach work (personal communications on 9 March 2015 and 1 April 2015).

The trends concerning the use of both alcohol and cannabis are comparable in this sample. Still, cannabis use in this sample is slightly higher than in the general Belgian population, which is estimated at 14% (De Donder, 2014). Also, there is no difference in ages and gender regarding cannabis and/or alcohol use. Problem use is more prevalent among men than among women. More than half of the participants report having already used these substances and half of these users describe their use as problematic. For non-problematic cannabis users, use is mostly described as “sporadic experimental use”. Problem use of both products is only acknowledged by participants above the age of 20.

None of the participants in the sample were contacted about primary use of cocaine. This could indicate that awareness about the use of this product is low in the Turkish community or that it remains a taboo subject. More than one in three participants reports having used cocaine. Half of these participants describe this use as problematic. These participants are mostly using heroin and cocaine alternately or together (snowball use). One of the heroin users who had a dual diagnosis of addiction and schizophrenia mentioned he uses cocaine in order “not to hear voices”. Further, in half of the cases, cocaine is used in a recreational way in nightlife settings.

Problem heroin use occurs in a considerably older age category than other substances (33–55). Users are mostly poorly educated single or divorced men. Two participants report one time experimental and non-problem use. The remaining heroin-using participants use it on a regular basis and usually in combination with methadone, cocaine and cannabis. The life story of these participants is quite similar (see *infra*).

More than one in five participants have used ecstasy. This use is only described as problematic in two cases. These two cases concern a short period of intensive and daily use. Participants who do not describe their use as problematic report that they have used it experimentally and on a sporadic basis in nightlife settings. Six participants have used speed, and three participants report this use to have been problematic. The nature of this problem use is similar to the problem use of XTC – a short phase of intensive and daily use.

We included an interview with a problem gambler, because gambling was mentioned both by community researchers and at least one key figure (personal communication, 9 March 2015) and in literature as a specific phenomenon in the Turkish Community (Laudens, 2013). In four of the interviews with problem heroin users, gambling is reported as having caused large amounts of debt. Gambling in these cases means playing poker and other card games in bars. Moreover, two participants report on the problem gambling of their fathers and one about her husband. Three other participants mention as an aside that gambling is a specific problem in the Turkish community in Ghent.

Finally, about one in four participants (n=13) mention the use of sedative (prescribed) medicine, i.e. benzodiazepines, sleeping pills, Valium, antidepressants, antipsychotics and codeine. Usually this medication is used in combination, but not in all cases. The mentioned codeine use concerns a stand-alone case of heavy use (2g/day). It is notable that even when the use of this medication is therapeutically supported, participants experience this use as problematic. The problematic aspect of the use of antidepressants is mostly linked to physical dependence on the substance and also stigma linked to their use. Seven participants report

that they have experienced at least one psychotic phase, three of whom had a dual diagnosis of addiction and schizophrenia. In this sample the use of antipsychotic medication is mentioned four times, but the actual use might be a little higher. The problem use of all prescribed medicines occurs in an older age category than other substances (35–46), with the exception of sleeping medication (19–45).

4.2.3 Ethnic identity

We talked about ethnic identity with 61 users and family members. When we ask participants whether they feel Belgian-Flemish or Turkish, 52 participants answered that they feel they are between cultures and that they feel Belgian in Turkey, and Turkish in Belgium. Half feel more Turkish, because:

- they have a different mentality (6);
- they are Muslim (5);
- of their language and culture (5);
- they have a different skin colour and/or do not feel accepted (5);
- they spend more time with Turkish people, are not Belgian nationals or have lived in Turkey for a long time (3).

Two participants note explicitly that they feel Turkish because, as ethnic Bulgarians in Belgium, they feel stigmatised, but were educated in the Turkish culture in Turkey. Five participants report that they feel human, not Belgian or Turkish. Two other participants report they feel they are Ghentians and two others report they feel Belgian because they are not typical Turks.

The question of what it actually means to be Turkish puts these answers in perspective. Being Turkish means, for most participants, to be proud of and to live by Turkish traditions, education, religion and language, and to attend family gatherings. To a lesser extent, participants mention the shared history, army service, fraternity, Turkish TV, being a migrant and that being Turkish “is in the blood”. Being Belgian, and to a lesser extent being Flemish, is in the first place associated with being born in Belgium, living in Belgium and having Belgian nationality. Freedom, equality and thinking about the future of the country are also mentioned. However, when participants are asked if they feel Belgian, most answer negatively, because they do not speak the language, are not Belgian nationals, or because they have a different religion and do not feel accepted.

When we compare the self-described non-problem (n=16) to problem users (n=39), there are no significant differences in whether they feel more Belgian-Flemish or Turkish. We should, however, note that the reasons given for not feeling Belgian are more specified in problem users. They more often report not feeling Belgian while they would in fact like to feel more Belgian. Four of them have difficulties acquiring Belgian nationality and six note that the fact that Belgians do not accept them is a reason why they do not feel Belgian. We will look at these answers in more detail in section 4.3.2.3 on racism.

4.2.4 Generations

In literature, a distinction is made between four Turkish generations on the one hand (Lievens, 1999; Van Kerckem et al., 2014), and four waves of migration on the other (Manço, 2012). The first migration wave consists of Turkish guest workers who came to Belgium in the 1960s. The second wave consists of the children of these workers who migrated to Belgium at a young age, mainly during the 1980s. The third wave consists of marriage migrants and was mainly situated between the 1980s and the year 2000. The fourth wave consists of elderly people who have grown old in Turkey and join their Turkish-Belgian children in Belgium today (Manço, 2012). The first and second migration waves constitute what we call respectively the first and

second generation, in layman terms. The third generation consists of the children of second-generation migrants. A fourth group in the sample is made up of newly arrived marriage migrants who arrived in Belgium after the migration stop of 1974.

The majority of this sample (n=26) belongs to the second generation of Turkish migrants. Their ages vary between 19 and 46. The third generation is represented by 16 participants born in Belgium between the ages of 18 and 35. Eight of our participants are marriage migrants, five men and three women between the ages of 35 and 55. We only interviewed one participant belonging to the first generation (60). Furthermore, some participants cannot be properly categorised in to generations as defined above: two came to work in Belgium in the 1980s and 1990s and one migrated to Belgium more recently to study. Most of the participants who describe their use as problematic belong to the second generation and to the group of marriage migrants. Most participants who do not describe their use as problematic belong to the third generation.

4.2.5 Language

We asked participants to report on their language knowledge (understanding, speaking, reading) on a scale from 1 to 5. For third generation migrants Dutch is the first or second mother tongue. Consequently, this group scores an average of 4.9. For the second generation an average of 4.3 is attained and only three participants report that they barely speak Dutch. We cannot report on the first generation, because we only interviewed one person belonging to this group. The average for the category of marriage migrants is 2.3. The interviews with these participants were consequently conducted in Turkish.

When we ask participants which language they prefer to speak, they unanimously say that they prefer Turkish because it is their mother tongue. Second and third generation Turkish and marriage migrants speak both Turkish and Dutch with friends and family. In the third generation we hear of some families who only speak Dutch within their family. In conclusion, it is notable that the average language skills of non-problem users is 4.8, whereas the average for problem users is 3.8.

4.2.6 Religion

Only three participants in this sample report not being Muslim. When we ask participants if they practise their beliefs only one in seven answers affirmatively. This is significantly less when compared to the general Turkish population, in which about 40% practise their beliefs (Manço, 2012). Practising Islam means praying five times a day, reading the Koran and participating in Ramadan. The participants declare that they do not practise because they do not have enough time, because they do not know how to pray or because they do not feel pure enough. Only a small minority of the participants (one in ten) goes to a house of prayer regularly. Participants give a number of reasons why they do not attend a mosque or other house of prayer. These reasons are mostly of a social nature: they encounter negative attitudes, they don't have good contacts or they don't feel accepted. Further, participants report that they learn quite a bit about Islam via the TV and the Internet.

Participants describe a very personal way of experiencing Islam. Many note that religion is something between the individual and god, and that it is about being a good person and finding support in your belief. We elaborate on how participants experience support of imams and hodjas in section 4.4.2 about help-seeking behaviour in relation to religion.

4.3 Nature and patterns of substance use

4.3.1 First time use

First time cannabis use of problem and non-problem users is mostly reported at the age of 16 in this study, although a considerable number of participants report that they started smoking cannabis between the ages of 12 and 16. This use can be characterised as experimental and usually takes place in a school context or in parks with friends, cousins or brothers. Participants state that this use occurred because of peer pressure (wanting to belong to the group, behaving tough), boredom and curiosity. This is in line with a recent participative study on Turkish youngsters in Ghent (Laudens, 2013). Two participants mention that one of the influences on their first time use was their fathers' use. Eleven participants report that their use occurred for the first time between the ages of 16 and 23. This later use is mostly linked to student life. Regular users attest to using cannabis to calm themselves down and relax.

First use of alcohol occurred at an average age of about 16. The participants report that this first use happens in social contexts, such as in nightlife settings or at weddings and with friends. Intensified alcohol use is often reported to be due to relationship difficulties. Three participants report that they were used to drinking in Turkey, but that their use intensified after their migration to Belgium. Two other participants state that they started drinking because of their father's drinking behaviour.

The first use of XTC and cocaine mostly occurs in nightlife settings around the age of 20 and is motivated by curiosity and the influence of friends. First time use of XTC occurs at the age of 20 and exclusively in nightlife settings. The use of speed occurs at an average age of 23 and is motivated by combating fatigue during nightlife activities.

First time use of heroin occurs at the average age of 20. In two cases participants report having started using heroin because of a lack of cocaine. Two other participants report heroin use because other family members use it. In two further cases participants started because they were involved in dealing. The remainder of heroin users started out using it with friends. Users mention that they did not know about the drug and its consequences during their first use.

First time use of all medicines is at 27 years and is usually accompanied by therapeutic treatment. The reasons for this use are familial problems, marital problems and in one case a feeling of insecurity because of the lack of a residence permit. Three participants started using, respectively, cannabis, cocaine and heroin when incarcerated.

“En ook vooral in de gevangenis, als ge zo in 6 vierkante meter zit, dan heb ik de behoefte gehad om te gebruiken, vooral cannabis. Om op mijn gemak te zijn, da maakt het verdragelijker”
(Demir, male, 33, cannabis)

“And especially in prison as well, when you are sitting in a space of six square meters, then I felt the need to use, especially cannabis. To feel at ease, that makes it more bearable.”
(Demir, male, 33, cannabis)

4.3.2 Reasons for continued problem use

When non-problem users are asked why they use substances, they refer to the circumstances of their use rather than intrinsic motivations for their use. They refer to acting tough at school or using at social events with family and friends, such as at marriages and during nightlife activities. Users who do describe their use as problematic display more awareness of their reasons to use. The most common reason for current use and peak use are marital problems and the consequences of divorce, such as not seeing their children. The second most frequent reason is difficulties in the family, such as the death of a family member or discordance. Several participants use substances such as medicines and cannabis to be less aggressive and to remain calm, sometimes but not exclusively when incarcerated. There is no distinction between the reasons for use and the type of substance used.

When asked if and why participants see their use as problematic, they first and foremost refer to their physical dependence on the substance. Moreover, participants refer to the fact that it has a big impact on their lives. The general positive feature of their use is that it makes them forget difficulties and feel calmer. In the case of heroin use, participants additionally refer to the loss of family and being incarcerated. In the case of problem cannabis use, participants also refer to the fact that it makes them too lazy, resulting in not progressing in life.

The life stories of the participants put these seemingly isolated reasons into perspective. They allow us to dig a little deeper into the reasons given. A significant number of the participants married at a fairly young age and say that the marriage was not totally their own decision (8). Half mention mental and physical misuse in a family and marital context. Three had to put off wedding plans because of their use. In this context, we should mention that some participants note that parents have tried to arrange marriage for their children to get them out of the drug scene. This partly ties in with Bucerius' (2014: 145) observation of German Turkish dealers who see marriage as a way to find a place outside of the drug market and to find an ultimate goal in life. Some participants refer to their stay in prison and involvement in the drug scene as a reason for continued use.

"ik kwam na vier maanden buiten en was nog 10 keer erger dan ervoor."
(Demir, male, 33, cannabis)

"I was released after four months and was 10 times worse than before."
(Demir, male, 33, cannabis)

"ik kwam buiten en iedereen was weg: getrouwd, kinderen gekregen enzo."
(Can, male, 33, heroin)

"I was released and everyone was gone: married, kids and stuff."
(Can, male, 33, heroin)

4.3.2.1 Early life experiences

Although this was not a specific topic in the interview guide, 24 problem users (out of 39) talked to us about their youth as one of the influences on their use. Fourteen participants attest to not having been able to finish their secondary education, and most of them started working at the age of 16. Most of these participants belong to the group of classic second generation migrants.

"Maar nee ja... de meeste komen naar hier, werken, vestigen ulder hier en die blijven hier. Maar die ouders hebben altijd gedacht, wij gaan terug, maar zij gaan niet terug, versta je. Daarmee... dat was niet leren of... zoveel mogelijk geld verdienen... maar zij zagen dat zo, het is niet omdat zij dat zo zagen dat wij (tweede generatie) dat ook zo zagen. Versta je..."
(Hikmet, male, 42, heroin)

"But no, yes... most of them come here, work, get settled and stay here. But those parents have always thought, we're going back, but they're not going back, you see. That's why... it wasn't learning or... making as much money as possible... but that's how they saw it, it's not because they saw it that way that we (second generation) had the same opinion. You see..."
(Hikmet, male, 42, heroin)

We identify a group of 11 men between the ages of 30 and 50 because of their similar situation. These men belong to the group of migrants that came to Belgium at a very young age. In several cases their fathers had left Turkey some years before the migration of the mother and the children. Some of these children had barely known their fathers at a young age. The migration to Belgium meant a rupture in the children's' living patterns and their upbringing. Additionally, the educational context of the village in Turkey suddenly fell away completely (De Gendt, 2014: 136). This generation of Turkish people growing up in the 1980s in Ghent is often referred to as "a lost generation" (De Gendt, 2014: 186). They lived in politically turbulent times

of growing racism, economic instability and the increasing conservatism of their parents. Many of these participants' parents did not expect their children to study. Some of the parents did not have the means to pay for further education, and most of them wanted their children to work as early as possible because this was the initial goal of their migration.

“Hij was de beste van de klas, hij wou hier dierenarts worden en zijn euhm, zijn schooldirecteur is komen smeken thuis of hij ASO mocht doen en ze vonden het nodig dat hij TSO deed. En dat interesseerde hem geen bal, beginnen spijbelen. Vroeger was de leerplicht tot 16 he. Dus van zodra dat hij kon, was hij weg he.” (Eser, 46, wife of heroin user)

“He was at the top of his class, he wanted to become a veterinarian here and his uhm, his principal, came begging for him to be in general secondary education (ASO) and they thought it was necessary for him to be in technical secondary education (TSO). And it didn't interest him at all, started skipping school. Education used to be compulsory until the age of 16, eh. So as soon as he could, he left, eh.” (Eser, 46, wife of heroin user)

Most of these 11 participants note that they did not feel comfortable in the school context, mostly because of their migrant background. Four of these men's parents arranged a marriage for them at the age of 18, mainly to try to help them settle down and have a better life. All except one have divorced. Three spent a large part of their adolescence in a youth centre. Six of these men were incarcerated for the first time around the age of 19, which seriously jeopardised their chances in the labour market. Ten people within this group started using substances between the age of 12 and 15. Three state that they were severely beaten up by their fathers because of their use.

“18. ik was juist 18 geworden. Ik was 's nachts 18 geworden. En 's morgens zat ik in de gevangenis. Zat ik bij de onderzoeksrechter en 's avonds zat ik er al in. Ik had gevochten in een dancing. [...] Dat was de allereerste keer. Ik weet nog hoe dat ik geweest heb. Ja, dat is de eerste keer dat ge zo tussen al die gangsters zit. Ge zijt pas achttien geworden. Pas. Nog maar een dag. En ge zit al in de gevangenis, aleja, dat is niet... en ja... dat was mijn eerste kennismaking met de criminaliteit zal ik maar zeggen.” (Hikmet, male, 45, heroin)

“Eighteen. I had just become 18. I had become 18 that night. And in the morning I was in prison. I was led to the examining magistrate and in the evening I was already there (in prison). I had a fight in a dance hall. [...] That was the first time. I remember crying back then. Yes, that's the first time you are put together with all these gangsters. You just turned 18. Just. Just a day. And you're already in prison, well, that's not... and yes... I'd say that was my first experience with delinquency.” (Hikmet, male, 45, heroin)

We discern a second smaller group of three participants who state that having been married at an early age was the main cause of their current substance use. These individuals are between the age of 39 and 45. Elif (female, 45 years old) tells the story of her father dying at a young age, followed by her mother sending her to Belgium to engage in a marriage with a Turkish-Belgian man. She suffered an abusive marriage and describes herself as a problem alcohol user. Tarkan (male, 39 years old) explains he was married at the age of 13 in Turkey. He divorced and came to Belgium to marry a Turkish-Belgian woman.¹⁸ This marriage is not what he had expected, which is why he has been treated for depression. A third female participant narrates a similar story in which her parents had a Turkish man come over from

¹⁸ Small-scale qualitative research with Turkish women (De Kock, 2012) confirms that in 2000 some Turkish women voluntarily choose to marry young men originating from Turkey. It could be hypothesised that this type of marriage was a social emancipatory practice for some second generation Turkish women. This specific choice enables these women to create more distance between themselves and their families by means of marriage (Lievens, 2000 in Schoonvaere, 2013). Furthermore, they could in part protect themselves from male dominance because their husbands did initially not speak the Dutch languages or have jobs.

Turkey. She suffered an abusive marriage and has been treated for severe depression over the past ten years.

“Ik trouwde op mijn dertiende toen ik nog kind was. Eigenlijk wou ik niet trouwen. Ik leerde in het leven dat niemand beslissingen voor jou mag nemen. Ik beslis zelf over wat ik wil. Uiteindelijk besloot ik dus om te scheiden van mijn vrouw.”
(Tarkan, male, 39, prescribed medication)

“I got married when I was 13 when I was still a child. I didn’t really want to get married. I learned that in life no one can make decisions for you. I decide what I want. Eventually I decided to divorce my wife.”
(Tarkan, male, 39, prescribed medication)

“Ik wilde niet trouwen. (Maar) omdat mijn moeder ziek was, moest er iemand zijn om haar te verzorgen. Ik was zelf jong. Ik wist ni. Ik was zelf kind, ik had kinderen. Dan ben ik beginnen gebruiken eh.”
(Engin, male, 40, heroin)

“I didn’t want to get married. (But) because my mother was ill, someone had to be there to take care of her. I was young myself. I didn’t know. I was a child myself, I had children. That’s when I started using, eh.” (Engin, male, 40, heroin)

The younger generations in the study find it harder to describe how they feel about early life choices and youth. As mentioned in the introduction, most third generation participants describe their use as non-problematic. However, most of the second generation problem users mention problems at school and with parents when referring to reasons for their use. Consequently, it is important to note that a recent participatory study in Ghent reports that the three most prominent problems of Turkish third generation youngsters include problems at school and racism (Laudens, 2013).

Three of the youngsters in the study did describe their use as problematic. Unfortunately we have no further in-depth information about the course of their use. Burcu (19 years old) repeatedly notes that he has no hope and no goals in life. He has not been able to finish secondary education and is not able to find a job. He smokes cannabis out of boredom. Kadriye (28 years old) explicitly repeats that she has been abandoned, that nobody accepts her for what she is (a user). Her father is a heavy cannabis smoker and so is she. She moved to the city to avoid the social control of her extended family. She has been in in-patient treatment several times, but does not seem to be able to shake her habit off. Ebru (25 years old) explains she had a good adolescence. Her parents have always treated her well, but for the last couple of years she has been addicted to alcohol. She drinks large amounts of alcohol in her room at her parents’ house on a daily basis. She has joined AA (Alcoholics Anonymous) but has not been able to shake her habit off yet. She gives no further reasons for her use.

4.3.2.2 Marital problems

A significant number of the problem users (13) refer to marital difficulties as a cause of their problem use. Half of these participants mention that the marriage their parents had arranged was a bad choice. One man and two women mention a non-voluntary marriage¹⁹ at the ages of, respectively, 13 and 18. Three of the participants mention that if they could do it all over again, they would not have moved to Belgium for marriage. The women in this sample resort to medication and alcohol to overcome the trouble they experience because of these marriages. The excessive use of prescribed medication in the Turkish community was confirmed by a general practitioner and a social worker (personal communications, 27 March 2015 and 7 September 2015). This trend is similar in men, although heroin is also used in this

¹⁹ It is important to distinguish between arranged marriages and non-voluntary arranged marriages. Most arranged marriages in the Turkish community are voluntary.

context in the case of men. Additionally, three men attest to having divorced due to their problem use.

4.3.2.3 Racism, perceived and structural ethnic discrimination

“Zij beginnen van nul de vlamingen. Ze beginnen van nul. En euh allochtoonse gemeenschap begint van -3.”
(Ender, female, 23, cannabis)

“They start from 0, the Flemish. They start from 0. And uhm, the foreign community starts from -3.”
(Ender, female, 23, cannabis)

The literature on the detrimental impact of perceived and structural discrimination on mental health has greatly increased in recent years (Krieger, 2014). Several questions in our interview guide, such as “Are you often confronted with your migration background?”, “How do you feel about Belgians?” and “How do you think Belgians see you?” led participants to talk about their experiences with racism and discrimination. Although it should be remembered that our questions were formulated quite straightforward (possibly triggering an affirmative answer), almost all participants have experienced racism and half give concrete examples. The determinants of difference in these answers seem to lie mostly in the generation participants belong to, their views towards new migrants, and their description of use as problem or non-problem.

Over half of the 39 problem users in this study give specific examples of discrimination in the educational, housing, health care and/or labour context.

“Toen ik mijn naam zei, was er opeens een stilte. Ze zeiden dan dat ze op dat moment niet zochten naar een nieuwe werknemer. Als ze nu horen dat ik vreemdeling ben, dan zeggen ze: ‘nee je bent niet zo gelijk de anderen, je bent anders.’ Dan zeg ik altijd dat ik ook turk ben en niet anders ben, maar ze blijven zeggen dat ik wel anders ben. Soms willen ze het eigenlijk niet geloven of aanvaarden dat ik turk ben [lacht].”
(Berna, female, 46, prescribed medication)

“When I said my name, there was a sudden silence. They said that they weren’t looking for a new employee at the moment. If they now hear that I’m a foreigner, they say, ‘No you’re not like the others, you’re different.’ Then I always say that I’m Turkish as well and that I’m not different, but they keep saying that I am different. Sometimes they don’t want to believe or accept that I’m a Turk [laughs].”
(Berna, female, 46, prescribed medication)

“t’ Is zeer moeilijk. En tis ook beetje wederzijds. Gelijk vroeger als ik werkte, was er doorgroei mogelijkheden. Maar echt de Belgische mensen kregen de voorrang. En dat maakt je psychisch kapot. Ja sorry dat ik dat moet zeggen maar allochtonen worden nog altijd gediscrimineerd.”
(Abdullah, male, 28, cannabis)

“It’s very difficult. And it’s also a little reciprocal. Like when I worked in the past, there were career opportunities. But the Belgian people were put first. And that’s what psychologically destroys you. Yes, sorry I have to say this, but foreigners are still discriminated.”
(Abdullah, male, 28, cannabis)

First generation migrants and marital migrants in this sample did not make statements about discrimination or they stated that they have not been confronted with discrimination because of their ethnic background. Second generation migrants, however, are less likely to interpret experiences of discrimination as isolated incidents. On the contrary, they perceive it as a

process of discrimination, marginalisation, disempowerment and social exclusion (Bucerius, 2014: 44).

Most of the participants are quite positive about Belgians in general. Many participants note that there are good and bad Belgians, racists and non-racists. They mention the socio-political climate that creates a fearful image of Muslims, and that they partially understand racist reflexes. This is also mentioned in a study on Turkish dealers in Germany (Bucerius, 2014: 126). One respondent puts it as follows:

“Als ik denk aan al die terreurorganisaties [...], dan stel ik mijzelf in de schoenen van de Belgen en vind ik het normaal als ze mij ook bijvoorbeeld terrorist zouden noemen. Als ik ooit geconfronteerd zou worden [met racisme], dan zou ik daar respect voor hebben.”
(Tarkan, 29, male, heroin)

“When I think about all these terrorist organisations [...], than I put myself in the Belgians’ shoes and I find it normal that they would call me a terrorist too, for example. If I was ever confronted [with racism], I would respect it.”
(Tarkan, 29, male, heroin)

Many accept the fact that they are seen as foreigners and that the racist encounters sometimes originate from that perspective. Moreover, they narrate that when it comes to prejudices and stigma, racism goes both ways: “the Turks” also have their prejudices towards “the Belgians”.

“Ik voel mij ni uitgesloten. Nee, nee. Ze mogen zeggen van : ‘Vuilen Turk’ ik zal er mee lachen.”
(Demir, male, 33, cannabis)

“I don’t feel excluded. No, no. They can say: ‘filthy Turk’ and I will laugh about it.”
(Demir, male, 33, cannabis)

“Van ja ‘die zijn toch racist [Turken over Belgen]. Wij worden ni aanvaard. Dat zijn toch klootzakken. Dat zijn smeerlappen, dat zijn schijnheiligen.’ Wij hadden ook veel vooroordelen. [...] Er is een stuk waarheid aan dat. Maar niet zo in ons hoofd echt zo vergroot. Der is zeker een waarheid over da. Wij worden ni aanvaard dit dat. Maar tis ni voor te zeggen dat dat over het algemeen zo is.”
(Arda, male, 36, ex-heroin user)

“Like, yes, ‘they are racist [Turks about Belgians]. We are not accepted. They are assholes. They are bastards, they are hypocrites.’ We had a lot of prejudices as well. [...] Part of that is true. But it gets blown up in our heads. There’s definitely some truth about it. We are not accepted and this and that. But you can’t say that that’s the case in general.”
(Arda, male, 36, ex-heroin user)

Similar to those participants who describe their use as problematic, half of the non-problem users report that they have experienced discrimination in the areas mentioned above. Yet, in the stories of these non-problem users we perceive a different narrative on racism and discrimination. Most importantly, there seems to be a greater insight into, and resilience towards, these issues. As most of the non-problem users have enjoyed higher education, they often refer to this as a weapon against discriminatory practices. They also mention more often than problem users that they have reacted to these practices.

“Ik heb ene keer meegemaakt. Da was toen, wij willen iets huren. Wij hebben een huisbezoek gehad. En toen ik begin Nederlands te spreken, dat ze tussen elkaar spreken, te zeggen das een buitenlander wat kan doen enzo... Vandaar dat ze hebben gehoord dat ik in de universiteit werkt heb, da was een beetje minder. Maar ik vind da toch discriminatie.”
(Cemil, male, 31, occasional alcohol user)

“I have experienced it once. That was when we wanted to rent something. We had a house visit. And when I start speaking Dutch, which they speak to one another, to say that’s a foreigner and what I can do and stuff... When they heard that I worked at the university, it was a bit less. But I still think that’s

discrimination.”

(Cemil, male, 31, occasional alcohol user)

“Kennissen die mij niet echt kennen kunnen soms scherp uit hun bocht komen. ‘het zijn weer de turken’ enzo, van die rare opmerkingen die ik hoor. Ik reageer daar niet op. Domme mensen.”

(Deníz, male, 34, occasional cannabis user)

“Acquaintances who don’t know me very well can be mean sometimes. ‘It’s the Turks again’ and stuff, those weird remarks I hear. I don’t react to it. Stupid people.”

(Deníz, male, 34, occasional cannabis user)

“Ik? Ik voel mij Belg. Dat zij me niet graag hebben betekent niet dat ik mij niet belg voel hé. Ik ben hier geboren. Da’s hier ook mijn land hé. Ik heb hier gewerkt, mijn ouders, mijn familie ook. Zij hebben veel gedaan voor belgie. Wij hebben ook belastingen betaald, wij hebben evenveel rechten zoals hen.”

(Tarik, male, 32, occasional cannabis user)

“Me? I feel Belgian. The fact that they don’t like me doesn’t mean that I don’t feel Belgian, eh. I was born here. It’s my country too, eh. I have worked here and so have my parents, my family. They have done a lot for Belgium. We have also paid our taxes, we have just as many rights as they do.”

(Tarik, male, 32, occasional cannabis user)

Finally, it is worth noting that in some cases the feeling of being discriminated and not “belonging” to Belgian society is directly linked to racist feelings towards other groups of new European migrants. Four participants report having encountered discrimination, but immediately change their approach when discussing the consequences of new European migration. They talk about challenges with new migrants and that these migrants are “far worse” than Turks. Two Turkish participants with a Bulgarian background in their turn attest to discrimination by Turks in the labour and housing market respectively (see chapter 5 for more information about discrimination towards people with a Bulgarian migration background).

4.3.2.4 Social networks

Twenty-six out of 39 participants who describe their use as problematic are unemployed. One in three is financially supported by the social security system because of depression or schizophrenia. One in three has full employment. All participants provided an insight into how they live their daily lives. We will give a short overview and compare those describing their use as problematic and those who don’t. What those groups have in common is that most of them describe their best friends as people with a migrant background (as opposed to “Belgians”).

“Ik kan niet meer functioneren op de arbeidsmarkt ik kan gewoonweg niet bedenken dat ik ooit terug kan gaan werken. Dit is een groot probleem ik weet niet hoe ik mijn dagen kan vullen. Geen inkomen, geen verwachtingen meer.”

(Derya, female, 38, prescribed medication)

“I can no longer function on the job market, I simply cannot imagine ever being able to go back to work. This is a big problem, I don’t know how to pass the time. No income, no more expectations.”

(Derya, female, 38, prescribed medication)

Users who describe their use as problematic are generally quite negative about their social lives. Some of them simply state “I don’t have a social life” when asked about what they do in their leisure time. Many mention that they used to go out, but that they have lost friends and family or have chosen to distance themselves from friends because of their use. One participant describes a double life: when he relapses in heroin use he stops contacting non-using friends until he is able to cope again. His non-using friends are unaware of these episodes. Three participants describe moving neighbourhoods in order to change their social environment.

The participants using heroin and methadone describe a very isolated life. They mention that they only have acquaintances and have no real friends they can trust.

“Voilà, heroïne is geen jointje dat je rondgeeft. Heroïne wil je met niemand delen [lacht] want dat is een zware uitgave. Dat is elke dag minimum 20 euro [...]. Minimum eh. [...] Tis zeer moeilijk om te vinden, hier in Gent. Je gaat ni springen van ja ik ga het delen met mijn vrienden. Want bij heroïnegebruik is er geen vriendschap. Het is ieder voor zijn eigen. ‘t Is nie alleen bij mij. Bij elke zware verslaafde is zo. Het is voor ieder zijn eigen.”
(Arda, male, 36, ex-heroin user)

“Voilà, heroin is not a joint you pass around. Heroin is something you don’t want to share with anyone [laughs] because it’s very expensive. That’s a minimum of 20 euros every day [...]. Minimum, eh. [...] It’s very hard to find, here in Ghent. You’re not going to say that yes, I’m going to share it with my friends. Because there is no friendship when it comes to heroin use. It’s every man for himself. It’s not only me. This is the case for every serious addict. It’s every man for himself.”
(Arda, male, 36, ex-heroin user)

To avoid problems, most of these users stay at home and have a monotonous daily routine of obtaining methadone from the pharmacy or local heroin substitution centre, watching TV, sleeping and using heroin when they have money (mostly at the beginning of the month). Four of them visit a local initiative for people with a dual diagnosis (Villa Voortman) on a daily basis and say that it is the only social activity they participate in.

Alcohol users do in general appear to be part of a larger network of friends. The stories of arts and music lovers lead us to assume that in this scene the consumption of alcohol by both men and women is generally well accepted. Problem alcohol and cannabis users often state that they prefer to stay at home and that they mostly use alone at home.

“Dat gaat niet! Vrienden overdrijven. Ze gebruiken 1 of 2 [joints] en zitten al te zeuren voor een 5^e. da ga niet. Da stoort mij. Drugs is privé. Je moet niet delen met iemands anders. Vanaf dat je deelt ben je een junkie. Waarom? Ge gaat alles weggeven, je gaat steeds meer gebruiken. Als je af en toe eentje gebruikt, moet je zeggen “ik heb geen geld meer” en loopt ge weg. Dat zijn verstandige mensen.”
(Tarik, male, 32, cannabis)

“That doesn’t work! Friends exaggerate. They use one or two [joints] and they’re already whining for a fifth one. That doesn’t work. This bothers me. Drugs are something private. You don’t have to share with others. From the moment you share, you’re a junkie. Why? You’ll be giving everything away and start using more. If you use one once in a while, you should say ‘I don’t have any money left’ and walk away. Those are smart people.”
(Tarik, male, 32, cannabis)

Although Ghent has a rich scene of Turkish clubs and associations, only a few participants (both problem and non-problem users) join in with activities at these or other associations. The only club activities that respondents mentioned were membership of a football association (6), a fitness club (6) and a basketball team (2). There are also individual accounts of being active in a charity organisation of a mosque, a boxing club and a karate club. Users describing their use as non-problematic seem to have a wider array of leisure activities, including visiting bars in the city centre (avoiding bars in ethnically dense areas), playing instruments and going out for dinner and to attend concerts.

4.4 Help-seeking behaviour

4.4.1 Perceptions of use and seeking help

“Ik denk dat de grootste oorzaak daarvan [taboe] ego is. Niemand wil aan anderen vertellen dat zijn of haar familielid zich in zo’n situatie bevindt. Ze proberen dat gewoon te verbergen. Ze zeggen dan: ‘oké, die gebruikt drugs, maar niemand mag dat weten.’”
(Aydan, female, 21, prescribed medication)

“I think the main cause of this [taboo] is ego. No one wants to tell other people that his or her family member is in this situation. They just try to hide it. They say: ‘Okay, he/she uses drugs, but no one should know about it.’”
(Aydan, female, 21, prescribed medication)

When participants are asked how they feel the Turkish community deals with substance use and problems caused by it, all respondents state that it is a taboo subject. Significant individual responsibility is expected from problem users and their families.

“Kijk moslims die aan drugs zitten, weten perfect dat ze dat niet mogen.”
(Abdullah, male, 28, cannabis)

“Look, Muslims that are using drugs know perfectly well that they’re not allowed to do so.”
(Abdullah, male, 28, cannabis)

The feeling of responsibility for one’s own behaviour is quite far-reaching. Users themselves often refer to it when rejecting help and explaining continued problem use. In addition, participants use individual responsibility as a defence strategy for their feeling of being stigmatised, excluded or having become the shame of the family. They note that people who stigmatise them have their own things to be ashamed of (responsibilities) in their families. Taboo, shame, stigma and individual responsibility are closely intertwined, and result in avoiding discussion about the issue of problem substance use and not sharing experiences outside the own household.

It is also hard to talk about the issue within the households. The younger participants note that their mothers are probably aware of their use, but avoid talking about it. When participants are able to discuss it with their mothers, users do not benefit from these conversations because the main topic is that they should stop using. Fathers do not seem to be included when it comes to discussing substance use. Married men do talk to their spouses about their use. Women, in contrast, seem to find fewer people to talk to in their close family, especially about problem use of cannabis and alcohol. Women using antidepressants and other medication do feel comfortable talking about it with sisters and female friends.

4.4.2 Religion and use

The interviews demonstrate a close interlinking of being Muslim, using substances and feeling a sense of belonging to the Turkish community in Ghent. Some research asserts that being religious may function as a protective factor for problem substance use. In this context, it is crucial to take a closer look at the links between substance use, belief system and belonging to the community.

First of all, the notion of *haram* (forbidden) was mentioned by about one in three participants when asked how they see their use from a religious perspective. However, this question was often asked in a way that revealed the opinions of the community researchers themselves towards the desired answer. The participants consequently note that gambling and the use of substances is *haram*. When we take a closer look at what this “forbidden” means to them, we get a wide array of interpretations and participants note that there is discussion about its interpretation and consequently which use is to be interpreted as *haram*. Participants mostly refer to the fact that the use of anaesthetising substances is forbidden. Further, mistreating the body is also considered *haram*. The use of medication, however, is considered *less haram*. Overall, participants seem to struggle to match their use with their beliefs.

“Het is eigenlijk heel moeilijk weet je, je struikelt met je geloof en je geweten: je weet dat het niet mag [middelen gebruik] en toch doe je het! In plaats van te denken wat de anderen over jou denken zit je te vechten met je eigen geweten want je weet dat je verkeerd doet door alcohol te gebruiken bv. je wilt het niet maar doet het toch, je hebt dat niet in handen!”
(Elif, female, 45, alcohol)

“It’s actually really difficult, you know, you struggle with your faith and your conscience: you know that you’re not allowed to do it (substance use) and you still do it anyway! Instead of thinking about what the others might think about you, you’re fighting your own conscience because you know you’re doing the wrong thing by using alcohol, e.g. you don’t want it, but you still do it, you have no control over it!”
(Elif, female, 45, alcohol)

“Ik ben getatoeëerd ook. Ik heb daar altijd zin voor gehad maar ik heb dat nooit niet laten doen omdat ik altijd hoorde dat dat volgens onze godsdienst verboden was. Haram noemen we dat, en uiteindelijk ben ik er op uitgekomen dat dat niet zo is maar dat dat niet graag wordt gezien. [...] en de gemeenschap waar ik woon nu, [...] ze hebben gezegd ge zijt ne zondaar. En ik heb gewoon een vraag gesteld [stilte]. [...] Ja dus het reinigingsritueel heb ik gevraagd van, ben je daarmee in orde als je uw onderhuid wast of uw bovenhuid? en iedereen heeft gezegd uw bovenhuid. Dus ik heb gezegd awel dat zit in mijn onderhuid. En ze zijn er nog niet mee gestopt van mij daarmee te ambeteren. En ik heb toen een vraag gesteld. Ik heb gezegd, hier ietske verder is er een klein parkske; ik heb gezegd uw kinderen zitten dar allemaal, ja hebben ze gezegd. Ga eerst eens gaan kijken naar al die drugsgebruik dat ze daar doen, toen hebben ze gezwegen en is er niets meer gezegd geweest tegen mij.”
(Kaan, male, 35, ex-anabolic steroid user)

“I have tattoos as well. I always wanted them but I never did it because I always heard that it was forbidden in our religion. Haram is what we call that, and eventually I discovered that tattoos are not forbidden, but that people just don’t like them [...] and the community I live in now, [...] they said you are a sinner. And I just asked a question [silence]. [...] Yes, so the cleansing ritual I asked, is it all right if you wash your epidermis or your dermis? And everyone said your upper skin [epidermis]. So I said well my tattoo is in my epidermis. And they still haven’t stopped pestering me about it. And then I asked a question. I said, a little further down the road here there’s a park; I said all your children are over there, they said yes. Go take a look over there first at all the drug use, then they kept silent and they haven’t said a word to me ever since.”
(Kaan, male, 35, ex-anabol user)

We pointed out earlier that the majority of the participants find strength in their belief. Some note that prayer has been of great help when incarcerated or during rehabilitation. Only three participants note that they often go to a mosque or house of prayer. The others say they do not, and half explain that they cannot go because substance use is forbidden or because they feel they are not accepted in the religious community. When asked if it is possible to talk to imams or hodjas about problem substance use, a large majority answer negatively because mosques are not the place for this kind of help, and because an imam is not the person to help with such problems, nor do they possess the skills to help in such cases.²⁰ Many participants say that they feel guilty towards their belief and that they are quite sure that the imam might be able to refer to other services, but that they would judge their behaviour in the first place.

Interviewer: “Is er niemand in de moskee die je kan helpen, aan wie je kan vertellen over je problematiek?”

Respondent: “Neen. Want ik ben degene die het eerst uit zijn hoofd moet het gebruiken zetten. En dan pas hulp zoeken van de omgeving.”

Interviewer: “Maar als je dat niet kunt, kan je niet gewoon bij iemand hulp gaan vragen? Is er niemand die dat doet in de moskee?”

²⁰ An imam is a person who leads prayers in a mosque in Sunni Islam. Further, the imam can be seen as a community leader and a person who provides religious guidance. In Shia Islam imams have a more significant position because they are believed to be appointed by god himself. Some say that hodjas are people who have performed the “hadj” (pilgrimage to Mecca), but in popular speech and in our interviews we hear that hodjas are wise people in some way or another (e.g. by having studied Qur’an or having enjoyed higher education) and are called upon for religious and other guidance. In some studies, hodjas are called faith healers (Edirne et al., 2010).

*Respondent: "Ik denk niet dat ze hulp kunnen bieden."
(Haluk, male, 39, alcohol)*

Interviewer: "Is there no one in the mosque that can help you, that you can tell your story about your problems to?"

Respondent: "No. Because I'm the one who needs to get the use out of my head. Only then can I search for help."

Interviewer: "But if you can't, can't you just ask someone for help? Is there no one that does this at the mosque?"

*Respondent: "I don't think they can offer me any help."
(Haluk, male, 39, alcohol)*

Problem users do search for religious help and support outside of what they perceive as their own religious communities. Two users say that they feel more comfortable in Moroccan religious communities.

"Maar als ge naar de moskee al komt, dan zijt ge al aanvaard, dan zeggen ze oh hij heeft zijn verstand gekregen. versta ja, hij is niet meer die persoon die hij geweest is maar hij probeert iets anders te zijn, het rechte pad ik zal het zo zeggen en dan word je wel aanvaard bij de Turken. Ze zijn wel vergevend he. Als ze zien van ja, ik wil het terug goed doen, dan wordt je wel aanvaard he. Maar ik ga toch liever bij de Marokkaanse gemeenschap gewoon omdat ze geen vooroordelen zouden hebben. Want als ik bij de Turken ga, heel Gent kent mij versta ja. Dan gaan ze zeggen, oei den diene, versta je. Dat heb ik niet bij de Marokkaanse gemeenschap, die kennen mij niet, die kennen mij gewoon als ne moslim, that's it."

(Hikmet, male, 45, heroin and methadone)

"But if you go to the mosque, you are already accepted, then they say, oh he's finally using his common sense. You see, he's not the person he used to be but he's trying to be something else, on the straight and narrow path, I'd say, and then you are accepted by the Turkish people. They are forgiving, eh. If they see yes, I want to do the right thing again, you are accepted, eh. But I prefer going to the Moroccan community because they wouldn't have any prejudice. Because if I go to the Turks, everyone in Ghent knows me, you see. Then they will say, oh no, him, you see. That doesn't happen to me at the Moroccan community, they don't know me, they just know me as a Muslim, that's it."

(Hikmet, male, 45, heroin and methadone)

Two family members report that they have visited imams in Turkey to deal with psychotic sons. They say that it was a kind of "last resort" solution after or parallel with therapeutic treatment and medication. They also report they have paid a lot of money for these treatments, but they have not been successful. One participant reports that a Turkish imam has visited him several times and has performed non-harmful rituals on him to help him stop hearing voices. This is partly in line with Oliemeulen and Thung's (2007: 121) observation concerning the fact that it is usually the family that initiates contact regarding religious help.

Additionally, several participants report on regular personal contact with an imam or hodja to talk about Islam, and that this is of great help for their emotional stability. Two women report that they would like to talk to a hodja, but that there are few female hodjas.

In conclusion, we stress that Islam consists of many religious branches and contains some popular beliefs that are not interpreted or picked up by all Muslims. When inquiring about consulting hodjas, the community researchers unanimously state that "charlatans" making money out of expelling ghosts, neutralising the spell of djins (a popular cultural belief), or protection from the "evil eye" do exist, but that they do not make up the majority of imams and hodjas (communication during intervision, 14 September 2015). The participants seem to confirm this statement. This is consistent with previous research that postulates that alternative treatment use in ethnic minorities is comparable to its use in the general population (Derluyn et al., 2008: 298; Knipscheer & Kleber, 2005).

Further, participants note that they are aware of lectures in mosque associations about substance use and how to deal with substance use in children. Still, none of the participants

has found genuine support in their own religious community. On the contrary, they are ashamed and feel excluded from these communities because of their use.

“We [respondent and husband] zijn dus voorstander van een Europees centrum voor de islam met een Europese opleiding. [...] Turkije is een zeer progressief land. [...] De erkende Turkse moskeeën hier die door Turkije gesubsidieerd worden die dan imams naar hier sturen, theologen, die zeven jaar unief gedaan hebben. Ze komen naar hier voor vijf jaar en ze gaan terug. En hier (in de buurt) was er ne keer een jonge gast, met een jong gezin, begin de dertig. En die kwam uit een grote stad. Hij voelde zich hier niet goed want dat is hier nog getto mentaliteit. Ze zitten hier eigenlijk op Turkije achter, de oudere mensen. In Turkije ging hij met zijn vrienden naar het strand, zelfs met zijn vrouw en kinderen, en ze gingen ne keer op een terrasje gaan zitten, dat is hier dus not done. Zeker hier met de Peribeyli's. En dan de laatste die ik gezien heb die is blijkbaar nu ook alweer weg. Dat was het andere extreme, ik wou met hem babbelen en ik stelde die een vraag maar die antwoorde aan mijn man. en die keek niet naar mij. Dat je denkt van dat is mogelijk in Iran, of in Afghanistan maar toch nie... in Turkije zelfs niet denkbaar. En dan nog zeker niet in Vlaanderen, wat voor mensen sturen ze naar hier, weet wel.”
(Eser, female, 46, wife of heroin user)

“We [respondent and husband] are all for a European centre for Islam with a European education. [...] Turkey is a very progressive country. [...] The accredited Turkish mosques here that are subsidised by Turkey and send imams to come here, theologians, that have studied at university for seven years. They come here for five years and then return. And here (in the neighborhood) there was a youngster once, with a young family, early thirties. And they came from a large city. He didn't feel good here because here there's still a ghetto mentality. In fact, they are behind Turkey here, the elderly. In Turkey he would go to the beach with his friends, even with his wife and children, and they would sit in an outdoor café, that's not done here. Especially here with the Peribeyli's [people from Peribeyli], and then the last one I saw has apparently left again as well. That was the other extreme, I wanted to talk to him and I asked him a question, but he replied to my husband. And he would not look at me. Then you think this is possible in Iran, or in Afghanistan but not... In Turkey this is unimaginable. And especially not in Flanders, the type of people they send here, you know.”
(Eser, female, 46, wife of heroin user)

“Ja, de imam geeft toch regelmatig preken hé. Dan leest hij verzen uit de Koran en daar staan “Natuurlijk een paar dingen over verslaving en hoe dat dat is, maar ik heb eerder het gevoel dat er gewoon verteld wordt dat het strafbaar is en waarom het verboden is, wat ik ook wel belangrijk vind. Dan krijg je ook inzicht over waarom het verboden is en wat het met een mens doet. Dus er wordt wel over gepraat, maar meer over waarom het verboden is en hoeverre je dan zondigt.”
(Evren, female, 18, alcohol)

“Yes, the imam often preaches, eh. Then he reads verses from the Koran and there are obviously a few things in there about addiction and what it's like, but I feel like it just tells us that it's punishable and why it's forbidden, which I find important as well. That also gives you an insight into why it's forbidden and what it can do to a person. So they do talk about it, but it's more about why it's forbidden and how much of a sin it is.”
(Evren, female, 18, alcohol)

4.4.3 Visiting Turkey

Five participants had travelled to Turkey to get clean and two other participants report secondhand on this practice. When the problem use concerns heroin, users usually take a large amount of methadone to Turkey and stay there with family or friends. One participant reports that he tried to enter a treatment centre in Turkey, but was not allowed to stay. This practice seems to be in line with the general habit of many Turkish Belgians of going to Turkey at least a few months a year.

“Zeker mensen van de eerste migratie, die zoveel maanden per jaar naar ginder gaan. [...] van ja dat is mijn antidepressivum, zoveel maand per jaar naar Turkije gaan.” (Fatih, male, 50, heroin)

“Especially people from the first migration, that go there several months a year. [...] like yes those are my antidepressants, going to Turkey this number of months a year.” (Fatih, male, 50, heroin)

Three participants report that they used their mandatory army service in Turkey to get clean. As Fatih (male, 50 years old, heroin) puts it, “Je moet zware fysieke inspanningen doen en euh... de afkickverschijnselen voel je niet”, “You have to do severe physical effort and uhm... you don’t feel the withdrawal symptoms”. Most of the participants report they have bought off or will buy off their mandatory army service. The three participants who have carried out their army service have continued their use after returning to Belgium.

“Ja want je kan dat afkopen he (legerdienst). Normaal gezien is het 15 maanden. Maar de mensen die in het buitenland leven die kunnen dat euh... in mijn tijd was het 5700 euro dat je moest betalen en dan moest je maar een maand meer gaan. Nu kan je dat nog afkopen maar het is 6700 euro ofzo. Het is wat duurder geworden.”
(Fatih, male, 50, heroin)

“Yes, because you can buy it off eh (army service). Normally it’s 15 months. But the people who live abroad can do that, uhm... When I was young, you had to pay 5,700 euros and then you only had to go for a month. Now you can buy it off as well but it’s 6 700 euros or something. It has become a bit more expensive.”
(Fatih, male, 50, heroin)

4.5 Experience with services

One in three problem users have asked general and mental health care services for assistance in dealing with their use. Half have attended several in-patient treatment centres. We can assume that the actual treatment gap is higher, because some users who do not describe their use as problematic might not have been in treatment while in fact they needed it.

4.5.1 In-patient care

Eleven participants have attended the in-patient centre De Sleutel. All these participants feel that this in-patient centre is very disciplined when compared to other centres. Four participants say that they have not stayed longer than a week to three weeks because of this. Four other participants state that this discipline was useful to them. Two heroin users state that they have been clean for, respectively, five and seven years after their stay in De Sleutel, but only one in eleven remains clean to this day. Some of the participants note that the principle of “breaking down and building up” is not the way they want to, or can, stop using. Most of these participants are persistent heroin users and two are cannabis users.

Ten participants have resided in specialised psychiatric centres within hospitals (PAAZ). They were hospitalised for problems with a wide array of substances (alcohol, cannabis, heroin, codeine and because of acute psychosis). Most were referred to a hospital by their general practitioner or psychiatrist. Half of these participants discontinued their stay. Two family members and one participant state that they were given too much anaesthetising medication, and two participants state that not speaking Dutch was the main problem in the hospital. Two other participants have presented themselves at crisis care (UPSIE-UZ) and do not understand why they were not admitted for a short stay (respectively, alcohol and heroin users).

Eight participants have regular contact with a psychiatrist or psychologist besides in-patient care. More than half of these participants are treated for depression, two for psychosis disorders and one for alcohol use. Participants note that it was not easy for them to initiate contact with these professionals because, as Derya (38 years old, female, prescribed medication) puts it: “Het is algemeen geweten dat een psychiater alleen gekken behandelt”, “It’s general knowledge that a psychiatrist only treats madmen”.

Generally, respondents are quite positive about the support of psychiatrists and psychologists, although two note having had problems because of language and cultural differences (mainly concerning family issues). This is in line with Acherrat-Stitou’s (2009) and Knipscheer and Kleber’s (2005) assertion that psychiatrists and psychologists should be wary of cultural

countertransference in the therapeutic relationship with clients with an ethnic background. At least three participants state that their psychiatrist or psychologist is of Turkish descent.

“Mijn problemen waren vooral gebaseerd op familiale kwesties. Er waren grote ruzies tussen mij en de familie van mijn man. Ik had problemen met mijn schoonmoeder. Ik heb erdoor afgezien. Omdat de psycholoog deze culturele waarden niet begreep, heb ik niet echt de hulp gekregen die ik zelf wou. Maar na een tijd ben ik veranderd van psycholoog. Die psycholoog had opleiding gekregen over verschillende culturen en die bekeken mijn problemen anders en snapten me ook meer.”
(Berna, female, 46, prescribed medication)

“My problems were mostly based on family matters. There were big fights between me and my husband’s family. I had problems with my mother-in-law. I had a hard time because of it. Because the psychologist didn’t understand these cultural values, I didn’t really get the help I wanted. But after a while I switched to a different psychologist. That psychologist was educated in different cultures and they looked at my problems in a different way and they understood me better.”
(Berna, female, 46, prescribed medication)

Six participants underwent eight treatments at the in-patient centre VITA (PC Sint-Jan Baptist) (5) and De Pelgrim (3). These centres are conceived as less strict because they have less restrictive visiting regulations, and participants report having stayed for longer periods of time in these centres. Several of these participants note that they have worked through some personal issues in these centres. It should be noted that participants who attended these centres all relapsed after a maximum of three months outside the centre.

There were individual accounts of in-patient stays at Ghuislain, K13, Sint-Camillus. Generally speaking, participants’ experiences in these centres were positive because they succeeded in staying clean.

4.5.2 Outreach, out-patient and crisis care

Only heroin users report the use of outreach and crisis care, and a heroin substitution centre. Seven users gave an account of their experiences in a heroin substitution centre. For many, attending a heroin substitution centre is the main activity in their daily routine. They greatly appreciate the understanding the general practitioners in this centre demonstrate for their general situation, and are positive about the flexibility shown concerning their substitution therapy.

“Toen ik daar [in Medisch Social Opvang Centrum] mijn levensverhaal in het kort moest samenvatten merkte ik dat die onder de indruk was van hetgeen er allemaal gebeurd was. In zijn beleving was dat, of die indruk kreeg ik althans, was dat een logisch gevolg, mijn gebruik. Hij bekeek mij niet als een junk of een crimineel, hij had eerder medeleven met mij. Waardoor dat hij mij dan ook meteen euh... oprecht geholpen heeft met een opname te zoeken.”
(Ismail, male, 35, heroin)

“When I had to tell my life story over there [in the heroin substitution centre] I noticed that he was impressed with everything that happened. To his way of thinking, or at least that’s what I thought, my substance use was a logical result. He didn’t see me as a junkie or a criminal, he felt sorry for me. That’s why he immediately, uhm... sincerely helped me with finding an admission.”
(Ismail, male, 35, heroin)

Two of these users mention monthly visits by mobile teams to support their mental well-being. Two other users report they don’t go to the heroin substitution centre for methadone because they do not want to be confronted with ex-users. Three participants report the helpful support of employees of the organisation “De Eenmaking”. We mention this service explicitly because professionals also referred to it. This organisation was meant to form a bridge between Turkish and Moroccan communities and treatment centres, but ceased to exist in 2012 when it was incorporated into the General Welfare Centre (Centrum Algemeen Welzijn).

Consistent with the accounts of the substance misuse centre use described above, none of the cannabis, alcohol or medication users have reported contact with outreach services. These individuals seem to be more inclined to obtain help from hospitals, general practitioners and individual psychiatrists and psychologists. Moreover, it is notable that only mental health care and medical outreach work is mentioned in the interviews; there was no record of contacts with socio-cultural outreach work by other social services.

4.5.3 Aftercare and continuing care

Three issues have caught our attention in the life stories of the participants: waiting lists, being expelled from treatment centres and the period following in-patient stays. Five participants mention their frustration about the fact that in-patient treatment centres have waiting lists that require patience at a moment when they are least likely to feel patient. The discouraging effect this has is confirmed in a small-scale study on psychiatric disorders in elderly people with an ethnic background in Ghent (De Neef, 2011).

“Ik kon nergens niet terecht. Dan heb ik mijzelf laten colloqueren bij wijze van spreken. Dan heb ik mij veertig dagen laten opnemen om mijn medicatie... en om alles op punt te laten stellen, en dan heb ik dat op punt gesteld. En na veertig dagen was't in orde kon ik weer weg.”
(Fatih, male, 50, heroin)

“I couldn't get help from anybody. That's when I had myself institutionalised, so to speak. That's when I was admitted for 40 days for my medication... and to finalise everything, and that's when I finalised that. And after 40 days, everything was okay and I could leave again.”
(Fatih, male, 50, heroin)

One participant was placed in an in-patient centre with the help of a community researcher shortly after the interview.

“'t is allemaal vers. Nog maar 4-5 maanden hervallen. Van 7 jaar clean te zijn. Tis nog vers. Ik wil geholpen worden. Snap je? Het hoeft ni 8-9 maanden te wachten eh. Ik heb nu nu nu. Laat mij daar (ziekenhuis) binnen geraken.”
(Can, male, 33, heroin)

“It's all fresh. I relapsed only 4-5 months ago. After being clean for 7 years. It's still fresh. I want to be helped. You see? It shouldn't be postponed for 8-9 months, eh. I have now, now, now. Let me be admitted there (hospital).”
(Can, male, 33, heroin)

At least four participants had been expelled from treatment centres for what they describe as minor offences. Being expelled from a centre often implies being included on a blacklist, which impedes problem users from re-entering other treatment centres in the future. This in turn contributes to the further societal isolation and a lack of therapeutic monitoring.

“Ge moet altijd zo'n beetje uw verhaal opschrijven en dan wordt dat geanalyseerd door die mensen om u aan te nemen of niet. En bij mij was het altijd negatief. Als ze mijn verhaal lazen van ja, inbreken en diefstallen en euh... gebruik en, aleja, ik heb alles gedaan behalve moord en pedofilie.”
(Fatih, male, 50, heroin)

“You always have to write down your story and it's all analysed by these people whether to accept you or not. And the response was always negative for me. If they read my story about, yes, burglaries and thefts and, uhm... using and, yeah, I've done everything but murder and paedophilia.”
(Fatih, male, 50, heroin)

“Ewel, tis iets heel simpel. Een pak sigaretten wordt gestolen. Ik gaat gaan zeggen. 'k vind mijn pak sigaretten. Ik riep tegen die jongen. Ik word uit de instelling gezet.”
(Can, male, 33, heroin)

"Well, it's something very simple. A packet of cigarettes is stolen. I'm going over to tell them. I find my packet of cigarettes. I yelled at that boy. I get expelled from the centre."
(Can, male, 33, heroin)

"Ik heb niet geslaan. Hij heeft ook niet geslaan, maar hij is beginnen brullen tegen mij. Maar hij zat daar al acht, negen maanden, snap je. En die nieuwe groep... waarin ik geïntegreerd was, ze hebben dat gezien en ze hebben moeten getuigen en ze hebben gezegd dat ik hem een kopstoot gegeven had. Maar ze zitten al met die gast acht negen maanden, ze gaan niet de nieuwkomer... verdedigen of de waarheid zeggen snap je."
(Ismail, male, 35, heroin)

"I didn't hit him. He didn't hit me either, but he started shouting at me. But he was there for eight, nine months already, you see. And the new group... the one I was integrated in, they saw it and they had to testify and they said I butt him with my head. But they have been with this guy for eight, nine months, they're not going to... defend the new guy or tell the truth, you see."
(Ismail, male, 35, heroin)

Four participants who are in this situation find great comfort in visiting the day centre Villa Voortman, an open centre for clients with a dual diagnosis.

Also, at least eight participants report that they have begun using again, less than three months after successful treatment. They report having a hard time maintaining their housing situation and easily come back into contact with users that they know. This problem becomes even more of an issue when they are incarcerated, because participants in that situation have often lost family and friends and their position in the labour market is seriously jeopardised. This is partly in line with Oliemeulen's observation that clients with an ethnic background are more likely not to receive follow-up after treatment (Oliemeulen & Thung, 2007: 147).

"die zes maanden en het leven tegemoet, de eerste drie vier weken spreekte weer met jan en alleman. Uw tijdsbesteding is vol maar naar verloop van tijd wordt alles weer normaal en verveelde u weer en het vlot niet gelijk of dat je wilt en dan was ik weer vertrokken."
(Ismail, male, 35, heroin)

"Those six months and back towards life, the first three to four weeks you talk to everyone and anyone again. You have a busy schedule but after a while everything returns to normal and you're bored and it doesn't go as easy as you want and then I started again."
(Ismail, male, 35, heroin)

"Maar op een dag moet gij terug beginnen met de echte dagelijkse leven eh. de kans dat je gaat hervallen is 95-99% eh. daar in het afkickcentrum, ze zeiden dat ik daar ging stoppen eh, maar dat de kans op herval zeer groot was. Dat is de waarheid. Ge moet voor u eigen uitmaken, ge moet voor u eigen die klik zetten. Ik ken veel mensen die gestopt zijn. maar ik ken ook veel mensen die ni kunnen stoppen."
(Arda, male, 36, ex-heroin user)

"But one day you have to get back to your normal life, eh. There's a 95-99% chance of a relapse, eh. Back there in the rehabilitation centre, they said I would stop there, eh, but that the relapse chances were very high. That's the truth. You have to decide that on your own, you have to flip the switch. I know a lot of people that quit, but I also know a lot of people who can't."
(Arda, male, 36, ex-heroin user)

"Toen ik naar afkickcentrum ging moest ik mijn appartement leegmaken. En achteraf kwam daar terug, en moest ik opnieuw op zoek naar een nieuw appartement. Terug nieuwe meubels kopen. Allez tis zeer moeilijk."
(Abdullah, male, 28, cannabis)

"When I went to the rehabilitation centre, I had to empty my apartment. And when I returned afterwards, I had to look for a new apartment again. Buy new furniture, again. Well, it's very difficult."
(Abdullah, male, 28, cannabis)

4.5.4 Referral systems

“Die mensen proberen het meestal op te lossen binnen hun eigen kring. Ze willen niet dat de buitenwereld dat ook te weten komt. Dus als ze een probleem hebben houden ze dat liever geheim.”
(Ilhan, male, 22, son of alcohol user)

“Those people usually try to fix things within their own circle. They don’t want the outside world to discover it as well. So if they have a problem, they’d rather keep it a secret.”
(Ilhan, male, 22, son of alcohol user)

At least seven participants report that they have gone to a rehabilitation centre because of the direct action of a family member. This seems to suggest that when the need for action becomes urgent, family members do find access to the health care system. Other referrals mentioned are a heroin substitution centre, the police for compulsory intake in crisis treatment, judicial interventions (drug court in the case of heroin) and, to a lesser degree, general practitioners, psychiatrists and psychologists. We note that in many cases the proactive intervention of a professional or volunteer makes the difference in referring problem users to rehabilitation or the social services they need. Many note that rehabilitation is a very personal process, and the fact that treatment models differ substantially across treatment centres should be taken into account by users when being placed in one of them. Further, some participants note that general practitioners, as frontline workers, should be more aware of the options that are available for rehabilitation.

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4.6 Discussion

This exploratory study is based on 62 interviews comprising 39 self-described problem users, 16 self-described non-problem users and seven family members of problem users. In the literature review we suggested several sensitising concepts, which we will elaborate upon in what follows. Using a community-based participatory research design for this study allowed us to gain an insight into use from the perspective of the Turkish community itself, as opposed to an outsider's academic perspective. The difficulties we encountered relate to reaching participants by means of respondent-driven sampling, the quality of the interviews and the time intensity for guiding and motivating the community researchers. We describe these and other pitfalls in detail in chapter 3 to inspire future research.

The top three substances used in this relatively small sample seems quite similar to use in the general Belgian population. Alcohol and cannabis are the main substances used (we did not include the use of tobacco in this study). The third most used substance is cocaine. In addition, the prevalence of prescribed medication use is quite high. Regarding prescribed medication, a large-scale Belgian study has demonstrated that psychological distress, depression and generalised anxiety are more prevalent among Turkish immigrants than in the general population in Belgium (Levecque et al., 2007).

It should be noted that the community researchers did not directly reach out to cocaine and heroin users, which could imply that awareness or willingness to talk about the use of these substances is quite low in the Turkish population in Ghent. The fact that continued and problem use is often attributed to family problems is also comparable to the general population, although marital migration is a specific risk factor (see *infra*).

The fact that most of the participants feel more Turkish than Belgian is in line with research on the general Turkish population in Belgium, which found that 78% feel exclusively Turkish (Manço, 2012). Most participants feel as if they are between cultures, and this is also in line with literature on ethnic identity (Rastogi & Wadhwa, 2006). We found, however, that not feeling Belgian is experienced as a more negative issue by problem users than by non-problem users, and more often results in feeling exclusively Turkish. These users do not feel Belgian because they cannot obtain Belgian nationality or because they feel discriminated against. This could contradict the thesis that a high level of ethnic self-identification combined with a low level of acculturation serves as a protective factor towards problem substance use (Taïeb et al., 2008). Further, it could confirm the theory of "reactive ethnicity" (Hagedorn, 2008) meaning that individuals feeling discriminated against or excluded are more inclined to fall back on a perceived ethnic identity, as exemplified in Flemish-Turkish youngsters by Ersanilli (2009: 56), and by Jamouille (2010) in her study on Turkish youngsters in Brussels.

We found large differences between the generations participants belong to. Self-described problem users are mostly second generation Turkish. We should, however, note that the number of participants belonging to this generation is also higher in this sample, which might distort this conclusion. Manço (2004) characterises second generation migrants as having fewer ties with a Turkish identity, having less social support and opportunities for social improvement. Bucerius (2014) in turn notes in her study on German-Turkish dealers that second generation migrants demonstrate a general lack of a consciously decided immigration experience. Escobar (in Kulis et al., 2009) raises the hypothesis that the acculturation gap between second generation Turkish people and their parents elevates risk behaviour such as problem substance use.

Third generation migrants are least willing to describe their use as problematic. This may be partly due to their young age and low awareness. The larger number of highly educated participants within this group when compared to first and second generation migrants could possibly be a protective factor as well. Nevertheless, third generation Turkish descendants also remain a group at risk, mainly because of ongoing discriminatory practices in education,

housing and the labour market (see *infra*).

Further, a significant number of marriage migrants experienced problem substance use. Taking into account that intercommunal marriages are the most prevalent type of marriage in the Turkish community (93%) (Manço, 2012) and that marriage migration is common practice in the Turkish community (Schoonvaere, 2013), special attention should be given to this target group. Further, recent research in the United Kingdom (Finney et al., 2015) confirms that being separated or divorced are strong predictors of poverty status and consequent detrimental mental health.

For marriage migrants, we can conclude that acculturative stress can be a risk factor for problem substance use both in men and women. For all generations and marriage migrants we stress the impact of perceived and structural discrimination on mental health, as confirmed in research by Kulis et al. (2009).

Concerning language there seems to be a significant difference between problem and non-problem users. On a scale of 1 to 5 non-problem users score 4.8 while problem users score 3.8. The fact that problem users more often belong to the group of classic second generation and marital migrants partly explains this discrepancy. Furthermore, it could imply that not speaking the language is a risk factor for problem use, but further research on this topic is necessary.

Second and third generation Turkish migrants describe feelings of perceived discrimination. Additionally, problem users seem to demonstrate less flexibility in coping with these feelings when compared to non-problem users. In line with Goffman's (1975, in Bucerius, 2014: 67) assertion that first generation migrants often accept the stigma associated with being outsiders and construct their lives around this stigma, first generation Turkish and marriage migrants indicate less discrimination. A recent quantitative study in Kurdish, Somali and Russian migrants in Finland confirms that unemployment and a poor economic situation are significant risk factors for detrimental mental health in these groups (Rask et al., 2015). The feelings of perceived discrimination reported in this study align with recent studies on structural discrimination in Flanders and Ghent:

- One in three people with a foreign-sounding name will be discriminated against in the housing market (Verhaeghe et al., 2015).
- Secondary school student with a migration background more often leave education without a diploma and are more often referred to vocational training (Agirdag et al., 2011; Boone et al., 2014).
- Only 10% of Turkish young people between the ages of 20 and 24 enter higher education (Manço, 2012: 4).
- Ethno-stratification in the labour market results in Turks and Moroccans having the highest rates of unemployment in the labour market. Not only are they less likely to find a job, they also have the lowest paying jobs (Verhaeghe, Van der Bracht, et al., 2012).
- Four in ten Turkish youngsters are unemployed (Manço, 2012).

This research found that social isolation might also be a risk factor. Several participants note that they feel comforted after the interview, because they have so few people to talk to about their situation. Participants who migrated without their family appear to have had more difficulty in creating a social network in Ghent. Furthermore, participants who have been incarcerated and problem users feel isolated from and stigmatised by the Turkish community in Ghent. The phenomenon of ethnic conformity pressure (Van Kerckem et al., 2014) within the Turkish community in Ghent and religious views on substance use play an important role in this isolation. Social isolation is closely interlinked with personal beliefs about what is forbidden (*haram*) in Islam. Problem users find strength in their belief, but they also feel excluded from their religious communities because of their use. This results in self-exclusion from these communities.

Social capital and belonging to different networks has been proven to increase mental health and stamina. However, this study demonstrates that belonging to the Turkish community in Ghent can be detrimental when dealing with problem substance use. Many participants lead isolated lives and do not engage in the various available networks, and many do not have friends to rely on. Additionally, most problem users do not have any leisure activities; undertaking such activities outside the therapeutic environment has proven to reduce the risk of relapse (Linan in Favril et al., 2015). Furthermore, when users have been incarcerated they become particularly vulnerable because they are not prepared for life outside prison and usually no longer have networks of friends and family, and they generally live in precarious conditions due to housing difficulties and their position in the labour market (Tieberghien & Decorte, 2008).

Perceptions of substance use influence help-seeking behaviour in the community. Problems concerning use are often only dealt with within the household while it is a taboo subject in the extended family and in the Turkish community at large. Also, within the household there is a close interlinking of taboo, shame, stigma and a perceived individual responsibility, which jeopardises early intervention in the family context. We find that ethnic conformity pressure has a large influence on help-seeking behaviour (Van Kerckem et al., 2013). A wish to avoid being labelled a substance user results in people not seeking help when needed and is a direct result of the stigmatisation of substance use in this specific Muslim community (Ciftci et al., 2013). The fact that stigmatisation is an extra risk factor in migrant communities (Sacré et al., 2010) is confirmed in the Turkish community in Ghent.

In line with Fountain and Hicks' observations in Turkish communities in London (2010), substance use in the Turkish community in Ghent is considered forbidden (*haram*). This jeopardises help-seeking behaviour. The notion of *haram* seems highly problematic within the Turkish community. For many Turks, Islam is a moral compass. By analysing the perspective of problem users we suggest that the concept of *haram*/forbidden is too static in the Turkish community in Ghent and is directly related to exclusion from religious communities. We therefore entreat mosque associations and Islamic educational bodies to open discussions about the interpretation and use of the dynamic concept of *haram* in Muslims' lives. The successful collaboration between the NPO Moslim Adviespunt and municipal services for parental support could be a starting point for this.

When use becomes an acute problem close family members do search for help from in-patient treatment centres. Problem alcohol, cannabis and prescribed medication use is more often dealt with by accessing treatment at hospitals, general practitioners and via psychiatrists and psychologist. Nevertheless, stigma and taboo create a barrier to seeking that help. Outreaching mental health care providers have rarely been mentioned, and only in the case of heroin use. Taking into account the large prevalence of social isolation as a reason for and result of problem substance use and also the high level of relapse it could be beneficial if social outreaching services sought better access to these individuals.

Users generally describe their use as problematic because of their physical dependence on a substance. This is confirmed by the reasons participants give for seeing access to in-patient care, whether successful or not, and by the large amount of participants resorting to hospitals in cases of problem use. This could imply that looking at addiction only from a medical and physical perspective (as opposed to taking into account social factors) jeopardises successful treatment.

At the service level, greater awareness and insight is needed towards the additional risk factors clients with a Turkish background face (marital hazards, the construction of ethnic identity, the notion of *haram*, exclusion in the Turkish community, structural and perceived discrimination). Part of this culturally sensitive care may include opening up the conversation about religion as a protective factor. Furthermore, it could include an intensified use of a "trialogue" that includes family members in the treatment of clients (Jamouille, 2010). But, most importantly, it implies

creating culturally sensitive organisational structures and dealing with structural discrimination at the service and policy level.

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5 SUBSTANCE USE IN EASTERN EUROPEAN COMMUNITIES IN GHENT

5.1 Eastern European communities in Ghent

In contrast to the case study among Turkish people with a long migration history to Belgium, in this chapter we focus on a relatively new group of migrants originating from Eastern European countries. One of the key recommendations from the ZEMIV project (Derluyn et al., 2008) is to study the situation of drug users with an Eastern European cultural background in Belgium, as they primarily appeared in low-threshold services, but were not accessing detoxification or residential services. Still, several practitioners state that there is a significant drug use problem in this population but there is no information available yet about this group.

The decision to work with the Bulgarian and Slovakian communities in Ghent was a pragmatic one. The research team responsible for this case study is based in Ghent. Additionally, the two largest groups of migrants in Ghent, after the Turkish, are the Bulgarians and the Slovaks.

5.1.1 Migration history

A recent study from the Municipal Integration Service of Ghent (personal communication, 31 March 2016) demonstrates an increase in new European Union (EU) citizens in Ghent (table 7). The number of new EU citizens migrating to Ghent from Central and Eastern Europe was calculated by means of the number of registrations at the Office for Migration of the Civil Affairs Department.

The relative and absolute number of new EU citizens in Ghent has significantly increased. This is presumably due to the accession to the EU of the Czech Republic and Slovakia in 2004, and Romania and Bulgaria in 2007 (Municipal Integration Service of Ghent, personal communication, 31 March 2016).

The number of Bulgarian newcomers is remarkably high compared to the total number of migrants coming from Central and Eastern Europe. On 31 December 2015 there were 8,193 registrations compared to a total of 12,540 new EU citizens in Ghent. About 65% of these newcomers originate from Bulgaria. Slovakian migrants are the second largest group of new EU citizens in Ghent, with a total number of 1,810 registrations by the end of 2015, or a total of 14.5% of all newcomers.

Even though this clearly indicates an increased number of new intra-European migrants, it is necessary to take some issues into account when interpreting the figures. In contrast to what these numbers seem to imply, intra-European migration is not a new phenomenon in Ghent. In the late 1990s several Slovakian Roma families migrated to Ghent, and they formed a point of reference for other families to join them later on (Hemelseet, 2013). Furthermore, some of these migrants had lived in Belgium illegally for years before they were able to register legally after the accession of their respective home countries to the EU. Therefore, a significant number of these “new” migrants have actually lived in Ghent for over 15 years.

Although the majority of non-registered Central and Eastern Europeans live in Brussels, Antwerp or Liège, a large number of non-registered intra-European migrants live in the city of Ghent. Several groups of intra-European migrants are consequently not included in the statistics. Also, the aforementioned numbers do not include people who have obtained Belgian nationality, children who obtained Belgian nationality when they were born, people who were

registered on the waiting list to obtain the Belgian nationality, people who are staying in Belgium for a short period of time or workers on secondment (Verhaeghe, Van der Bracht, et al., 2012: 26).

Table 7: The evolution of EU citizens in Ghent from 2003 to 2015 (Integratiedienst, 2016)

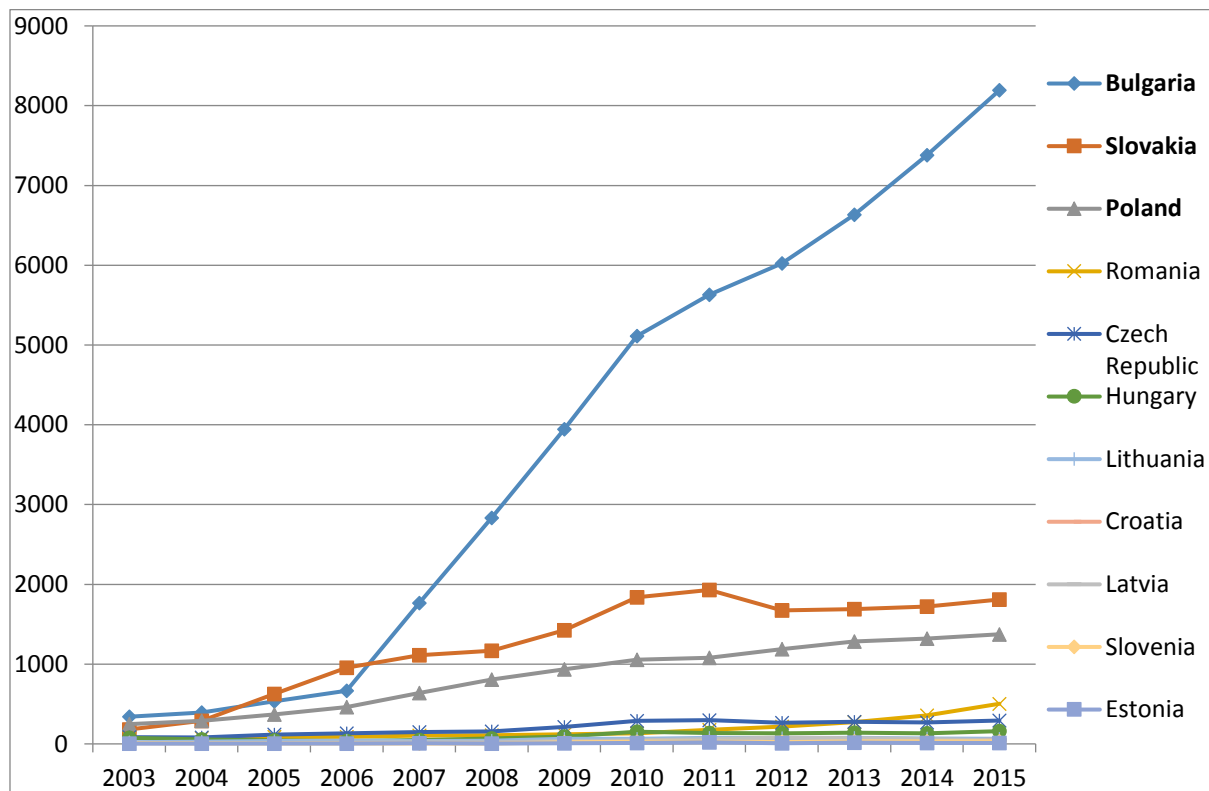


Table 8: EU citizens in Ghent at the end of 2015 (Integratiedienst Gent, 2016)

Nationality	2015	%
Bulgaria	8,193	65.4
Slovakia	1,810	14.5
Poland	1,374	10.9
Romania	503	4.0
Czech Republic	293	2.4
Hungary	160	1.3

Nationality	2015	%
Lithuania	64	0.5
Croatia	53	0.4
Latvia	45	0.3
Slovenia	33	0.2
Estonia	12	0.1
Total	12,540	100

The significant – and still increasing – presence of Bulgarian Roma and Turkish Bulgarians in Ghent cannot be seen separately from the large Turkish community in the city. Hemelsoet (2013) reports that the common language of the two communities facilitates the search for a job and a house; Bulgarian minority groups often find a place to live in the Turkish community in Ghent. Bulgarians are often employed by Turkish people in Ghent, as a result of their facing a very difficult search for employment due to their vulnerable profile (i.e. illiteracy, very little or no experience on the labour market, little or no knowledge of the Dutch language, uncertain residence status and health problems). When they fail to find a legal job in the formal sector they usually end up in the underground economy. In this environment their precarious situation and low bargaining power makes them highly vulnerable to discriminatory practices in the form of longer hours and non-payment of various bonuses, or even of wages (Delaunay et al., 1998). In turn, this exploitation reinforces their precarious situation. However, through these opportunities they try to survive in Belgium (Hemelsoet, 2013). Looking at the numbers of the Register of Population and Foreigners, the neighbourhoods in Ghent with the highest concentration of Bulgarians are Rabot-Blaisantvest, Sluizeken-Tolhuis-Ham and Dampoort (with more than 8% of the total population). Slovaks can principally be found in the neighbourhood Brugse Poort-Rooigem, but also in Muide-Meulestede-Afrikalaan and Macharius-Heirnis. In absolute numbers the neighbourhoods Sluizeken-Tolhuis-Ham, Dampoort, Brugse Poort and Rabot score highest. However, researchers point to the differences between Bulgarian and Slovakian citizens in Ghent. Bulgarians are in the middle of assembling ethnic networks, especially in neighbourhoods with a lot of Turkish people, whereas Slovaks are currently establishing small and casual groups (Verhaeghe, Van der Bracht, et al., 2012).

5.1.2 Ethnicity

Bulgaria is historically a multicultural society with several established ethnic minorities. The population of almost 7.5 million inhabitants of this South-East European country is composed of the Bulgarian (ethnic) majority (84.8%) and a number of ethnic minority communities, among which Bulgarian Turks (8.9%) and Bulgarian Roma (4.8%) are the largest. The presence of the minorities varies strongly across the 28 districts of Bulgaria. For example, in some districts there are no Bulgarian Turks whereas in others they are the numeric majority (Visintin et al., 2016). The Bulgarian constitution forbids discrimination, recognising the right of ethnic minorities to preserve their culture and religion and to study and practise their mother tongue. Nevertheless, both ethnic minorities, but in particular the Roma, are discriminated against (ECRI, 2009; Mudde, 2005; Pamporov, 2009; Vassilev, 2004).

Most Bulgarian and Slovakian migrants in Ghent belong to minority groups in their country of origin (Hemelsoet, 2013). A large proportion of the economic migration of Bulgarians belongs to the Turkish-speaking minority group and to the Roma community. These two groups migrate from a country that offers them few opportunities for employment, economic welfare and education, and has also experienced some extreme forms of historic and current discrimination (Ganeva, 2013; Tomova, 2011). Bojkov (2004) reports that Bulgarian minority groups migrate to escape social exclusion and poverty in their country of origin. Bulgarian Turks, for example, were forced to change their “Muslim” names into “Christian” names and to convert to Christianity during a forced assimilation campaign (the Revival Process, from 1984 to 1989) (Eminov, 1997). Another example is discrimination in employment, education and health care in the country of origin, as well as their being often victims of corruption in police and justice contexts (Filipova, 2015). The hatred towards these minority groups can be very profound at times. As in most European countries (Dimitrova et al., 2014; Tileagă, 2006), Roma are the most stigmatised ethnic group, eliciting harsh antipathy among ethnic Bulgarians and being stereotyped as lazy, criminals, living on social aid, incompetent and dirty (Bakalova et al., 2014; Pamporov, 2009). In April 2016 the European Roma Rights Centre reports an incident concerning a 17-year-old Roma boy who was brutally hit by an ethnic Bulgarian boy because

the Roma boy indicated that he felt equal to ethnic Bulgarians. The minority groups hold a weak socio-economic position in their country of origin, in contrast to ethnic Bulgarians, which does not necessarily change through migration. An estimated 50% of the Bulgarians, 90% of the Slovaks, 90% of the Romanians and 50–90% of the Czechs in Ghent are Roma (Hemelsoet, 2013; Verhaeghe et al., 2012).

“Roma” is not a nationality; it is an ethnic identity. That is the reason why it is impossible to count the exact number of Roma. Furthermore, they often do not report they are Roma for obvious reasons, including feelings of shame and inferiority. According to an estimate by Ghentian professionals in socio-cultural and other organisations, the number of Bulgarian Roma is about 4,428 of the 7,380 registered Bulgarians by the end of 2014, and the number of Slovakian Roma is about 1,550 of the 1,722 registered Slovaks, representing respectively 60% and 90% (Municipal Integration Service Ghent, personal communication, 11 February 2015). Bulgarian Roma are less visible because a lot of them speak Turkish and are lost in the larger Turkish-speaking community in Ghent, which leads to confusion when practitioners attempt to differentiate between the two ethnicities, i.e. the two Bulgarian minority groups (Hemelsoet, 2013).

5.1.3 Health

European research paints an alarming portrait of the health of Roma in their countries of origin (Bartosovic, 2015). In Bulgaria, for example, at least one person in more than 30% of the Roma households suffers from a serious chronic disease or disability. Unhealthy habits among Roma, such as smoking (more than 50% of all men), problem alcohol and drug use (present in 17.4% of all households) and poor diet, are widespread (Babinská et al., 2014).

In December 2015 the research team for this case study visited the Czech Republic, a country with many Roma communities. During a walk through Prague guided by Professor Dr Petr Matousek, psychologist at the Department of Addictology, First Faculty of Medicine, Charles University Prague and General University Hospital and specialist in substance use among ethnic minorities and Roma, the circumstances of people living in poverty and deprived living conditions in an urban context was delineated, together with information on some specific addiction care services. The team also visited Člověk v tísni (People in Need), a non-governmental, non-profit organisation based on the ideas of humanism, freedom, equality and solidarity in Usti nad Labem near Prague. This helped them understand the history and current situation of a Roma community in a more rural and remote area. Člověk v tísni has been providing social services since 1999 and is active in 60 towns in the Czech Republic, and also in Slovakia. In 1999 Člověk v tísni introduced a concept of social counselling using fieldwork, whose main purpose was to help people from socially deprived areas. Gradually, the scope of their activities has expanded and in 2006 its social integration programmes were launched. The organisation’s activities can be divided into several phases. They initially attempt to halt the progressive social decline of individuals or households. As soon as the situation is stabilised, the next task is to find a solution for the problems that created the social deprivation. The ultimate goal for the future is to reach a state when the family, having developed sufficient competences, will be able to solve their problems without their assistance. A formal visit to this organisation and informal meetings with fieldworkers, counsellors, educational consultants and the coordinator of their office in Usti nad Labem indicated why Roma never or rarely find access to health care. The poor health status of Roma is clearly linked to their vulnerable social and economic situation, but also to thresholds in health care (see *infra*). After the fall of communism the threshold to visit a doctor was increased for Roma. In some countries of origin discrimination and corruption occur. Many Roma are fully self-reliant because they have little opportunity to obtain legitimate care in a corrupt health system (Člověk v tísni [People in Need], personal communication, 1 December 2015). Additionally, Roma often depend on spoken knowledge narrated from generation to generation (Stad Willems et al., 2015).

Thresholds that limit access to health care in countries of origin are: distance (Roma communities are remote from institutions), little or no knowledge about prevention, no financial means for purchasing consultations or medication, cultural differences, administrative thresholds and discrimination. In Bulgaria organisations are attempting to reverse this situation by working with health mediators from the Roma community. In doing so they attempt to reach the Roma community by building bridges through working with a person of trust and eliminating the language barrier (Stad Willems et al., 2015).

5.1.4 Substance use in Bulgaria

A fourth national representative study among the general population was carried out in Bulgaria in 2012 with a sample of 5,325 people aged 15–64 on their use of and attitudes towards different psychoactive substances (the previous surveys were in 2005, 2007 and 2008) (EMCDDA, 2013). The data indicated that cannabis was the most frequently used substance, with last year prevalence at 3.5% and last month prevalence at 2.0%. When compared to the previous studies, a steady and significant increase in last year and last month prevalence of cannabis use was reported among the general population. Cannabis also remained the most frequently used illicit substance among young adults aged 15–34. Last year and last month prevalence also increased among this age group when compared to previous years: in 2012 a total of 8.3% reported they had used cannabis at least once in the last 12 months, while the rate was 6.0% in 2008, and 4.4% in 2007. For the same age group, last month prevalence of cannabis use was 4.8% in 2012, an increase from 1.4% in 2008 and 1.2% in 2007. Ecstasy was the second most prevalent substance, and the studies show an increase in its use since 2007, in particular among younger adults. Prevalence of amphetamines, cocaine and heroin use has remained low among the general population, and the latest study confirmed a declining trend in the reported use of these substances since 2005.

5.2 The participants

This study sample consists of 68 respondents. All respondents were predominantly recruited by the community researchers and meet the following inclusion criteria: they describe themselves as belonging to the particular community or target group under study (i.e. the Bulgarian, Slovakian or Czech community in Ghent), they are between 15 and 65 years old, and they have last year experience with illegal drug use or episodes of excessive drinking.

The majority of these respondents are of Bulgarian descent (n=43). Most describe themselves as having Turkish ethnic roots. Only one of the Bulgarians describes himself as Roma. Taking into account their family and migration histories we suppose that this number is higher but was not reported upon because of stigmatisation of Roma in Ghent. The second biggest group in our sample are Slovaks (n=19), all of whom describe themselves as Roma. The Bulgarian/Slovakian divide in our sample is representative of the Eastern European communities in Ghent and is a result of the fact that four of the community researchers that conducted most of the interviews were of Turkish-Bulgarian and Slovakian Roma descent. The six remaining respondents are of Czech Roma descent. The respondents of Czech Roma descent are methadone users (as a substitute for heroin) and these interviews were conducted by the project assistant. They are not included in the analysis since they were not transcribed in time.

5.2.1 Socio-demographic characteristics

The average age of the participants is 33.8 years old. Most participants are between 25 and 35 years old (n=27). Nineteen participants are between 36 and 56 years old and the remainder are younger than 25. Three in four participants are male (n=41) and one in four is female (n=21). Half of the participants have completed secondary education. One in ten participants is poorly educated and another one in ten has completed higher education. We have no conclusive information about the education of ten respondents. Three in four of the participants are legally or illegally employed, and one in five is unemployed. Half of our respondents are single, of which nine are divorced. The other half is evenly divided into married individuals and people living with their partners. Half of our respondents have between one and three children. Twenty of the respondents have divorced at least one partner in their lives. We do not have enough information to report on residence permits. Eight respondents are Belgian nationals, and the majority have dual Bulgarian/Belgian nationality. At least one in seven respondents mentions that they have resided illegally in Belgium for several years before obtaining a residence permit.

5.2.2 Reasons for migration

The majority of the participants in our sample are second generation migrants. They moved to Belgium at a fairly young age with their parents. More than half of the participants have lived in Ghent for over ten years. One in five arrived in Belgium less than a year ago and the remainder of the participants (one in four) has been in Belgium between one and five years.

More than half of the respondents say that the reason they moved to Belgium is that they were in search of economic prosperity. They expect to make more money in their host country than they would in their home country. Additionally, they believe that it is easier to find a job in Belgium and that the available jobs are better and less strenuous. Nevertheless, later on in the interview most participants refine the assessment they had made before coming to Belgium, and state that finding a job in Belgium and the kind of jobs are not what they expected.

“De reden van mijn verhuis is de belachelijk lage lonen die je daar krijgt. Hier zijn de lonen hoger.”

(Konstantin, male, 27, Bulgarian)

“The reason why I came here is because of the low salaries [in Bulgaria]. Here [in Belgium] the salaries are higher.”

(Konstantin, male, 27, Bulgarian)

One in four mentions that having family in Belgium made it easier for them to migrate to the country. These participants often have an uncle, cousin or father living and working in Belgium and migrate later on, with or without the rest of their family (i.e. mother, siblings, grandparents, children).

“Eerst is mijn vader naar België gekomen, omdat hij hier familie heeft. [...] Vervolgens is mijn moeder naar hier gekomen. En daarna ik. Ik ben vooral hier omwille van mijn familie.”

(Milena, female, 27, Bulgarian)

“First my father came to Belgium because he had family here. [...] Then my mother came. And then I came. The main reason why I'm here is because of my family.”

(Milena, female, 27, Bulgarian)

One in seven mentions that they were discriminated as Turkish Bulgarians or Roma in their country of origin. We can suppose that this number is in fact higher but that, due to a lack of trust in the community researcher, not all respondents mention this. Respondents state that their living situation could no longer be maintained in their country of origin because of discrimination at work, at school, in their social life or in their neighbourhood. They wanted to flee injustice by moving to another country.

“Ik woonde in Bulgarije, in een mooie stad, Lovetch. [...] De meeste van mijn jaren heb ik daar doorgebracht, maar elke dag werd de politieke systeem erger en erger. Omdat we tot de minderheden behoren, werden we verchristend en de politie heeft ons gedwongen om onze Turkse namen te veranderen in Bulgaarse namen. Deze naamverandering werd ook toegepast op de graven van onze grootouders. Dit was de eerste aanleiding waarom we wouden vluchten uit het land. We waren genoodzaakt om te vluchten. Hier zijn we aangekomen als immigranten met nieuwe namen en gebroken eer. We zochten naar een uitweg en in leven blijven.”
(Miroslav, male, 54, Bulgarian)

“I used to live in Bulgaria, in a nice city called Lovetch. [...] I spent most of my life there, but the political system got worse and worse every day. Since we belong to a minority group, we were Christianised and the police forced us to change our Turkish names into Bulgarian ones. This change of names was also done on our grandparents’ graves. All this was the first reason why we want to flee the country. We were forced to do so. We arrived here with new names and broken honour. We were looking for a way out and staying alive.”
(Miroslav, male, 54, Bulgarian)

Lastly, a minority of respondents moved to Belgium because of personal problems such as divorce (n=3) and problem substance use (n=2).

“Ik heb gehoord dat er veel verslaafden hier zijn en ik hoopte op hulp. Ik wist ook van het bestaan van bepaalde organisaties.”
(Aleksandar, male, 30, Bulgarian)

“I heard that there are a lot of addicts here and I was hoping for help. I also knew some organisations.”
(Aleksandar, male, 30, Bulgarian)

5.2.3 Ethnic identity

When we ask respondents if they feel Belgian only three answer positively. One in eight respondents states that they want to feel Belgian but that they cannot because they do not speak the language (i.e. Flemish), they do not work here, or because they have not been here long enough.

“Ik ben Roma, ik kan zomaar Belg niet worden, ik kan mij alleen aanpassen.”
(Andrej, male, 29, Slovakian)

“I am Roma, but I cannot become Belgian that easily, I can only adapt.”
(Andrej, male, 29, Slovakian)

The majority of the respondents report that they do not feel Belgian because they were not born here. They feel Bulgarian or Slovakian Roma, and are proud to be so.

“Ik kan me niet Belg voelen, omdat ik hier niet geboren ben. Ik probeer wel iemand van hun te worden. [...] Een Belg is iemand die in België geboren is, wanneer hier geïntegreerd bent, de geschiedenis van het land kent, hier opgegroeid is... Ik ben een Bulgaar en daarom ken ik enkel de Bulgaarse geschiedenis. Ik voel me eerder Bulgaar. Omwille van de tradities en gewoontes - de zogenaamde Balkan syndroom.”
(Dimitar, male, 46, Bulgarian)

“I cannot feel Belgian, because I was not born here. I am trying to become one of them. [...] A Belgian is someone who is born here, when one is integrated, knows the history of the country, is raised here, ... I am Bulgarian and therefore I know the Bulgarian history. I feel more like a Bulgarian because of the traditions and habits – the so-called Balkan syndrome.”
(Dimitar, male, 46, Bulgarian)

Most of these respondents do not see the fact that they feel Bulgarian rather than Belgian as a problem or a barrier to building a life in Belgium. They are also very positive towards what they perceive as being Belgian (e.g. working hard, having certain rights and freedoms). Most

Roma, for example, are proud to be Roma but do not necessarily have negative feelings towards Belgians.

Only one in eight respondents display what we might call a reactive identity: they feel more Bulgarian/Slovakian or Roma because they have had negative experiences with Belgians. Another five respondents explicitly note that they do not know how to feel and that they feel in between two or more cultures and nationalities.

“Ik kan me niet als Belg voelen. [...] Of ik me Bulgaar voel? Deze vraag kan ik niet correct beantwoorden. Bulgarije heeft ons weggejaagd. [...] Ik wil niet terug naar Bulgarije. Daar kijken ze ook zo naar ons. [...] We zijn van Turkse origine en daarom behoren we tot de minderheden. Voor ons is er daar om deze reden geen werk. Vergelijkbaar met hier [...]. Aan ons wordt vooral zwaar en vuil werk aangeboden. [...] Ik weet niet als wie ik me voel. Ik ben hier 15 jaar, ik volgde cursus maatschappelijke integratie en Nederlandse talen. Nu nog steeds gaan ik lessen volgen. Ik doe me best om hier in het land te integreren. Uiteindelijk heeft België haar hand aan ons gestrekt. Ze heeft ons een onderdak gegeven. België heeft heel goede zaken voor mij gedaan. Anders weet ik niet waar ik zou zijn en wat ik ging doen.”
(Miroslav, male, 54, Bulgarian)

“I cannot feel Belgian. [...] Do I feel Bulgarian? I cannot answer that question. Bulgaria has chased us away. [...] I don't want to go back to Bulgaria. There as well, they look at us in a certain way. [...] We are from Turkish descent and that is why we belong to a minority. Therefore there is no job for us in Bulgaria. It is similar to here. [...] we are offered mostly hard and dirty work. [...] I don't know which nationality I feel I am. I've been here for 15 years now, I took a course on social integration and Dutch language. Now I'm still taking classes. I try my best to get integrated into the country. Belgium has helped us after all. She has given us shelter. Belgium has done a lot of good things for me. If not, I wouldn't know where I would be and what I would be doing.”
(Miroslav, male, 54, Bulgarian)

5.2.4 Communities and religion

When we ask Bulgarian respondents if they believe a Bulgarian community exists in Ghent they all confirm this. However, their description of the Bulgarian community reflects the transposition of political and religious trouble in the home country to Belgium. All 43 Bulgarians confirmed the existence of a Bulgarian community, but they relate to this perceived community in a particular way. Respondents identified three Bulgarian communities in Ghent: the Turkish-Bulgarian community, the “ethnic” Bulgarian community and the Bulgarian Roma community.

“Er bestaat niet zoiets als homogene Bulgaarse gemeenschap in Gent of in België. [...] Er zijn eerder groepsgemeenschappen van studenten, van werkenden, van Bulgaarse minderheden... Er zijn Bulgaren van verschillende etnische groepen die ook hier vertegenwoordigd zijn in de Bulgaarse gemeenschap. Wij mogen de Bulgaren niet onder een noemer zetten.”
(Anastasiya, female, 30, Bulgarian)

“There doesn't exist something like a homogeneous Bulgarian community in Ghent. [...] There are more like groups of students, working people, Bulgarian minorities... There are Bulgarians from different ethnic groups that are represented here as well in the Bulgarian community. We can't classify all Bulgarians under one heading.”
(Anastasiya, female, 30, Bulgarian)

Most Bulgarian respondents who self-identify as Muslim (n=12) and those who have not stated their religion but mention their best friends are Turkish (n=8) can be considered Turkish Bulgarians. All these respondents mention they do not feel connected to the Bulgarian community, or only to their close group of Bulgarian friends and family. Six of these respondents explicitly mention that they avoid contact with the Bulgarian community because it consists of “different groups”, without going into further detail.

“Een Bulgaarse gemeenschap? Ik wil daar niet op antwoorden. [...] Er zijn veel zigeuners. Het is vol met zigeuners. [...] Nee, dit is geen Bulgaarse gemeenschap. Dat wil ik 100 keer zeggen: hier zijn er geen Bulgaren. [...] Ik voel me niet thuis in de Bulgaarse gemeenschap, maar in het huis van mijn broer wel. [...] Ik behoor niet tot de Bulgaarse gemeenschap in Gent, en ik zal nooit behoren. [...] Ik en jou, we behoren tot de Bulgaarse gemeenschap, we kunnen met elkaar praten. Met ‘hen’ kan je niet praten.”
(Pavel, male, 47, Bulgarian)

“A Bulgarian community? I don’t want to answer to that. [...] There are a lot of gypsies. In fact, it’s packed with gypsies. [...] No, this is not a Bulgarian community. I want to say that a hundred times: there are no Bulgarians here. [...] I don’t feel at home in the Bulgarian community, but in my brother’s home I do. [...] I don’t belong to the Bulgarian community in Ghent, nor will I ever. [...] Me and you, we belong to the Bulgarian community, we can talk to each other. With ‘them’, you can’t talk.”
(Pavel, male, 47, Bulgarian)

When comparing these answers to the answers of Bulgarians who identify themselves as Christians and do not mention Turkish friends, it becomes clear why the former group of respondents does not feel part of “the Bulgarian community”. Ten of these respondents explicitly and pejoratively note that Bulgarians in Ghent are Roma or Turkish-Bulgarians, which implies that the ethnic discrimination towards Turkish Bulgarians and Bulgarian Roma (as documented in Bulgaria) persists in the Ghent Bulgarian communities. The fact that at least four Turkish Bulgarians report labour exploitation by Turkish Ghentians seems to confirm that no solidarity exists between Turkish and so-called “ethnic” Bulgarians in Ghent.

“In België is de gemeenschap te gemengd. De minderheid, die in Bulgarije woont met Roma en Turkse origine, is verhuisd naar België. [...] Ik kan mij niet als thuis voelen maar het is aangenaam om mensen te ontmoeten die dezelfde taal praten. [...] De meesten wonen zo goed als mij. Die zijn de normale werkende mensen. De anderen die in een thuis met tien personen samen wonen en wonen met OCMW is hun eigen probleem. [...] Ik zou de Bulgaarse gemeenschap in Gent als ‘gekleurd’ omschrijven. Zo als in Bulgarije, er zijn mensen die zeggen dat ze Bulgaren zijn maar zij zijn minderheid. [...] Ik voel geen verbondenheid met hen en het is beter om mij niet te verbinden. Hoe meer je je verbindt met die gemeenschap hoe meer problemen je hebt.”
(Zdravko, male, 32, Bulgarian)

“The community in Belgium is too diverse. The minority, in Bulgaria people with Roma and Turkish background, has moved to Belgium. [...] I can’t feel at home with them, but it is nice to meet people that speak the same language. [...] Most of them live as good as me. These are the normal working people. The others who live in houses with ten people and live from the Public Centres for Social Welfare, it’s their own problem. [...] I would describe the Bulgarian community in Ghent as ‘coloured’. Similar to in Bulgaria, there are people here that say they are Bulgarian, but they are a minority. [...] I don’t feel any connection with them and it’s better not to. The more you connect to that community, the more troubles you are getting yourself into.”
(Zdravko, male, 32, Bulgarian)

The neighbourhoods mentioned by the participants regarding where in Ghent a lot of Bulgarians live, shop and come together are Dampoort and Sluizeken-Tolhuis-Ham. These two neighbourhoods correspond largely to the places of residence of the respondents.

“Eén van deze buurten is Wondelgemstraat. Waarom? Omdat er daar veel Bulgaars gesproken wordt. Tolhuislaan en Sleepstraat zijn bijna dezelfde. Er zijn veel Bulgaarse (voedings)winkels in Gent.”
(Borislav, male, 21, Bulgarian)

“One of these neighbourhoods is Wondelgemstraat. Why? Because many people there speak Bulgarian. Tolhuislaan and Sleepstraat are about the same. There are many Bulgarian [food] shops in Ghent.”
(Borislav, male, 21, Bulgarian)

The story of Slovakian Roma (n=18) is somewhat different. When these respondents are asked if they believe a Slovakian community exists in Ghent they all respond positively. However, all except one state that they do not feel part of this community. Five of these respondents say that they feel more related to their extended family than to a proper “community”.

“De Slowaakse gemeenschap bestaat, maar ik zou dit niet benoemen als een gemeenschap, ze zijn niet mensen met dezelfde mening. [...] We zijn niet zo een gemeenschap die altijd samen is en samen aan één draad trekken. Het is meestal in familiale kring. Twee of drie families, broers en zussen met ouders. Zij zijn als een kleine gemeenschap.”
(Alena, female, 33, Slovakian)

“The Slovakian community exists, but I would not identify it as a community, they are not people who share the same opinion. [...] We are not a community that is always together and pulls the same rope. It is predominantly about family circles. Two or three families, brothers and sisters with their parents, they are like a small community.”
(Alena, female, 33, Slovakian)

Two Slovakian respondents explicitly mention not wanting contact with Roma who are not from Slovakian origin. Five respondents do not feel part of the community (it is not clear if they mean the Slovakian or Slovakian Roma community) because they respectively do not trust its members (2), prefer to take responsibility for themselves (2), or are stigmatised as a substance user (1).

“Ik voel mij niet goed thuis in de Slowaakse gemeenschap in Gent. Ik vertrouw hen niet meer. [...] De Slowaakse gemeenschap in Gent is moeilijk te omschrijven.”
(Casimir, male, 40, Slovakian)

“I don't feel at home in the Slovakian community in Ghent. I don't trust them anymore. [...] The Slovakian community is hard to describe.”
(Casimir, male, 40, Slovakian)

“Er zijn veel Roma hier, maar zij zijn zoals andere. Zij mij bekijken als iemand die verslaafd is.”
(Jaroslav, male, 29, Slovakian)

“There are a lot of Roma here, but they are like everybody else. They look at me like I'm an addict.”
(Jaroslav, male, 29, Slovakian)

5.2.5 Racism, perceived and structural ethnic discrimination

When we ask participants how they feel Belgians perceive them, whether they are confronted with their migration background or whether they have the feeling that they are discriminated against, we get a variety of answers. It should be noted that racism and discrimination are very complex for Eastern European migrants because they are confronted with various types of racism and discrimination. The type of discrimination that is mentioned most (1/6) is discrimination in the labour market and at work.

“De Belgische mensen hebben niet altijd respect voor de vreemdelingen. Als het om de Bulgaren hier gaat, is een verhaal apart. [...] Ik voel discriminatie vooral als ik op zoek ga naar werk. [...] Ik ben jarenlang op zoek naar werk. Eerst worden de Belgen aangenomen, vervolgens wij.”
(Kristina, female, 18, Bulgarian)

“The Belgian people don't always respect foreigners. And when it concerns Bulgarians, it's even another story. [...] I especially feel discriminated when I'm looking for a job. [...] For years and years I've been looking for a job. First Belgians get hired, only then Bulgarians.”
(Kristina, female, 18, Bulgarian)

Generally speaking, respondents seem to display considerable tolerance towards racism; many mention, for example, that they have been discriminated against or have experienced racism but that these experiences are far worse in their home countries. Slovakian Roma, for example, feel that Belgians discriminate them but that Slovakian non-Roma are far worse.

“Hier is beter. Ik was ook in Slowakije en ik heb veel daar gezien en hier is beter. [...] Hier is ook discriminatie, maar niet zo als daar in Slowakije. Hier is meer culturen en zo dus hier is dat minder. In Slowakije zijn enkel Roma die anders zijn.”
(Nicholai, male, 27, Slovakian)

“Here it’s better. I was in Slovakia as well and I have seen a lot there, and here it’s better. [...] There is discrimination here too, but not like in Slovakia. There are more different cultures here and so there is less discrimination. In Slovakia it’s only the Roma that are different.”
(Nicholai, male, 27, Slovakian)

Turkish Bulgarians in their turn mention that they have been discriminated against by people with a Turkish migration background in Ghent while working for them.

“De meeste grote stress kwam door te werken voor de Turken in Gent. Ze belazeren ons heel vaak en maken misbruik van ons werk.”
(Venteslav, male, 22, Bulgarian)

“The greatest stress came from working for the Turkish people in Ghent. They deceive us all the time and abuse our work.”
(Venteslav, male, 22, Bulgarian)

Then again, Bulgarians who do not have a Turkish background note that they feel discriminated against by Belgians and that the reason for this is the large presence of Turkish Bulgarians and Bulgarian Roma, whom they, as Bulgarians, do not relate to.

“Onlangs had ik een gesprek met een politieagent. [...] Hij legde de nadruk op de volgende. Hij zei “We zijn beu van drie nationaliteiten. Eerst en vooral van de Turken. Als er een schiet- of vechtpartij is er meestal een doodgeval. Sowieso slagen en verwondingen soms dood. Ten tweede, de Bulgaren. We zijn beu van hun diefstal en financiële fiscale fraude. En ten derde, zijn de Noord - Afrikanen. We zijn beu van hun drugshandel.” De politie zei dat ze beu waren van deze drie nationaliteiten.”
(Evangeliya, female, 22, Bulgarian)

“I had recently been talking to a police officer. [...] He emphasised the following. He said, ‘We’ve grown tired of three nationalities. First of all the Turks. If there’s a shooting or a fight, there’s usually deaths involved. Definitely assault and battery and sometimes death. Second, Bulgarians. We are tired of their thefts and financial fiscal fraud. Third, North Africans. We’re tired of their drug traffic.’ The police said they’d grown tired of these three nationalities.”
(Evangeliya, female, 22, Bulgarian)

5.3 Nature of substance use

5.3.1 Prevalence in our sample

As described earlier, our sample consists of two major subgroups – participants of Bulgarian origin and participants of Slovakian origin. Because of the large differences in the reported prevalence and the interviewer bias in our snowball sample (see supra) we will discuss the prevalence of substance use in these groups separately. We should stress that our sample is not representative of Bulgarian and Slovakian individuals residing in Ghent.

5.3.1.1 Bulgarian respondents

The most reported substances in the Bulgarian sample are cannabis (77%), alcohol (58%) and cocaine (32%) (table 9). One-third of all 43 Bulgarian respondents categorise their use as

being problematic, whereas the majority of the respondents (n=30) claim their use is not problematic (table 9). Almost half of all respondents use only one substance, mostly cannabis or alcohol. The other half report the use of two or more substances.

Table 9: Prevalence of substance use in the Bulgarian sample (n=43)

Substance	Total	Non-problem drug use	Male	Female	Problem drug use	Male	Female
Cannabis	33	24	17	7	9	5	4
Alcohol	25	17	11	6	8	6	2
Cocaine	14	12	7	5	2	1	1
Sedative (prescribed) medication	3	2	0	2	1	0	1
Amphetamines	2	0	0	0	2	2	0
Heroin	1	1	0	1	0	0	0
XTC	1	1	1	0	0	0	0
Piko	1	0	0	0	1	1	0
Glue	1	0	0	0	1	1	0

The most frequently reported substance in the Bulgarian sample is **cannabis**. One of the criteria for inclusion in the project was having last year experience of illegal drug use; more than three in four Bulgarian respondents report lifetime use of cannabis, and one in three reports current use of cannabis on a regular basis. One of the respondents uses cannabis as an alternative, “less harmful” substance than heroin. Seventy-three per cent of all cannabis users in the Bulgarian sample do not define their use as being problematic, all of whom are under the age of 35. The other 27%, including respondents of all age categories, recognise that their use is a problem.

“Ik controleer mijn cannabis gebruik voorlopig. Het is dus niet problematisch.”
(Kristina, female, 18, Bulgarian)

“So far I have my cannabis use under control. So it’s not problematic.”
(Kristina, female, 18, Bulgarian)

Table 10: Age and problem substance use in the Bulgarian sample (n=43)

Age range	Non-problem drug use	Problem drug use
18–25	9	2
26–35	16	3
36–45	2	1

46–55	3	5
56+	0	2
Total	30	13

More than half of the Bulgarian respondents use alcohol frequently. Similar to the cannabis users in this sample, one-third of the alcohol users are female and two-thirds are male (table 9). At first sight, there are no big differences between these findings and the use of alcohol in the Belgian population (Drieskens & Gisle, 2015: 48). More than two-thirds of all alcohol users in our sample do not think their use is problematic, and the remaining third do think their use is a problem (table 9). The majority of the respondents that report non-problem use (n=13) are between 18 and 35 years old, and only four are older than 35. Remarkably, six of the eight respondents that describe their alcohol use as being problematic are between 46 and 56, the two remaining individuals are in their thirties.

“Mijn alcohol gebruik kan ik wel als problematisch omschrijven. [...] Ik besepte het voor eerste keer wanneer mijn vrouw mij verlaten had. Mijn vader maakte mij altijd opmerkingen, wanneer hij nog leefde. Ik besef het. Er zijn financiële implicaties van mijn gebruik, zeker.”
(Mikhail, male, 55, Bulgarian)

“I think I can describe my alcohol use as being problematic. [...] I realised it for the first time when my wife left me. My dad always criticised me, when he was still alive. I am aware of it. There are financial implications of my alcohol use, that’s for sure.”
(Mikhail, male, 55, Bulgarian)

Almost half of the Bulgarian participants in our sample have ever used cocaine, and one-third still consumes the product. Some of these people specifically mention the use of cocaine in combination with alcohol. In contrast to the gender division among cannabis and alcohol users in our sample, almost half of the cocaine users are women (table 9). Cocaine use usually takes place in nightlife settings. One of these people uses cocaine as an alternative to XTC. Only two cocaine users think their use is problematic (14% of all cocaine users), and both are in their early forties. The other twelve cocaine users in our sample (86%) see their use as not being problematic, all of them being younger than 35.

“Bijvoorbeeld als we op een trouwfeest zijn of een andere feestje, gaan we achter cocaïne en snuiven we. [...] Ik ben niet verslaafd. Ik neem het niet elke dag. Enkel tijdens feestjes.”
(Evangeliya, female, 22, Bulgarian)

“For example, when we’re at a wedding party or another party we buy some cocaine and sniff it. [...] I’m not addicted. I don’t use it every day. Only at parties.”
(Evangeliya, female, 22, Bulgarian)

Compared to cocaine, the use of ecstasy is less common among Bulgarian participants. One in seven Bulgarian participants used to use XTC but only one consumed it more than three times last year.

“Cocaïne gebruik ik in de weekends als ik uitga. Vooral nemen we deze in de disco. Ik word er vrolijker van, voel me beter en word niet snel zat. Ik krijg ook geen slaap. Ik voel me echt goed.”
(Radoslav, male, 32, Bulgarian)

“Cocaine use during the weekends when I go out. We especially use them in the discotheque. It makes me happier, I feel better and I don’t get drunk often. I don’t get tired either. I truly feel good.”
(Radoslav, male, 32, Bulgarian)

Four Bulgarian respondents referred to heroin as a substance they had consumed in their lifetime. Three of them had ceased this use before arriving in Belgium, and only one of them is a current heroin user. Two Bulgarian participants report current amphetamine use. One in ten participants reports experimental use of piko before emigration from Bulgaria. Piko is a Bulgarian name for a methamphetamine, also known as crystal meth. Only one participant reports current use of Piko. Additionally, three Bulgarian respondents used sedatives (antidepressants and painkillers), two of them on a daily basis.

“Ik neem veel pijnstillers. [...] Mijn psychische toestand was niet zo goed op een bepaald moment ben ik naar een dokter geweest en sinds dan gebruik ik dagelijks en ik kan niet zonder hen. Ik moet die innemen.”
(Vallentina, female, 56, Bulgarian)

“I take a lot of painkillers. [...] At a certain point in the past my mental condition wasn't so healthy and I went to the doctor. Ever since I use painkillers on a daily basis and I can't do without them. I have to take them.”
(Vallentina, female, 56, Bulgarian)

5.3.1.2 Slovakian respondents

The most reported substances in the Slovakian sample are alcohol (74%) and cannabis (21%) (table 11). Fifteen of all 19 Slovakian respondents categorise their use as not being problematic, whereas a minority (n=4) describe their use as problematic. All but two respondents in our sample use only one substance, predominantly alcohol. Only two Slovakian respondents use two substances, in both cases alcohol combined with either cocaine or heroin.

Table 11: Prevalence of substance use in the Slovakian sample (n=19)

Substance	Total	Non-problem drug use	Male		Female		Problem drug use	Male		Female	
Alcohol	14	12	9	3	2	0	2				
Cannabis	4	2	2	0	2	1	1				
Cocaine	1	0	0	0	1	0	1				
Heroin	1	1	1	0	0	0	0				
Sedative (prescribed) medication	1	1	0	1	0	0	0				

Three in four Slovakian respondents report lifetime alcohol use; of these, one in four is female, three in four are male. More than half of these respondents currently use alcohol on a weekly basis. As described earlier, the actual rates may be higher, because some respondents may have omitted to mention its use, whether purposely or not, during the interview with the community researcher. Considering the whole Eastern European sample, including Bulgarian, Slovakian and Czech respondents, most problem alcohol users in our sample are of Slovakian descent. However, 86% of the Slovakian alcohol users in our sample do not think of their use as being problematic, in contrast to two respondents (14%) who do think their use is a problem, both female.

“Mijn alcohol, het is niet goed, niet gezond, maar als ik drink voel ik me beter op mijn gemak. [...] Liever drinken dan veel pillen nemen.”
(Vladislava, female, 51, Slovakian)

“My alcohol use, it’s not good, not healthy, but when I drink I feel better and more at ease. [...] Rather drink than take a lot of pills.”
(Vladislava, female, 51, Slovakian)

Table 12: Age and problem substance use in the Slovakian sample (n=19)

Age range	Non-problem drug use	Problem drug use
18–25	3	0
26–35	7	3
36–45	4	0
46–55	1	1
56+	0	0
Total	15	4

Without attempting to generalise findings, the prevalence of cannabis use in the Slovakian sample of this study is notable. Only one in five Slovakian respondents reports on cannabis use, while almost one in four states that cannabis is used regularly in their community.

“Ik gebruik alleen marihuana. [...] Deze maand heb ik het zo ongeveer drie, vier keer genomen. [...] Al mijn vrienden gebruiken ook marihuana.”
(Wenceslas, male, 45, Slovakian)

“I only use marihuana. [...] This month I used it about three or four times. [...] All of my friends use marihuana as well.”
(Wenceslas, male, 45, Slovakian)

Only three respondents report the use of a substance other than alcohol and cannabis. One person uses both alcohol and heroin on a regular basis, one combines alcohol and cocaine, and one uses sedatives. Finally, none of the Slovakian respondents reported using XTC and amphetamines.

5.3.2 Use in the communities

When we ask participants if substance use is common in people of Bulgarian/Slovakian origin living in Ghent, a large majority of the respondents answer in the affirmative. Many respondents state that “everyone uses substances”. Of course, because we only spoke to individuals who themselves use these substances this perception might be distorted.

However, all Bulgarian respondents state very openly that the use of cannabis, cocaine and alcohol is common in their own circles and generalisable for Bulgarians living in Ghent.

“Bijna iedereen die hier woont in de Bulgaarse gemeenschap in Gent gebruikt drugs, volgens mij. Iedereen die niet in zijn eigen land woont gebruikt drugs.”
(Zdravko, male, 32, Bulgarian)

"I think almost everyone that lives here in the Bulgarian community in Ghent uses drugs. Everyone that doesn't live in their own home country uses drugs."
(Zdravko, male, 32, Bulgarian)

The younger respondents (20–35) note that the use of cocaine at the weekend is well accepted among young people. They perceive using cocaine as being inseparable from going out with friends.

"Cocaïne komt veel voor binnen mijn vriendenkring als we uitgaan. [...] Het is normaal, precies alsof je brood aan het eten bent."
(Kristina, female, 18, Bulgarian)

"The use of cocaine occurs frequently among my friends when we're going out. [...] It's normal, it's like eating bread."
(Kristina, female, 18, Bulgarian)

Older respondents, in their turn, note that alcohol is well accepted and new drugs such as cocaine are used more by the younger generation.

"Hmm... Voor mijn vrienden is dat normaal want iedereen gebruikt alcohol. [...] Sommige gebruiken uit verveling, andere door verslaving gelijk mij. [...] Alcohol is normaal in Bulgaarse gemeenschap."
(Miroslav, male, 54, Bulgarian)

"Hmm... My friends think it's normal, because everyone drinks alcohol. [...] Some drink because they are bored, others because they are addicted. [...] Alcohol is normal in the Bulgarian community."
(Miroslav, male, 54, Bulgarian)

"Ongeveer 70% heeft ooit iets uitgeprobeerd. Vooral de jongeren nemen veel middelen. [...] De jongeren nemen vaak cannabis. XTC wordt minder genomen. Cocaïne en alcohol zijn ook frequent terug te vinden."
(Viktoriya, female, 38, Bulgarian)

"About 70% has ever tried something. Especially youngsters take a lot of drugs. [...] The youngsters often use cannabis. XTC is being used less though. Cocaine and alcohol are also to be found frequently."
(Viktoriya, female, 38, Bulgarian)

All the Slovakian respondents say that alcohol use is common in their close circles and community. In this group some participants are also worried about the use of other drugs, such as cocaine, by the younger generations.

"Mijn drinken is niet een probleem. [...] Mijn vrienden drinken ook, en als we samen komen doen we het opnieuw. [...] Dat is niet een probleem, we amuseren allemaal samen. [...] Drinken is normaal in Slovaakse gemeenschap, maar laatste tijd zie ik dat er meer en meer ander drugs in mode komt."
(Andrej, male, 29, Slovakian)

"My drinking is not a problem. [...] My friends drink alcohol as well, and when we come together we always do it again. [...] It's not a problem, we are all having fun. [...] Drinking alcohol is normal in the Slovakian community, but lately I can tell that there are more and more other drugs coming up."
(Andrej, male, 29, Slovakian)

5.4 Patterns of substance use

Half of the respondents started using mostly alcohol, cannabis and cocaine before migrating to Belgium. The average age of first time use of these three substances does not differ a lot, respectively 21, 19 and 22 years old.

Over one in three respondents state that they have started using more in Belgium, for diverse reasons, for example the death of a relative, divorce or losing work and financial problems.

“Ik gebruik meer nu dan vroeger. [...] Omdat hij mij verlaten heeft en ik ben alleen met de kinderen.”
(Evelina, female, 34, Slovakian)

“I now use more than I used to. [...] Because he left me and now I am alone with the children.”
(Evelina, female, 34, Slovakian)

Three respondents note that the reasons for their use have changed from recreational motives to relieving stress.

“Vroeger was het cannabis om te amuseren altijd met vrienden erbij. Nu gebruik ik om niet gestresseerd te zijn, rustig te kunnen worden, zich op het gemak voelen.”
(Ladislav, male, 28, Slovakian)

“At first I always used cannabis to have fun with my friends. Now I use it to reduce stress, to calm down, to feel comfortable.”
(Ladislav, male, 28, Slovakian)

The Bulgarian respondents say that cocaine and alcohol are usually used together in nightlife settings (specifically in Bulgarian nightclubs) to keep the energy flowing. In three cases the use of cocaine is also mentioned to have better and longer sex. The commonest reason for using both alcohol and cannabis is to calm down and relax.

“Hele week heb ik stress en dan op het einde van de week wil je vergeten de stress en zo, en dan ga je drinken.”
(Jaroslav, male, 29, Slovakian)

“The whole week long I have stress and then at the end of the week I want to forget the stress and everything and then you start drinking.”
(Jaroslav, male, 29, Slovakian)

5.4.1 Problem drug use

“Mensen die gebruiken gaan niet zeggen ‘het is een probleem’. Alleen mensen die niet gebruiken spreken daarover.”
(Vladimir, male, 31, Bulgarian)

“People that use won’t say ‘it’s a problem’. Only people that don’t use talk about this.”
(Vladimir, male, 31, Bulgarian)

One in five respondents see their use as problematic. This low rate could be due to the judgemental way in which the question was asked by the community researchers. One in four respondents who do not describe their use as problematic do mention that their close family describes their use as problematic, mostly among Slovakian Roma (n=10).

“Ik vind mijn alcohol niet problematisch. [...] Mijn familie, ja, zij zeggen dat, maar ik luistert niet aan hen.”
(Zdenko, male, 35, Slovakian)

“I don’t think my alcohol is problematic. [...] My family, yes, they say that, but I don’t listen to them.”
(Zdenko, male, 35, Slovakian)

Participants with Bulgarian roots more often mention that they would never talk about their use with close family because it is a taboo subject.

“Als mijn ouders dit zouden te weten komen, dan zullen ze kapot van gaan. Ze mogen het niet weten. Mijn broer is ook zo. Hij heeft nooit iets gebruikt. Ik ben de enige en als dat

*uitkomt, zal ik de "zwarte schaap" zijn van het gezin."
(Svetlana, female, 32, Bulgarian)*

*"If my parents found out, they would be devastated. They can't find out. My brother is very much alike. He has never used anything. I'm the only one and if that were revealed, I would be the 'black sheep' of the family."
(Svetlana, female, 32, Bulgarian)*

Some respondents mention that they cannot talk to family members about these things because they live too far away. Consequently they do not receive peer or family feedback on their use. When we ask respondents what their friends think or say about their use one-third of the respondents answer that their use is the same as their friends and consequently is considered normal. Only two of these 21 respondents describe their use as problematic.

*"Ja we drinken graag samen. En zij denken ook niet dat er problematisch is, we denken dat de drugsgebruik slechter is. Harde drugs."
(Alena, female, 33, Bulgarian)*

*"Yes, we like to drink together. They don't think it's problematic either, we think drug use is worse. Hard drugs."
(Alena, female, 33, Bulgarian)*

5.4.2 Reasons for continued use

We asked the respondents why they started using a substance, and why they continue using substance(s). These reasons are the same for some of the respondents, and different for others. Three main reasons for continued substance use can be distinguished: marital problems, financial problems and stress..

*"Je feest en je vergeet over de problemen thuis, de facturen van België, de werkloosheid, de relatiebreuk... Alles in feite."
(Milena, female, 27, Bulgarian)*

*"You party and you forget that you have problems at home, the Belgian bills, unemployment, break-up... Everything really."
(Milena, female, 27, Bulgarian)*

*"In Bulgarije nam ik minder alcohol. Sinds dat ik hier in België ben, drink ik elke avond alcohol. De problemen en stress hier dwingt me om alcohol te nemen."
(Miroslav, male, 54, Bulgarian)*

*"In Bulgaria I used to drink less alcohol. Ever since I arrived in Belgium, I've been drinking alcohol every night. The problems and stress here force me to use alcohol."
(Miroslav, male, 54, Bulgarian)*

5.4.2.1 General well-being

We asked respondents to rate their happiness in life on a scale of 0 to 10, with 0 being "unhappy" with their lives and 10 being "completely happy". Only one in six respondents rate their happiness between 7 and 10. These positive evaluations of their life are mostly defined by being happy in their family, and in two cases by having a good job and having a house in Bulgaria. Almost half of the respondents rate their happiness between 1 and 5. Over one-third of the respondents state that they would be happier with more financial security, by means of a better job. One in four claims that improving their family situation would make them happier, whereas one in eight reports that having a diploma would make them happier. We will elaborate upon these issues below.

5.4.2.2 Financial and work-related problems

“De betalingen overschrijvingen die we krijgen, dat komt zoveel bij mij. Ik zou moeten speciale richting afstuderen om dit alles te kunnen begrijpen.”
(Alena, female, 33, Slovakian)

“The transfer payments we get, I get them really often. I should graduate from a special course to be able to understand all of this.”
(Alena, female, 33, Slovakian)

At least one in ten respondents mention that they use substances because of financial troubles. Some have migrated to Belgium in an attempt to improve their financial situation in Bulgaria. One in six respondents say that they would like to be better paid in their job. Five respondents say that they want a job but are not able to find one. Some state that they might not have migrated to Belgium if they had known they would not be able to find a job. The exploitation of Bulgarian Turks by Turkish employers, and ethnic discrimination among Bulgarian Turks, and Bulgarian and Slovakian Roma in terms of work, housing and social environment is mentioned several times in this context as being the fundamental cause of their financial problems.

“Toen ik de eerste dag hier aankwam werd ik gevraagd een joint te roken of wat te nemen. De meesten zijn er gewend aan. Ofwel gaan ze naar de casino gokken. Dat komt door het hard werk bij de Turken. Deze die de taal niet kennen werken voor de Turken. En daar wordt je uitgeperst als een citroen. Ik heb begrip voor het behoefte naar stimulerende middelen voor die mensen omdat je anders het werk niet aankan.”
(Timotei, male, 27, Bulgarian)

“When I arrived here the first day, I was asked to smoke a joint or to take white [cocaine]. Most are used to it. Or they go to a casino to gamble. This is because of the hard work they do for the Turks. Those who don't know the language, work for the Turks. And there you're squeezed like a lemon. I understand the need for stimulating substances for these people because if you don't, you can't handle all the work.”
(Timotei, male, 27, Bulgarian)

5.4.2.3 Family problems

One in three respondents is positive about their family group because they are happy living with their parents or their partners. However, one in five respondents mentions using substances because of family problems.

“Mijn moeder is gestorven. Met mijn vader heb ik goede relatie. Sinds mijn vrouw weg gegaan was, begon om te drinken. Zij is met een andere persoon weggelopen. [...] Toen ik 24 jaar oud was ben ik begonnen met alcohol. Meer intensieve van mijn 35 jaar. Toen heeft mij mijn vrouw verlaten.”
(Hristo, male, 50, Bulgarian)

“My mother died. I have a good relationship with my dad. Since my wife left me, I started drinking. She ran off with someone else. [...] When I was 24 years old I started drinking alcohol. More intensively from the age of 35. That was when my wife left me.”
(Hristo, male, 50, Bulgarian)

Many respondents have very complex family structures in which several family members live in other countries. One in four respondents mentions that some of their family members live in Bulgaria, Greece, Spain and Canada and that they miss them. It is notable that only Bulgarian respondents mention family members abroad and their consequent loneliness in Ghent. At least seven of the Bulgarian respondents report that they feel lonely in Ghent.

“Ik voel mij wel verwant maar mijn leven is wat verschillend omdat ik alleen ben. En dan is het leven saaier en daarom drink ik om te ontspannen. [...] Iedereen in de Bulgaarse gemeenschap is te zelfstandig en kijkt naar zijn eigen interesse. [...] Ik woon alleen. Ik heb

drie kinderen en ben wel gescheiden. Ik heb geen contacten met mijn ouders, we hebben slechte connectie en ben niet geïnteresseerd in niemand. [...] Alcohol maakt mij gelukkig, ik vind maar alleen een positieve kant aan alcohol drinken omdat ik mijn problemen vergeten.”
(Krasimir, male, 37, Bulgarian)

“I feel connected, but my life is quite different because I am alone. And then life is more boring and I drink to relax. [...] Everyone in the Bulgarian community is too independent and looks at his own interest only. [...] I live alone. I have three children and I’m divorced. I don’t have any contact with my parents, we have a bad relationship and I’m not interested in anyone. [...] Alcohol makes me happy, I can only find a positive side to alcohol because it makes me forget.”
(Krasimir, male, 37, Bulgarian)

Some Slovakian Roma participants state that divorce is a reason for continued use, but they are usually surrounded by a large family circle they can count on. This network and social support ensures that divorce is not a primary reason for continued use among these participants.

One in three participants is divorced. Five say that they suffer because they do not see their children anymore, usually because the children are in Bulgaria. Eight respondents explain that they started using more after the break-up or divorce from their partner. Three respondents also mention violence in these relationships and one other says they are divorced because of serious addiction problems.

“Ik zou één ding willen veranderen en dat is mijn gezin behouden zodat mijn kinderen een vader hebben.”
(Viktoriya, female, 38, Bulgarian)

“I would like to change one thing and that’s keeping my family so my children can have a father.”
(Viktoriya, female, 38, Bulgarian)

“Wij hadden grote familieproblemen. En ik zou niet zo vroeg trouwen.”
(Vladimir, male, 31, Slovakian)

“We had big family issues. And I wouldn’t marry that young.”
(Vladimir, male, 31, Slovakian)

Another three respondents say the loss of a family member caused an increase in their use.

5.5 Help-seeking behaviour

“De beste vorm is om met iemand te praten zo als we nu met jou (community researcher) praten.”
(Vladislav, male, 50, Bulgarian)

“The best form to talk to somebody is like we’re talking to you now [community researcher].”
(Vladislav, male, 50, Bulgarian)

When we ask participants if they have had any experience with substance abuse treatment or other specific services for their substance use only five answer in the affirmative. Three have contacted, respectively, a general practitioner for problem alcohol use, a psychologist for suicidal thoughts and emergency care for problem use. Two other respondents have attended heroin substitution centres in Bulgaria. Three other participants mention they regularly talk to the priest (1) and a trustworthy person in a mosque (2). Nevertheless, during the interviews, nine participants specifically asked the community researcher for help. In five cases they asked for help in finding a psychologist or psychiatrist. One participant asked for assistance in finding

somebody to trust who can help them get over addiction, one participant asked for help with alcohol addiction, and another asked for help with translation.

At least four respondents mention that language is a large barrier to accessing health care. Another three participants mention that treatment is too expensive for them. The majority of respondents do not know the Dutch language. When asked what the ideal help would be, one in three Bulgarian respondents say psychological help. One in five of all respondents note that, initially, wanting to stop is the key to successful substance abuse treatment. It is worth mentioning that when we ask respondents if they have received any help from their family, all Slovakian Roma who describe their use as problematic answer positively while only a small minority of the Bulgarians answers positively. On the contrary, the Bulgarians mention that ideal help would consist of talking to someone they are not familiar with in any way.

When we ask if participants know something about substance abuse treatment services in Belgium, most answer negatively. The services they say they regularly use are trade unions, health insurance, Public Centres for Social Welfare (OCMW) and, to a lesser degree, schools, municipal neighbourhood centres and a general welfare centre. Such venues could offer opportunities for prevention and information initiatives targeted at Eastern European users.

“En waarom moet iemand van de gemeenschap iets doen, Als er bepaalde organisatie zijn moeten gewoon preventies nemen op tijd de mensen te informeren en zorgen...”
(Petar, male, 28, Bulgarian)

“And why should someone from the community do something? If there are some organisations they should take preventions in time to inform and care for people...”
(Petar, male, 28, Bulgarian)

Both Slovaks and, to a lesser degree, Bulgarians state that co-ethnics do talk about substance use with each other but that no one perceives it as problematic.

“Ja, ze spreken de kinderen aan maar denk jij dat er geluisterd wordt? Het zijn heel slechte reacties van Slovakien. De Belgen zijn in deze zaken anders gemakkelijker.”
(Casimir, male, 40, Slovakian)

“Yes, they’re talking to the children but do you think they’re listening? Slovaks give very bad reactions. Belgians are easier in these cases.”
(Casimir, male, 40, Slovakian)

Contrarily, mostly Bulgarian respondents also note that drug addiction is a taboo subject and that co-ethnics will not necessarily help each other in cases of problem use.

“In principe ontwijk ik Dampoort want daar wonen veel mensen uit mijn streek in Bulgarije. Daar ga ik nooit naartoe. Waarom? Ik gebruik wiet en ze roddelen vaak over mij dat ik een verslaafde ben en zo voort... Zelf informeren ze mijn kennissen van Bulgarije dat ik wiet gebruik. Ik word vaak gebeld en geconfronteerd of dat echt zo is.”
(Venteslav, male, 22, Bulgarian)

“Normally I avoid Dampoort because there’s a lot of people from my region in Bulgaria living there. I never go there. Why? I use weed and they often gossip about me that I’m an addict and so on... They even inform my Bulgarian acquaintances that I’m using weed. I’m often called and confronted to see if that’s actually the case.”
(Venteslav, male, 22, Bulgarian)

5.6 Discussion

This exploratory study of substance use in the Bulgarian (n=43) and Slovakian (n=19) communities in Ghent provides us with some insights that can be adopted by care services and practitioners. These will allow them to better reach and approach these groups and

substance users, in the community in particular. In this section we will discuss the most significant findings.

A recent trend in Belgium is the great diversity in the origin of migrants. In the twentieth century the majority of foreigners originated from neighbouring countries or from the Mediterranean Sea area (the borderlands of Europe, Africa and Asia). More recently, great migration flows have occurred from Sub-Saharan Africa, South and East Asia, Latin America and, since the year 2000, from Central and Eastern Europe (ANSAY et al., 2012). By the end of December 2015 there were 8,193 registrations of Bulgarian newcomers in Ghent compared to a total of 12,021 new EU citizens and a total of 256,235 inhabitants. About 68% of the newcomers originate from Bulgaria, and about 3% of the whole population in Ghent is from Bulgarian descent. In Brussels Capital Region there were 9,746 Bulgarian newcomers compared to 1,163,486 inhabitants by the end of 2014 (Hermia, 2015). Hardly 0.8% of the whole population in Brussels Capital Region originates from Bulgaria. The presence of a large and well-integrated group of Turkish migrants in Ghent can be an influencing factor for Bulgarian migrants in their decision to move to Ghent. Slovakian migrants are the second largest group of EU citizens in Ghent, with 1,810 registrations by the end of 2015 (Integriedienst, 2016). The proportions of Bulgarians and Slovaks in Ghent mentioned above are similar to in the current study. In the total sample of 68 participants – of which 62 were transcribed and analysed – over two-thirds are of Bulgarian descent and almost one-third are of Slovakian descent. Different reasons for migration are mentioned, such as the search for economic prosperity, family already residing in Belgium, being discriminated against in their home country, and personal problems such as divorce and problematic substance use.

As to the ethnicity of these groups, the literature points out that most Bulgarians and Slovaks in Ghent belong to minority groups in their country of origin. This is also reflected in our study. Most of the respondents of Bulgarian origin have Turkish roots, one is Roma and a minority are ethnic Bulgarian. Furthermore, all Slovakian respondents are Roma. These groups are mentioned by Bulgarian respondents when they map the different communities in Ghent. They confirm that there are three different Bulgarian communities in Ghent, i.e. Bulgarian Turks, ethnic Bulgarians and Bulgarian Roma. They affiliate to the group that they are part of, and do not feel connected to the other groups in the city. This implies that ethnic discrimination towards Bulgarian Turks and Bulgarian Roma (as documented in Bulgaria) persists in Ghent's Bulgarian communities. As to the Slovakian Roma in the study, they confirm the existence of a Slovakian community in Ghent, but say that they do not feel part of this community for various reasons.

Somewhat related to this issue is the reported perceived and structural ethnic discrimination. The Eastern European migrants in this sample are confronted with multiple discrimination. They report being unlawfully discriminated on multiple grounds, i.e. because of more than one characteristic such as age, sex, religion or race, both in their home country and in their host country. Nevertheless, they show a high level of tolerance towards racism from native Belgian people in Ghent, because they say that the racism experienced in their home country or between the different communities in the host country (i.e. the ethnic Bulgarian community, the Bulgarian Turk community and the Bulgarian Roma community) as being far worse than the racism they experience from Belgian people. Eastern European migrants are repeatedly confronted with this multiple discrimination in various areas in their lives, such as in the labour market, when searching for housing and in their daily social life and neighbourhood. Hearing or reading their names or deficient language skills often is sufficient for an employer to refuse to hire them or a house owner to refuse to rent them a place to live. The Eastern European respondents in this study are associated with a certain stereotype. They say that they are associated with crime and abuse, poverty, laziness, living on social aid and incompetence (Bakalova & Tair, 2014). An important question and challenge for all parties involved (i.e. the respective communities, social workers, health services, policy-makers, etc.) is how we can

remove the stigma and stereotypes that Bulgarian and Slovakian communities are confronted with.

Very few of the respondents (only three) feel Belgian, whereas the majority feel Bulgarian or Slovakian Roma and are proud to be so. However, one in eight wants to feel Belgian, but fails to do so due to problems related to language, work, the period residing in Belgium or due to not being born in Belgium.

Bulgarians in this study most frequently use cannabis, followed by alcohol and cocaine. Slovakian respondents report a high use of alcohol, whereas cannabis and cocaine are rarely seen, according to the respondents. The most problematic alcohol users are of Slovakian descent. It is notable that the majority of the respondents state that their use is not problematic from their perspective, but that their friends and/or family define it as problem use.

Very few respondents in the study have experience with help or treatment for their addiction problem or have been looking for help in the past. They state that the ideal help for addiction is psychological rather than medical or physical help. They look at addiction as a mental issue and are convinced that talking to a psychologist will help. However, none of the participants who describe their use as problematic has ever looked for or received psychological help for their addiction. The main reasons are the language barrier or financial issues. These reasons are common in comparable research.

Participants mention three services as sources of guidance or help, not necessarily related to addiction. First, they mention general practitioners in local district health centres. A general practitioner is an easy accessible point of contact for the Bulgarian and Slovakian communities, and they access them either for themselves or for their children. This channel could be further developed to work around alcohol and drug prevention and treatment. It is important to inform and raise awareness among general practitioners about their key role in the lives of people from Bulgarian or Slovakian descent in Ghent. General practitioners should also be informed about the alcohol and drug treatment field in general, and available prevention activities and institutions. They should be aware of the signs of alcohol and drug addiction and what to do when they notice a problematic situation.

This could be done by organising a seminar where the key findings of this and other similar studies are presented, along with an overview of the alcohol and drug treatment field in Ghent and the surrounding area, and information on recognising problem substance use and people or situations at risk. Allowing for debate and an exchange of experiences will enhance a better understanding of the topic, make it a mutual point of interest and create a support platform among general practitioners. An information leaflet containing the same information as the seminar and useful web links and addresses could be disseminated both digitally and by post.

The second institution that participants mention is the Public Centre for Social Welfare. People of Bulgarian and Slovakian descent in this study often experience difficulties finding housing and earning enough money. In an attempt to overcome their problems they repeatedly consult the Public Centre for Social Welfare. We have to seize this opportunity to reach the target group and offer help, guidance or assistance concerning drug-related issues. A movement towards an umbrella approach and collaboration between institutions with a rather different focus, content-wise, would provide a possible response to the issues raised by this study. The more that employees of the Public Centre for Social Welfare are up to date on and sensitive to substance use in the Bulgarian and Slovakian communities, the higher the chance (problem) substance use in these communities will be identified and people will be guided and assisted, not only with their primary request for help (e.g. housing or financial issues) but also with their substance use, which is often a problem that people conceal behind other issues. In Ghent the Public Service for Social Welfare is working on closer collaboration with the NPO Eclips, a mental health centre. They are exchanging expertise on a regular basis, for example between Eclips' prevention team for alcohol and drugs and the Public Centre for Social Welfare' social

workers. Furthermore, Eclips organises seminars and training for employees of the Public Centre for Social Welfare on alcohol and drug prevention.

The third source of help that the Bulgarian and Slovakian community participants mentioned a number of times is trade unions. Many Bulgarians and Slovaks are members of a trade union. Some trade unions already provide information leaflets about drugs at work, but this could be expanded to provide broader support that doesn't only focus on drugs at work, and they could offer more appropriate guidance for these particular target groups.

The respondents say they know these three channels offer help with a very specific related issue (i.e. health, work, housing), but they know of few or no institutions they can approach about an addiction problem. Help from someone they trust in the community itself might help to meet this lack of knowledge and encourage them to take a step towards asking for help. In Bulgaria organisations currently try to create change by working with health mediators from the Roma community. In Ghent, social workers from the Public Employment Service (VDAB) work with two individuals who liaise (i.e. create a bridge) with the Bulgarian and Slovakian communities in Ghent. They are of Bulgarian and Slovakian descent and live in the communities. They have an office in the Public Employment Service building, which makes it easier for the communities to reach out to the Service. The liaison persons have stated that they are overwhelmed with work and their help is much requested and needed. This is an initiative that can only be applauded, and ideally should be expanded not only to job-related institutions, but also to other services (e.g. addiction treatment services). The liaison persons are eliminating the language barrier, one of the most important issues for Bulgarian and Slovakian migrants. For written support, information or services such as brochures and web pages, the language and illiteracy barrier can be obviated by translating the text and by working predominantly with images.

When visiting Člověk v tísni (personal communication, 1 December 2015) in Usti nad Labem near Prague (Czech Republic) during field research, a non-governmental, non-profit organisation based on the ideas of humanism, freedom, equality and solidarity, social workers state that Roma apply a survival strategy. This means that they remain at a certain level and seem to make little or no effort to make their life better. Prevention and self-care is not a priority for them. They live in the here and now and do not consider the future. Throughout the interviews in this study sample, a similar mindset appears. The respondents prioritise work and housing rather than health and healthy habits. The fact that only a minority of the respondents identify their use as being problematic is part of this attitude. We have to work towards a greater awareness of health and prevention in general, and problem substance use in particular, among the Bulgarian and Slovakian communities. This demands an integrative and inclusive approach by general practitioners, work and housing services, persons of trust, and many others, and requires long-term effort.

The last notable conclusion is the feeling of loneliness and isolation the participants in this study sample report on. Literature (Verhaeghe et al., 2012) supports this finding and states that Bulgarians and Slovaks live in what is effectively a closed ethnic enclave in Ghent. They are quite isolated and dependent on similar networks (e.g. the Turkish community). The respondents say they have little or no contact with the citizens of Ghent, although many of them state they have a good relationship and understanding with their close neighbours. Related to this issue is the lack of leisure activities. There are hardly any leisure activities in Ghent that reach out to and bring together Bulgarian and Slovakian people (whether addicted or not) with other citizens of Ghent. This can possibly be explained by the scarcity of community organisations and the fact that existing socio-cultural organisations do not reach the majority of the Bulgarian and Slovakian communities. Street-based social workers and neighbourhood workers have an important role to play in this regard. For example, activities that are organised in the neighbourhood must be open to people from those communities, and a street-based social worker with Bulgarian and Slovakian roots should be employed to reach out to the communities.

DRAFT

6 ASYLUM APPLICANTS, REFUGEES AND UNDOCUMENTED MIGRANTS

We will now take a closer look at the characteristics of the group of asylum applicants, refugees and undocumented migrants. We ground our description both in literature and in the description of the participants of this case study.

6.1 Introduction

6.1.1 Definitions

Many definitions exist to describe refugees, asylum applicants and undocumented migrants (Keygnaert et al., 2014). Moreover, definitions change over time and differ from country to country.

Refugee	Based on the 1951 Geneva Convention, ²¹ a refugee is a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him- or herself of the protection of that country, or to return there, for fear of persecution.
Asylum applicant	<p>Based on the 1951 Geneva Convention, an asylum applicant is someone who is seeking international protection. In countries with individualised refugee status determination procedures, an asylum applicant is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum applicant will ultimately be recognised as a refugee, but every refugee was initially an asylum applicant.</p> <p>All foreigners arriving in Belgium are entitled to apply for asylum and ask for the protection of the Belgian authorities. This application is called the asylum procedure. The Belgian Government looks at whether the foreigner meets the criteria defined by the 1951 Geneva Convention relating to the status of refugees.²²</p>
Undocumented migrant	Undocumented migrants are individuals without a residence permit authorising them to regularly stay in their country of destination. They may have been unsuccessful in the asylum procedure, have overstayed their visa or have entered irregularly. ²³

6.1.2 Specificities

The case study of asylum applicants, refugees and undocumented migrants is different from the other three case studies mentioned in this report (Turkish, Eastern European and Congolese communities), because of the selection by (legal) residence status instead of ethnic

²¹ The 1951 Convention Relating to the Status of Refugees, and its 1967 Protocol, UNHCR.

²² <http://fedasil.be/en/content/asylum-belgium>

²³ <http://picum.org/en/our-work/who-are-undocumented-migrants>

background or nationality (as is the case in the other three case studies). Consequently, some of our observations overlap with the other three case studies, because some of our participants share the same ethnic background or nationality with the other case studies.

Refugees, asylum applicants and undocumented migrants differ substantially from migrants and migrant communities that are well established in a host country. The major differences lie in their diversity as a group: different nationalities, languages, ethnic, religious and cultural backgrounds come together in this group (Lutz et al., 2007). This means we cannot speak about a homogeneous group (Burnett et al., 2001), and at least in some aspects (such as language, nationality and residence status) they may be even more heterogeneous than the other three study groups involved in this project.

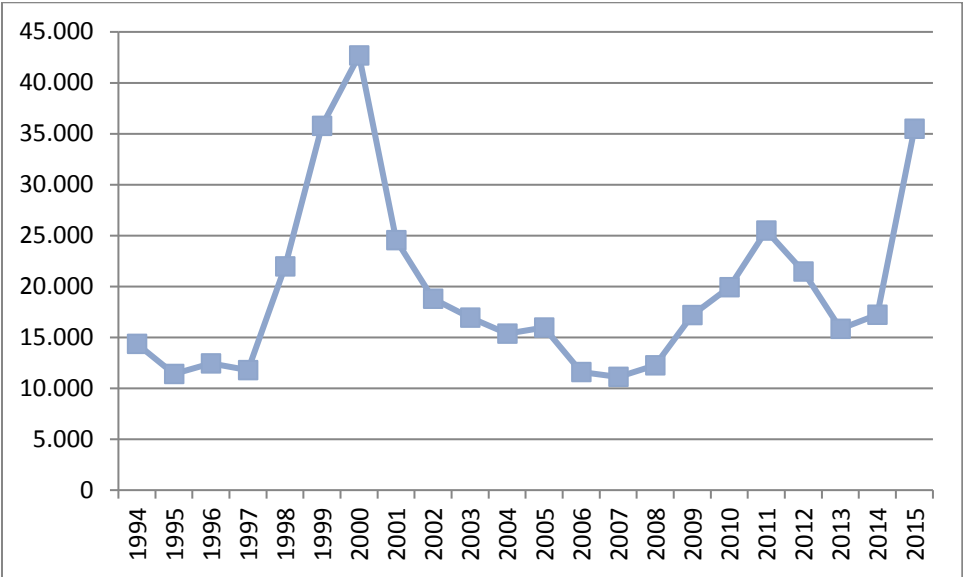
What they do have in common as a group is a wide range of (migration-related) experiences – in their home country or in other countries – that may affect their health and current well-being (Burnett & Peel, 2001). More specifically, their migration histories in combination with traumatic experiences in the home country or during the flight from home to the host country are possible risk factors for substance use (Derluyn et al., 2008; Derluyn et al., 2012; Muys, 2010). Also, little is known about how a status of insecurity and uncertainty about one's future might impact on substance use or abuse.

Another point of similarity is that all respondents have quite recent migration experiences and have not been in Belgium for very long, rendering it more likely that there are still ongoing acculturation and other processes. Further, several participants in this study share particular migration experiences that happened in the home and host country (e.g. time spent in asylum centres, acculturation processes, insecurity about their current and future residence status, constrained living circumstances because of their undocumented status). For many participants, the migration trajectory is not (yet) "history", but an ongoing process.

Because the target group of asylum applicants, refugees and undocumented migrants is so diverse it is particularly important to demarcate the target group. Refugees, asylum applicants and undocumented migrants have in common that they are all still uncertain about their potential future in the host country (Lutz & Schatz, 2007). Specifically for the group of asylum applicants, they are mostly living in collective asylum centres (waiting for the approval of their asylum application) – i.e. as a community of asylum applicants.

Regarding the total number of asylum applications in Belgium, there was a large increase in 2015 (table 13) compared with 2014. The total number of asylum applications doubled from 17,213 in 2014 to 35,476 in 2015. This high number is still lower than the peak of 42,691 asylum applicants in the year 2000. In 2015 a total of 63.1% of all new asylum applicants originated from three particular countries: Iraq, Syria and Afghanistan. However, the diversity of new asylum applicants in Belgium is very wide, because they originate from 135 different countries.

Table 13: Number of asylum applications in Belgium, 1994–2015



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6.2 Socio-demographic characteristics of the participants

It is important to note that the sample of this qualitative study is not representative of all asylum applicants, refugees and undocumented migrants in Belgium. As mentioned in chapter 3, respondents were mainly recruited using respondent-driven sampling, through the community researchers. Selection criteria were restricted to: belonging to the particular community or target group under study; age between 15 and 65; and experience with illegal substances or episodes of excessive drinking. Diversity in the sample in terms of gender, type of residence documents, residence in Belgium, and nationality, was monitored and redirected by the project assistant. In total we interviewed 71 people. Unfortunately, four interviews turned out to be unusable²⁴ for further research, and consequently we included 67 interviews in our analysis.

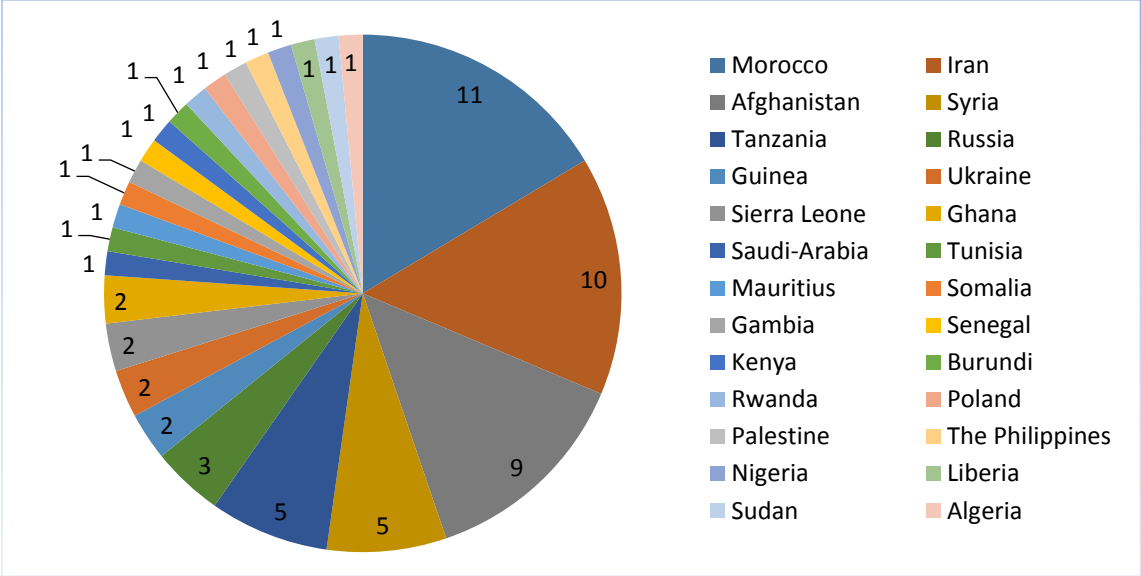
6.2.1 Gender

Regarding the gender of the sample of respondents, 83.6% are men (n=56), and 16.4% are women (n=11).

6.2.2 Country of origin

Almost half of the sample come from three countries: Morocco (16.4%), Iran (14.9%), and Afghanistan (13.4%). This most likely relates to the countries of origin of almost half of the community researchers. The search for respondents through snowball sampling has thus impacted this composition. Besides these three main countries, a wide variety of nationalities are involved (table 14).

Table 14: Countries of origin in the sample of asylum applicants, refugees and undocumented migrants



6.2.3 Type of residence documents

As has been mentioned, three different groups can be distinguished: asylum applicants, refugees, and undocumented migrants. All share the experience of fleeing from their homeland to the host country, often quite recently.

Within the category “refugees” we grouped the respondents with refugee status, and also those with subsidiary protection (although no respondents defined their residence status as such) –

²⁴ For one interview, almost no information was recorded on paper. One respondent did not fall into the category of asylum seeker, refugee or undocumented migrant. Another respondent was interviewed twice by two different community researchers. Finally, one interview was accidentally not recorded, so no transcription could be done.

i.e. individuals with one of the following residence permits: one year, two years, five years or permanent.

In addition to the 30 refugees (44.8%) we also reached 31 undocumented migrants (46.3%). Only a minor part of the respondent group (n=6; 9.0%) was still in the asylum procedure (see table 15 for an overview on the residence status related to participants' nationalities). A potential explanation for the low number of asylum applicants in this case study was given by the community researchers; several researchers explained during intervision moments and individual meetings with the project assistant that it was very hard to convince people who were involved in an ongoing asylum procedure to participate in this sub-study. The following quote can help to explain why so few asylum applicants were willing to participate in this research:

“Ik wil met niemand daarover spreken omdat ik bang ben dat ik daardoor geen verblijfsvergunning krijg en teruggestuurd wordt naar Afghanistan. Daarom wil ik ook niet dat u mijn stem opneemt, anders zou het probleem kunnen zijn voor mijn asielaanvraag. Ik vertrouw in u omdat u zweerde dat dit absoluut anoniem blijft.”

(Afghan, female, asylum applicant, translated from Dari into Dutch, SI3)

As a consequence, some participants (all of whom are asylum applicants), asked us not to audiotape their interview. At the community advisory board meetings it was suggested that the research terminology might have deterred people from participating. For example, the word “interview” could have provoked negative feelings and anxiety among asylum applicants, given that they related this term to the interviews for their asylum application.

Table 15: Type of residence permit by nationality in the sample of asylum applicants, refugees and undocumented migrants

Country of origin	Type of residence permit			TOTAL
	Asylum applicant	Refugee	Undocumented migrant	
Afghanistan	2	5	2	9
Algeria	0	0	1	1
Burundi	0	1	0	1
Philippines	0	1	0	1
Gambia	0	0	1	1
Ghana	0	0	2	2
Guinea	1	1	0	2
Iran	0	8	2	10
Kenya	0	0	1	1
Liberia	0	0	1	1
Morocco	1	0	10	11
Mauritius	0	1	0	1
Nigeria	0	0	1	1
Ukraine	0	2	0	2

Palestine	0	1	0	1
Poland	0	0	1	1
Russia	0	3	0	3
Rwanda	0	1	0	1
Saudi Arabia	0	1	0	1
Senegal	0	0	1	1
Sierra Leone	0	0	2	2
Sudan	0	0	1	1
Somalia	0	1	0	1
Syria	1	4	0	5
Tanzania	1	0	4	5
Tunisia	0	0	1	1
TOTAL	6	30	31	67

Table 15 links the country of origin of the respondent to their residence status. It is noteworthy that almost all of the Moroccan respondents (10 out of 11) are undocumented. Most of the Afghan, Iranian and Syrian respondents have a temporary or permanent residence permit as recognised refugee or under subsidiary protection – respectively five out of nine respondents, eight out of ten respondents, and four out of five respondents.

Furthermore, most respondents with an African background are undocumented migrants (16 out of 23 respondents); four of these are of Tanzanian descent.

To focus on the smallest group of asylum applicants, two participants are of Afghan origin; Syria, Morocco, Tanzania and Guinea are the other countries of origin for the other four asylum applicants. If we compare these nationalities with the official numbers of applicants for asylum by nationality from the CGVS²⁵ (Commissariaat-Generaal voor de Vluchtelingen en de Staatlozen) in Belgium, three of these countries are mentioned in the top ten of applications for asylum in 2015: Afghanistan, Syria and Guinea. Applications for asylum from individuals from Morocco and Tanzania are rather limited in these statistics.

6.2.4 Number of years in Belgium

Almost all respondents have been in Belgium for at least one year. The largest group of 38 respondents (56.7%) has resided in Belgium for over five years or more. A small group of respondents have been in Belgium for less than a year. They are represented both in the group of asylum applicants (n=1) and refugees (n=2). The largest group in the category of respondents who have been here between five and fourteen years are undocumented (n=17). The largest group for the other two categories (1–4 years and 15 years or more in Belgium) are refugees (respectively N=10 and N=6).

Table 16: Number of years in Belgium in the sample of asylum applicants, refugees and undocumented migrants

Time in Belgium			
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²⁵ http://www.cgvs.be/sites/default/files/asielstatistieken_december_2015.pdf

Less than 1 year	3	4.5%
1–4 years	18	26.9%
5–14 years	27	40.3%
15 years or more	11	16.4%
Unknown	8	11.9%
TOTAL	67	100.0%

6.2.5 Religion

The religion that participants adhere to is quite diverse, but Islam predominates. However, a quite large group indicate that they are not religious (table 17). A very diverse picture is sketched by the participants' narratives. Religion does not play any role in the lives of some participants, while others consider it a crucial element in their lives.

“Geloof speelt een belangrijke rol in mijn leven. Ik ben moslim, ga regelmatig naar moskee en bid dagelijks en volg de ramadan. Voor mij is het belangrijk dat ik een lid ben van mijn religieuze gemeenschap”.

(Afghan, male, refugee, translated from Dari into Dutch, SI2)

“All religions mean nothing for me, I do respect people they believe in it and I do respect their beliefs, but for me I found nothing in it persuaded me... honestly.”

(Syrian, female, refugee, translated from Arabic into English, SD1)

Table 17: Religion in the sample of asylum applicants, refugees and undocumented migrants

Religion		
Christianity	9	13.4%
Islam	22	32.8%
Buddhism	1	1.5%
Non-religious	22	32.8%
Unknown	13	19.4%
TOTAL	67	100.0%

6.3 Substance use

6.3.1 Self-reported substance use

Participants were asked about their use of legal as well as illegal substances or medicines. Prevalence rates in our sample can be found in table 18. These numbers include only the self-reported substance use of the respondent. So the actual use is probably higher because respondents may not mention – consciously or unconsciously – the use of certain substances they use or have used in the past.

Moreover, a distinction is made between recently used substances (used by the respondent in the last 30 days) and substances used over their entire lifetime. Concerning the ranking of the most used substances, there is not much difference between substances used recently and those used in their lifetime. Cannabis is the most used substance in this sample, followed by alcohol and cocaine. Heroin use is almost as high as cocaine use.

We also included the use of tobacco in this particular case study. Professionals at the community advisory board who work with refugees, asylum applicants or undocumented migrants had mentioned that people who didn't smoke tobacco before, started to do so in an asylum centre. This was confirmed during our interviews. Furthermore, tobacco is often mentioned as a stepping-stone to other substances.

“I started with normal cigarettes firstly, and then I used hashish and other substances”
(Moroccan, male, undocumented migrant, translated from Arabic into English, SD2)

Nevertheless, tobacco use is probably not reported in all cases because it was not the main focus of this study.

Table 18: Recent and lifetime use of substances in the sample of asylum applicants, refugees and undocumented migrants (n=67)

Self-reported substance use	Recent use (last 30 days)		Lifetime use	
Cannabis²⁶	37	55.2%	49	73.1%
Alcohol	36	53.7%	42	62.7%
Cocaine	14	20.9%	28	41.8%
Heroin	12	17.9%	21	31.3%
Opioids	5	7.5%	8	11.9%
Tobacco (including chewing tobacco)	5	7.5%	9	13.4%
Sedative (prescribed) medication²⁷	4	6.0%	4	6.0%
Methadone²⁸	2	3.0%	4	6.0%
Antidepressants²⁹	2	3.0%	2	3.0%

²⁶ Including marihuana and/or hashish

²⁷ Including benzodiazepines (for example diazepam/Valium).

²⁸ Medicine that is used as substitute product for heroin users who are in treatment.

²⁹ For example, Seroquel XR.

Magic mushrooms	1	1.5%	1	1.5%
Antipsychotics³⁰	1	1.5%	1	1.5%
Amphetamines	1	1.5%	1	1.5%
Ecstasy	1	1.5%	4	6.0%
Tramadol	1	1.5%	2	3.0%
Morphine	1	1.5%	1	1.5%
Dimedrol	0	0.0%	1	1.5%
Water pipe	0	0.0%	1	1.5%
Captagon	0	0.0%	1	1.5%
Kosha	0	0.0%	1	1.5%

6.3.2 Problem or non-problem substance use?

“I myself don’t have any problem but some people told me that I have a problem, but I don’t feel that, I don’t bother anyone”.

(Syrian, male, asylum applicant, translated from Arabic into English, ES1)

This quote gives an impression of the meaning of problematic substance use in this study. It is important to note that we applied self-reporting of problem use. So we asked respondents whether they see their own use as problematic, from their point of view, as opposed to the perspective of their family, friends, professionals in substance misuse treatment, or any other person.

The results indicate that almost two-thirds of the respondents (n=43) report problem use (now or in the past), while one-third (n=24) do not see their use as problematic. When studying problem use by the type of residence permit (table 19), there seems to be an (almost) equal division between problem users and non-problem users for the group of asylum applicants and refugees. In the group of undocumented migrants there are a lot more problem users than non-problem users. Looking at the number of years in Belgium (table 19), the largest proportion of problem users can be found in the category of respondents who have been in Belgium for 1–4 years.

Table 19: Problem use by type of residence permit and number of years in Belgium in the sample of asylum applicants, refugees and undocumented migrants.

Type of residence permit		Non-problem use	Problem use	TOTAL
	< 1 year	1	0	1
	1–4 years	0	2	2
	5–14 years	2	1	3
	TOTAL	3	3	6

³⁰ For example, Paraxetine EG.

Refugee	Number of years in Belgium	< 1 year	2	0	2
		1–4 years	3	7	10
		5–14 years	3	4	7
		15 years or more	3	3	6
		Unknown	3	2	5
TOTAL			14	16	30
		1–4 years	0	6	6
		5–14 years	5	12	17
		15 years or more	1	4	5
		Unknown	1	2	3
TOTAL			7	24	31
		< 1 year	3	0	3
		1–4 years	3	15	18
		5–14 years	10	17	27
		15 years or more	4	7	11
		Unknown	4	4	8
TOTAL			24	43	67

6.3.3 Reasons for first use

The community advisory board suggested that when studying the respondents' motivation for using substances it would be important to identify where participants used substances for the first time.

A proportion of the participants in this case study started using substances in their country of origin, and some started to use substances while in the host country of Belgium. Among the latter group were a considerable proportion of the undocumented migrants participating in this study. Some participants started using substances for the first time during their migration journey.

When participants were asked about why they started using drugs, different explanations and personal stories were given. We distinguish between the reasons mentioned by participants who started using substances in their home country, by those who initiated their substance use in Belgium, and by the few participants who started using substances while fleeing from the home to the host country.

In general, social networks, particularly friends, have an important impact on participants starting to use substances. Participants' social networks seem to have a greater impact than

the location of first use. Yet this influence often co-occurs with interviewees' stressful life situations.

6.3.3.1 Country of origin

Most of the participants who started using substances in their country of origin indicate that they started using with friends, in a recreational way, and that this was also prompted by the fact that in particular countries specific substances seem to be easily available.

"I started drinking alcohol early in my life, trying it was related to feeling myself a man no more a boy, I started with soft drinks like beer and Champagne when I was 14, when I was 18 I started to drink other alcoholic kinds. Me and my friends made a competition about drinking much and keep ourselves stable."

(Syrian, male, refugee, translated from Arabic into English, SD6)

Another group of participants explain that they first used substances because of problems in the family context (e.g. the death of a parent, misuse or mistreatment by a partner).

"Ik werd uitgehuwd toen ik 14 jaar was. Ik ben vier keer zwanger geraakt maar elke keer een miskraam als gevolg. Mijn man ging een tweede keer trouwen omdat ik geen kinderen ter wereld kon brengen. Ik werd regelmatig geslagen door mijn man en ook door zijn nieuwe vrouw. Ik heb dagen zonder eten doorgebracht. Ik wou scheiden, maar mijn man stemde daar niet mee in. Uiteindelijk heb ik elders opvang gekregen waar mijn man mij niet kon vinden. Daar ontmoette ik een vrouw die verslaafd was aan alle soorten drugs. Ze werd mijn best vriendin. Spijtig genoeg nam ik haar verslaving over. [...] Toen ik daar in het vrouwenhuis was, had ik veel verdriet en was ik enorm bang van mijn man. Omdat een man in Afghanistan alles kan doen. Ik kon niet slapen, niet concentreren en ook niet nadenken. Mijn vriendin wilde me helpen door mij drugs te geven om me zo in rust te brengen. Door het verdriet en eenzaamheid vond ik hierdoor mijn troost. Toen dacht ik dat ik sowieso vermoord ging worden door mijn man. Ik voelde me goed toen ik onder invloed van drug was."

(Afghan, female, asylum applicant, translated from Dari into Dutch, SI3)

Other participants explain their first use in the context of serious political problems, war and armed conflicts in their country of origin. One respondent says the presence of a dictatorial regime in the country of origin was the reason for drug use.

"Cannabis in Syria rarely existed, I just tried it the first time some months before I left Syria, the hashish and cannabis started just after the Syrian misery started. As I was watching my country destroying, while I can do nothing regarding that... Use them [the drugs] to forget really, the feeling of inability to do something, as I said before, is the worst feeling can be ever. Moreover, you feel helpless towards your country, your community and your history... This homeland that you loved and raised in. The matter that when you use hashish for the first time, there will be no more barrier to hold you back from using it again."

(Syrian female, refugee, translated from Arabic into English, SD1)

A smaller group of participants explain their first use in the context of having no job and no future in their country of origin.

"In Africa, we didn't have a job, we didn't have nothing. So it's like now, we used to meet a lot of friends. The same places, the same houses, the same rooms, we come, sit and talk, we have nothing to do. Somebody come with this, somebody comes with coke, somebody comes with heroin, somebody come with the drinks, somebody comes with the weed. But on the table, all of this to share. We use all to share. So I simply started there. They told me, you have to try this, have you tried this? I said yeah why should I? They convinced me. They said: When you do this, everything is... The time we meet each other, everybody, it's hard to explain, they say 'yesterday I was in a social'... They refused me, this and this, everybody has this story. They say yes, they told me I have to leave (order to leave the territory), they say, try this, and when you try it... You feel okay. You feel happy"

(Tanzanian, male, asylum applicant, no translation, CH1)

6.3.3.2 Host country

First time use in Belgium is also explained by a diverse spectrum of reasons. These elements are often directly related to problems with residence documents. Yet, some respondents with legal residence documents (e.g. with refugee status) experience similar problems to undocumented refugees, such as the lack of a job, a limited social network, no housing, etc. Somehow, their migration background plays an important role in the first use. Yet, in the context of the host country, participants mention different elements occurring at the same time, and closely linked.

First, several participants mention high levels of stress in relation to the negative answers they received on their asylum application and their lack of residence documents.

“I started to smoke, and smoke heroin, then smoke cocaine. For the problems. No papers”.
(Tanzanian, male, undocumented migrant, no translation, DE3)

Some participants point to the hard life in asylum centres. Moreover, the uncertainty caused by the lack of residence documents and the loneliness they face considerably impact their mental state. All these elements contribute to the initiation of their substance use.

“First time I got affected by substances it was in the refugee camp and with Afghans, when I had no documents, centre was a place like a jail [...] On that time when I started, I was very sad, because I had no contact with my family, I had no documents, and my mind was not working properly.”
(Afghan, male, refugee, translated from Pashtu into English, HA9)

Some participants actually start substance use at the moment they receive the negative answer to their asylum procedure:

“[T]hey take my paper after six years that I was here. I was working before, I didn't use drugs. They took my paper and I was getting crazy that someone came to me and gave me something. I was getting crazy.”
(Iranian, male, undocumented migrant, no translation, DE8)

Friends also have a large impact on substance use. Several participants mention that their overall lack of activities, in particular the lack of a job, in combination with strong feelings of loneliness, painful memories about past experiences, and a lack of any future perspective induce huge stress and pain; these feelings are then often alleviated by the substances they are using.

“Sinds ik hier in Gent woon, kwam ik in aanraking met deze middelen omdat ik mijn tijd wou vullen. Door mijn eenzaamheid, zonder werk en geen positieve toekomst, geraak ik zwaar onder druk. Door het gebruik van deze middel verlicht het gevoel van de pijn. Stel je eens voor dat ik werk heb, dan heb ik geen tijd om na te denken over mijn donkere verleden, over mijn familie. Zo voel ik me minder eenzaam, en geen straatloper. Ik zou ook niet zo veel vrije tijd hebben om samen met mijn vrienden uit te gaan en deze middelen te gebruiken.”
(Afghan, male, refugee, translated from Dari into Dutch, SI2)

A few participants indicate no particular reason for their first substance use. They describe their use as experimental with friends. “Experimenting with friends” is described less frequently when first use happened in the host country, when compared to first use in the country of origin.

“Er is eigenlijk geen speciale oorzaak maar dat was gewoon iedereen doet het en ik wil iets proberen een soort experimenteren in mijn leven.”
(Filipino, male, refugee, no translation, MO3)

Lastly, the availability of drugs in Belgian society is also mentioned.

“Maar jammer, in België overal drug beschikbaar is. Overal kan je gemakkelijk drugs vinden. [...] Als het niet gemakkelijk te vinden was, dan zou je ook minder gebruiken. Als in iedere straat mensen staan drugs te verkopen en de politie doet niets; in zulke omgeving word je gemakkelijk verslaafd.”
(Iranian, male, refugee, translated from Farsi into Dutch, FA2)

6.3.3.3 During the migration journey

A last, small group of respondents mention that they used substances for the first time while travelling to Europe and Belgium. Difficult and dangerous conditions characterise the flight experience of these respondents.

“When I left Afghanistan and I moved to Europe through an illegal way, on the way we have to stay in jungles, water, mountains, and we had worries about our life and worries about our families. So my friends, I was accompanying them on the way, they were using substances, and they told me to feel relax and not to have worries about the dangerous ways we are passing, about your life and family, so use substances, that will forget all your worries that you have. So there I started with my friends to use substances.”

(Afghan, male, refugee, translated from Pashtu into English, HA5)

Some declared they were put in prison in a country on their way to Belgium, where they started to use substances.

“When I got into Greece from Afghanistan, I was in jail, inside jail police gives us cigarette. I spent lots of time there in jail and saw lots of difficulties, that’s why I got affected by using and starting substances.”

(Afghan, male, refugee, translated from Pashtu into English, HA2)

6.3.4 The path to ongoing and problem substance use

The reasons for problem use and those for continued use are similar. However, sometimes the reasons for continued use alter, or additional motives arise.

6.3.4.1 The role of the migration background

The lack of residence documents and uncertainty about the future are the most important reasons why respondents keep using substances over time or start to use substances in a more problematic way.

“I started under the stress situations here in Belgium, still now I am using it, because I do not have documents, when I use hashish or mervana I feel like I have everything in my life (documents, wife, money, house and etc.), and it help me to forget for moments about my situations.”
(Afghan, male, undocumented migrant, translated from Pashtu into English, HA6)

Some participants mention that they started to increase their use of substances because of their undocumented situation:

“Oui, j’ai augmenté ma consommation parce que je n’ai plus les papiers, la solitude. Ma famille (ma mère) me manqué.”
(Moroccan, male, undocumented migrant, translated from Arabic into French, ME6)

This undocumented status results in very difficult living situations, including living on the street, lack of income, lack of job opportunities, poor housing, lack of activities during the day, etc. The stress related to these extremely difficult living conditions is sometimes indicated as the main reason why recreational use became problematic, in an attempt to alleviate this huge emotional burden.

“In het begin gebruikte ik niet elke dag. Het was als plezier toen ik in Iran was. Ik was niet verslaafd, maar hier in België... Stel je voor dat je één dag identiteitskaart heb en de dag daarna illegaal. Als je

in de kou moet buiten blijven, wat doe je dan? Ik gebruikte opium of alcohol, wanneer moest ik buiten slapen. Ook voor plezier om een dag blij te zijn, maar de Belgen hebben hun eigen werk en mag kiezen voor hun gewenste job. Dus ze hebben veel opties voor het leven en hebben geen middelen nodig om ze blij te maken. Ik heb een verdrietig leven, ik gebruik opium om ten minste een paar uren blij te zijn en mijn problemen vergeten”.
(Iran, male, refugee, translated from Farsi into Dutch, FA6)

Some participants say that the difficult living conditions in a transit country where they stayed for a certain period of time led to their problem use of substances.

“Twee jaar geleden werd ik in Griekenland verslaafd aan alcohol. Daar had ik een zeer moeilijke levenssituatie. Ik had geen verblijfsvergunning, geen werk, geen toekomst, geen huis om te wonen. Meestal sliep ik onder de bruggen of op straten. Alcohol was de enige manier om even te kunnen rusten en pijn te kunnen vergeten. Maar wanneer het effect van de alcohol was uitgewerkt, realiseerde ik mij de benarde situaties weer”.
(Afghan, male, refugee, from Dari to Dutch, SI1)

Other participants mention that their living conditions are so difficult that they are thinking about committing suicide. In the following quote the participant suggests that the alienation he feels is no longer bearable.

“I left 1998 and I lived in Spain, then went to Italy; then France until I came to Belgium in 2012. But until now, I didn't find settlement. Maybe I'll go to Sweden or Norway or any country that I can find myself; or I'll take more doses of heroin and end my life, wallah [swearing], I get tired from this alienation. I love my homeland, but what to do back there with all the suffering and the hard living.”
(Moroccan, male, undocumented migrant, translated from Arabic into English, ES5)

Respondents with a (temporary or definitive) residence status also mention difficult living circumstances as a reason to increase their use of substances, in particular the lack of a (proper) job and related income, a lack of things to do and too much “free time”, and the overall loneliness they are facing.

“I increase when I got to refugees centre, and I increase a lot when I got documents, I look for work for more than a year, and I could not find, even when I find, it is not permanent, it is work for one week, one month or two months, I do not know why I do not get job.”
(Somali, male, refugee, no translation, HA10)

Some participants also mention difficult experiences and emotional problems in the past, alongside their current difficult living conditions, which they try to manage by taking substances.

“Ik heb te veel vrije tijd, geen werk, geen andere bezigheden, daarom ging ik regelmatig naar mijn vriendinnen en gebruikten we samen drugs. Mijn zwarte verleden, mijn eenzaamheid en mijn heimwee zijn ook de sterkste redenen dat ik nu de middelen gebruik. Ik voel geen verschil tussen vandaag en vroeger in mijn middelgebruik. [...] Eigenlijk heb ik al een paar keer aan mezelf gezegd dat ik het niet meer zal gebruiken, maar als ik telkens in een emotionele put zit, gebruik ik het weer.”
(Afghan, female, asylum applicant, translated from Dari into Dutch, SI3)

Most participants mention the impact of their (lack of) social network on their problem use of substances: some mention the negative impact of friends using substances onto their own addiction problems, while others mention that their addiction prevents them from establishing social networks with people from their own nationality or ethnic background or with Belgian people.

“Ik heb minder contact met Afghanen omdat ik er niet zo goede ervaring mee heb, bijvoorbeeld word ik verslaafd door hen”.
(Afghan, male, asylum applicant, translated from Dari to Dutch, SI1)

Some participants indicate that experiences of racism and discrimination, and the related limited social network, the lack of a job and the precarious financial situation, result in an intensification of substance use in the host country:

“Ja, heel weinig gebruikte ik in Iran. Elke weekend of om de twee weekenden. Ik ben gek geworden. Ik ben niet junky. In het Apartheidsregime werden handen en voeten van de mensen vastgebonden, maar hier [in België] word je mond gesloten. Ik was bijna opgenomen geworden in een psychiatrische inrichting door de politie, terwijl ik geen geschiedenis had als een psychopaat. Als je financiële en sociale problemen hebt en je familie voor 15 jaar niet kunnen zien en je wordt overal gediscrimineerd, gemeente, interimkantoor en geen aangifte kan indienen omdat de politie doet dat niet. Dus om al deze problemen te vergeten gebruik ik drugs. [...] Zolang dat ik geen vrijheid heb om te praten, gebruik ik drugs en ik weet dat ik een dag dood gevonden word in een straat”.

(Iranian, male, refugee, translated from Farsi into Dutch, FA6)

Being confronted with these acts of discrimination or racism, and the overall feeling of not belonging to the Belgian society, leads to increased substance use, in an effort to deal with the feelings of disempowerment.

Table 20: The impact of migration background on substance use by non-problem and problem use in the sample of asylum applicants, refugees and undocumented migrants

Whether migration background has impact on substance use	Non-problem use	Problem use	TOTAL
No	9	8	17
Yes	12	27	39
Unknown	3	8	11
TOTAL	24	43	67

While studying problem use among the interviewees it became clear to us that their migration background plays an important role. Their undocumented status, combined with uncertain and difficult living conditions, is a central factor in many cases.

Participants were explicitly asked during the interviews if their migration background had an influence on their substance use. About 58% (n=39) of the interviewees say this is the case (table 20). However, this number is probably an underestimation because not all respondents replied in detail about this topic. Of the 39 participants who claim their migration background plays a role in their substance use, most (69%) indicate their use is problematic (table 20).

Another example is given below about the role of the migration background on (problematic) substance use. This participant visited a doctor because of stress-related problems and insomnia. She felt misunderstood during her consultation, and blames the doctor for her addiction to prescribed sedatives.

“Twee jaar geleden ben ik naar de dokter gestapt. Ik was heel gestresseerd toen en had problemen om in slaap te vallen. Dokter heeft slaappillen voorgeschreven en sindsdien gebruik ik die pillen elke avond. Ik kan nu niet zonder. En dat is nu de probleem. Ik ben nu verslaafd aan die pillen. Dokter wou niet echt luisteren naar mijn verhaal, die keek constant naar zijn horloge en wou echt niet naar mijn slechte Nederlands luisteren. Hij heeft gewoon iets voorgeschreven zonder na te denken, denk ik.”

(Russian, female, refugee, translated from Russian into Dutch, WA3)

6.3.4.2 Other problems related to the use of substances

Although not explicitly asked, many participants mention that problem use of substances creates other problems.

Health problems – often of a serious nature – are frequently mentioned. After health issues, financial problems are most often reported.

“Ik besef dat het gebruik van deze middelen echt problematisch werd omdat ik constant hoest en er moe van liep. Mijn keel en mijn borstkast doen pijn. Fysisch ben ik echt zwak geworden, kan niet snel lopen, niet goed voetballen. Daarnaast heb ik nu slaapstoornissen en het gevoel dat ik te zwak geworden ben op vlak van sexuele activiteiten. Ook het geld dat ik er voor uitgeef.”
(Afghan, male, refugee, translated from Dari into Dutch, SI2)

As indicated when stipulating possible reasons for problem substance use, emotional and mental problems are frequently mentioned:

“It affects a lot my financial situation, it affects now also my health. I feel my body is not strong like before. Before, when I wake up in the morning, after taking the drugs, I feel like sober, but now, when I wake up, all my body hurts, and I feel discomfort. It affects me a lot, I feel the sadness and am always stressed, hating everything, then I wish that God helps me to stop taking these things”.
(Tunisian, male, undocumented migrant, translated from Arabic into English, ES4)

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6.4 The road to professional support

About one-third of the respondents (n=21) have received formal or professional care. Two-thirds of the respondents (n=43) have never received any professional care or support.

It is notable that over half of the self-reported problem users have never received any professional help (n=23). Consequently, less than half of these problem users (n=18) have received professional help or support. Some reasons for this treatment gap are mentioned later in the report (see section 2.3).

Furthermore, within the group of asylum applicants and refugees only one-third of the self-reported problem users found their way to professional support, while in the group of undocumented migrants more than half did so (table 21). However, this result may be affected by the impact of the NPO Free Clinic, which offers professional addiction care to undocumented migrants, or may be caused by having a longer period of residence in Belgium (although their Dutch language abilities may on the contrary have limited their access to care).

Table 21: Experience of formal help, by type of residence permit and problem substance use, in the sample of asylum applicants, refugees and undocumented migrants

Type of residence permit		1.1 Experience of formal help			TOTAL
		No	Yes	Unknown	
	No	3	0		3
	Yes	2	1		3
	TOTAL	5	1		6
	No	14	0	0	14
	Yes	10	5	1	16
	TOTAL	24	5	1	30
	No	3	3	1	7
	Yes	11	12	1	24
	TOTAL	14	15	2	31
	No	20	3	1	24
	Yes	23	18	2	43
	TOTAL	43	21	3	67

6.4.2 Reasons for tackling substance use

Participants mention a variety of reasons for seeking help for their addiction problem or why they should stop using substances. Health and financial problems are already causing participants to seek professional help with their addiction problems, but they also mention some other more specific reasons.

The possibility of being reunited with family members, or a longing for this to occur, is mentioned as a reason to stop using substances.

“Ik doe mijn best om ermee te stoppen voordat mijn vrouw naar België komt. Een Afghaanse vrouw zal nooit een verslaafde aanvaarden als haar echtgenoot. Ook doe ik mijn best een goede voorbeeld te zijn voor mijn toekomstig kind”.
(Afghan, male, refugee, translated from Dari into Dutch, SI1)

The importance of having residence documents, in relation to the familial situation, is also mentioned in this respect:

“If they give me now my paper, I stop with methadone, and I try to organise my life because now I have a child. My child is almost nine years. And I need to think about him and not about myself”.
(Iranian, male, undocumented migrant, no translation, DE7)

One participant narrates how he arrived in Belgium with a serious addiction problem and withdrawal symptoms, and was referred to a heroin substitution centre by a doctor at the asylum centre where he was staying at that time.

Another participant says that a prison sentence helped him to stop using substances.

“I knew, it was a problem to me, when I lost five years from my life in the jail. There, I stopped everything, even the cigarettes. I was jailed three times. The last one was three years and four months. The last one, I felt I was wrong and guilty, and I should not go through this way”.
(Tunisian, male, undocumented migrant, translated from Arabic into English, ES4)

In a few cases the migration experience itself was the start of receiving adequate substance misuse treatment. As this Palestinian refugee explains:

“I’m now far away from what I was. I’m very different from when I first came. I was an addict to drugs, now I have my medicine and always I have it with me, I’ve stopped the drugs to the medicine. In our countries (Arabic countries) there is no treatment from addiction. What I’m taking now as a medicine is prohibited in my country. There [in Palestine], I have to think from where I can get my drugs, how can I buy it, how can I get the money to buy it, then I have to think: how can I deal with it; I was afraid that the authorities may get me in prison, sometimes even the person whom I deal with, is a collaborator with the authorities in this case, I may be get in a deep problem. [...] I’ve a huge change in my life here [in Belgium]. I can find my medicine easily [...]. I was addicted in my country, but here, I started to be treated. I have now a document file in a sanatorium to treat addiction in Ghent. I stayed two months there, then I was transferred to Sint-Niklaas, I’m now following the treatment from the pharmacy”.
(Palestinian, male, refugee, translated from Arabic into English, ES2)

6.4.3 Experience of substance misuse treatment

Most of the respondents who had experienced substance misuse treatment received professional support through a heroin substitution centre, which is an out-patient heroin substitution service. The treatment often consisted of the prescription of medication for the substance user by a general practitioner. However, it was not always clear whether these consultations were executed within the framework of a broader treatment programme or not.

One participant explicitly mentions his satisfaction with the professional support he received during treatment at a heroin substitution centre, but warns of the risk of being addicted to methadone.

“Ik was tevreden [over de professionele ondersteuning]. Gewoon één ding vind ik belangrijk te zeggen en dat is als een verslaafde vraagt om de dosis van de vervangmiddel te verhogen, de dokter doet dat en dat vind ik niet goed, omdat vervangmiddel gebruiken is het ook verslaving. Moet je dat gedurende een korte periode gebruiken en dan afbouwen tot nul mg. Anders word je verslaafd op de vervangmiddel. [...] Ik herinner me dat iedereen naar daar [Medisch Social Opvang Centrum] gingen voor behandeling. Opium was duur en om onze kosten te verminderen gingen we daar vervangmiddel

vragen, maar we wisten niet dat verslaving op methadon is erger dan opium”.
(Iranian, male, refugee, translated from Farsi into Dutch, FA2)

An out-patient mental health centre (CGG) is also mentioned during one of the interviews, as a treatment to stop substance use.

“You see, this card here, you see [shows a card from a local mental health centre]. I go there, because now I stopped to smoke. The things still come in my mind every day. So I go to look for another way. Maybe they can help me”.
(Tanzanian, male, asylum applicant, no translation, CH1)

6.4.4 Barriers to professional substance misuse treatment

Few participants found professional treatment, which highlights the need for further investigation of the barriers to professional substance misuse treatment among these groups. A number of factors are mentioned by the participants, which will be discussed below.

6.4.4.1 Lack of knowledge

A first barrier is that many respondents simply don't know that professional substance misuse treatment exists for them, or they don't know where to go to find it. A possible reason here could be that in their countries of origin there was no such professional support for people with of addiction problems.

“Tot nu toe heb ik nergens om hulp gevraagd want wist niet dat er voorzieningen voor bestaan”.
(Afghan, male, refugee, translated from Dari into Dutch, SI1)

6.4.4.2 Lack of residence documents and ongoing residence procedures

The residence status of participants has already been mentioned as an important reason for participants' problem substance use. It is also a significant barrier to obtaining professional treatment. Several respondents say that they have been denied certain types of treatment because of their undocumented status.

“I know there is help, but if anyone has no residency papers like me, they won't help him, they only help the very bad hopeless conditions, I knew centres like, for example, the drug rehabilitation centre, and if I go there, they won't help me. [...] He was my friend [the one who died] in Brussels, and he was in a very bad condition. He went to the drug rehabilitation centre, they refused to help him, because he didn't have the residency documents, they asked for the card [SIS card] to reduce the cost of treatment, and if I don't have the residency papers, I can't pay the cost of my treatment”
(Tunisian, male, undocumented migrant, translated from Arabic into Dutch, ES4)

One participant even reports how, initially (when he had a temporary residence document), he received professional support, but he was refused further support once his temporary documents had expired.

“When I had documents to stay in Belgium, I received treatment. But now I don't have documents, so I receive nothing, no treatment”.
(Afghan, male, undocumented migrant, translated from Dari into English, HA1)

Also, if an individual is still in an ongoing (asylum) procedure they are very anxious about what would happen if their addiction problems are revealed, and obtaining treatment from relevant services is therefore considered to be too risky.

“Ik wil met niemand daarover spreken omdat ik bang ben dat ik daardoor geen verblijfsvergunning krijg en teruggestuurd word naar Afghanistan. Daarom wil ik ook niet dat u mijn stem opneemt, anders zou het probleem kunnen zijn voor mijn asielaanvraag. Ik vertrouw in u omdat u zweerde dat dit absoluut anoniem blijft”.
(Afghan, female, asylum applicant, translated from Dari into Dutch, SI3)

6.4.4.3 Language problems

Language problems are another obstacle that is mentioned, both for accessing services and during the treatment programme itself.

“The rehabilitation from addiction needs two ways: one is the medical treatment and the other is psychological treatment, and for that, I have to stay in the sanatorium from four to six months, but I can’t talk the language, so how can I get treated without communication?”
(Palestinian, male, refugee, translated from Arabic into English, ES2)

Another participant mentions – in addition to language problems – her feeling of not being heard by her doctor.

“Dokter wou niet echt luisteren naar mijn verhaal, die keek constant naar zijn horloge en wou echt niet naar mijn slechte Nederlands luisteren.”
(Russian, female, refugee, translated from Russian into Dutch, WA3)

6.4.4.4 Lack of trust

Some participants explicitly mention an overall distrust of a certain type of substance misuse treatment. In particular, several substance users with an Iranian background are reluctant to use methadone as a treatment. One participant reports that he would not feel respected if he were treated in this way:

“Ik ken alleen maar een organisatie waar je moet elke dag gaan je mond open doen en ze druppelen iets [methadon] in je mond. Dat vind ik een soort belediging. Een verslaafde is ook een mens en moet gerespecteerd worden. Ik geef niet toe dat ik een verslaafde ben; als ik dat toegeef, dan moet ik zeker daar gaan om iets in mijn mond te druppelen. Ik ga nooit naar zo’n organisaties omdat ze geven je iets om jouw pijn te stoppen, maar je voelt een andere pijn omdat word je niet gerespecteerd.”
(Iranian, male, refugee, translated from Farsi into Dutch, FA6)

Another participant mentions the rumours that are circulating about substance misuse treatment in specific communities. These myths can create huge distrust for this type of treatment.

“Some of them don’t know how to find the way to the help; and some of them afraid to take the medicine [...] They think that they may become a guinea pigs [...] the Arabs afraid from the Belgian that they may use them as an experiment.”
(Saudi-Arabian, male, refugee, translated from Arabic into English, ES3)

6.4.5 Suggestions to improve substance misuse treatment

Although not extensively, some suggestions were made during the interviews to improve the professional care systems for people with addiction problems. Besides tackling the above-mentioned barriers, the following suggestions were made.

First, several participants highlight the importance of mental health support by a psychiatrist or psychologist as a factor in substance misuse treatment. Some of these participants remark that there is a unilateral medical approach to substance misuse problems. For these participants, medical treatment (for example by means of methadone) is not the only approach. A few participants suggest treatment without medicinal support.

“Ze moeten psychische hulp verlenen, omdat verslaving is in je hersen. Verslaving is een gewoonte. [...] Het is een deel van hun leven en alleen een psychjater kan dat doen. Ze hebben speciale methoden die kunnen een verslaafde behandelen, bijvoorbeeld ze moeten iets vervangen in hun

dagelijkse leven.”

(Iranian, male, refugee, translated from Farsi into Dutch, FA3)

Second, participants suggest that it is important that the client remains in control of the help that is provided. However, this is related to the first suggestion. Substance users should be able to decide which kind of treatment they would like for their problem substance use.

Third, the role of the community is mentioned, since this has an impact on possible cultural differences (traditions and habits) of the substance user.

“Our community has tradition and customs which came somehow from the religion, but the right way to deal with these people (who drink a lot) should be by considering him a person who needs help, and the community must help him, you can add that there are no civil organisations to offer education and awareness for such issues. So for these reasons you can say that the way that community do is ok”.

(Syrian, male, refugee, translated from Arabic into English, SD4)

Last, several participants mention the importance of personal motivation when stopping using substances, as stopping gives them a goal in life. They do not see their substance use as the cause of their problems, but rather as a consequence of the problems in their lives. Some of them make this suggestion more concretely by suggesting that finding a job or becoming a student is part of the answer. Few participants indicate other kinds of treatments, such as doing sports.

“I just need the help to have a work, to go to study and to have normal life, these can help me to stop using substances.”

(Afghan, male, refugee, translated from Pashtu into English, HA5)

6.4.6 Experiences with other types of professional support

Some other types of professional support are mentioned in the interviewees' narratives, in particular care from a medical doctor (general practitioner), support in low-threshold well-being services (general welfare centres), support with their overall financial and living situation (Public Centre for Social Welfare), and support with their job chances or career opportunities (Werkwinkel, a division of the Public Employment Service). Also, local organisations that provide free food are mentioned, in particular by undocumented migrants.

“Ik heb me ingeschreven bij alle interimkantoren, werkwinkels enz... Ik woon hier graag, maar het enige dat me echt frustrereert, is mijn werkloosheid. [...] Als ik zonder werk hier en daar in de stad loop voel ik me absoluut niet goed in mijn vel. Ik denk dat iedereen me ziet als een straatloper. Ook voel ik me niet goed bij mijn landgenoten en ben beschaamd dat ik nog altijd geholpen word door OCMW.”

(Afghan, male, refugee, translated from Dari into Dutch, SI2)

6.4.7 Discrimination

Some participants mention the problem of discrimination. They describe it in terms of their experience of being discriminated against, or as a fundamental problem in Belgian society, or as a specific problem that occurs in the context of professional support.

One respondent describes discrimination as a societal problem.

“Wij vluchtelingen zijn geïsoleerd hier in de Belgische gemeenschap en dat is een reden dat we getrokken worden aan drugs. Ze [de Belgen] willen ons niet, ik kan dat zien en voelen, ze zeggen dat soms.”

(Iranian, male, refugee, translated from Farsi into Dutch, FA3)

Others give concrete examples of discrimination during their experiences with professional care organisations or public services.

“In the X municipality, I had no papers that time but I have a permission to stay in Belgium, I used to go there for some documents and the lady who was working there was so nice to me, and she talk to me in French and she has been facilitating all my issues. One day, I had to get a proof of my identity from the municipality to receive some money from outside of Belgium; then that lady asked for my passport, as soon as she saw my Moroccan passport she became another person, even she called the police and she said that I have a fake passport and that I am not Moroccan... all the three or four months before she was normal, I don't know if she thought that I cheated her, no need to tell her that I am Moroccan without a reason for that, and she is dealing with me not with all Moroccans so she has to not treat me as a Moroccan but as any other person.”

(Moroccan, female, asylum applicant, translated from Arabic into English, SD7)

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6.5 Informal support: addiction as a taboo

6.5.1 Support from the family

Informal support for substance use from family members is an exception. Almost all participants explicitly indicate that they do not want their family – mostly still residing in their country of origin – to know about their substance use or addiction problem.

“My parents asked me about my use of drugs, I don’t know how they were informed that I smoke cannabis, but I denied and said it was not true.”

(Rwandan, male, refugee, translated from Kinyarwanda into English, MA2)

Participants are very fearful of being stigmatised or even excluded, although many regret that they cannot be open with their family members.

“Ik ben getrouwd en heb geen kinderen, had ook een goede relatie met mijn familie. Ik doe er alles aan hen van de waarheid over mijn verslaving te onthouden. Als mijn vrouw en mijn familie dat te weten zouden komen, zou dit zeer denigrerende situaties teweeg brengen. Ik word als een straatloper gezien. Niemand heeft respect aan mij. En iedereen lacht mijn familie uit. Het frustreert me natuurlijk enorm. Omdat mijn familie een zeer belangrijke rol speelt in mijn leven”.

(Afghan, male, asylum applicant, translated from Dari into Dutch, SI1)

Furthermore, addiction problems are surrounded with great stigma.

6.5.2 Support from the religious community

As has been mentioned, one-third of the participants claim not to be religious. Over half indicate they are religious. The participants were asked whether religion plays a role in their substance use and in the support they receive for their addiction problems. The topic of substance use from a religious point of view is experienced by respondents in a variety of ways – even if their belief is the same.

Some respondents are totally devoted to their religion and listen carefully to religious advice:

“I go every Friday to the Mosque, and there I hear advice like: Allah (God) may keep our sons from those things, and I heard the Imam advises the families to watch their children not to go in that way, I mean the drugs road, but in the end I think it’s not a religious matter”.

(Tunisian, male respondents, undocumented migrants, translated from Arabic into English, ES4)

Other respondents know the point of view of their religion, but don’t take it into account in their own life:

“Mijn hobby’s zijn koken, samen met vrienden naar muziek luisteren, alcohol drinken, marihuana roken en samen met vrienden uit te gaan. Ondanks dit ook in het Christendom verboden is, toch drink en smoor ik.”

(Afghan male, asylum applicant, translated from Dari into Dutch, SI1)

Some interviewees attribute a (potential) positive role to religion and religious beliefs in their recovery process from addiction problems.

Interviewer: “So you think that the religious community may find solutions for these people?”
Respondent: “Maybe if they go look for these people, they may find solutions for the young Muslims who deal with these substances. Like me myself, I can’t go to them to solve my problems, but if they themselves looked for me or guided and helped me to get back to the right way, maybe I’m not like what I’m now! Every person has his reason, but if they look after him, they may save him and help him”.

(Tunisian, male, undocumented migrant, translated from Arabic into English, ES4)

Yet, others see their problematic substance use as in stark contrast with their religion, which makes it even more difficult for most of them to accept their problems and certainly to talk about it.

"I wish I can get rid of that thing [cocaine], it is not for us [Muslims]. It is prohibited in our religion. I hope that God will lead me to be strict to my religion [...], because I like my religion".
(Tunisian, male, undocumented migrant, translated from Arabic into English, ES4)

For most participants, the contrast between the religious prescriptions about substance use and their own addiction problems makes it impossible for them to talk about this addiction with religious servants or with community members.

Interviewer: "Can you speak with religiously committed persons?"
Respondent: "Honestly, no! I dare not! Not because I fear to speak with them, but I respect the person for not to know about my drugs problems. I go to the Mosque and I follow my prayers".
(Tunisian, male, undocumented migrant, translated from Arabic into English, ES4)

6.5.3 Informal support from friends or peers

In contrast with a lack of openness with familial or religious circles about their addiction problems, most participants do speak about their substance use with friends or fellow substance users.

Some participants even indicate that they talk about their problems with friends or peers (often also substance users) belonging to their own nationality or ethnic community.

"Ik spreek er met me mijn familie niet over. Het is een grote schande voor mijn familie en voor mijn landgenoten. Volgens de Islam is het gebruik van deze middelen sterk verboden. Daarom spreek ik er enkel met mijn vrienden over, met wie ik het samen gebruiken".
(Afghan, male, refugee, translated from Dari into Dutch, SI2)

In some cases they have been encouraged by friends in their social network to look for help and seek for professional support.

"So that time, I say to my friend, 'you know this situation?' He said, 'yes, I know', so 'how can I start to live there?' He said if you go live there, there's this place, the heroin substitution centre, you get the methadone and you get okay this and this'."
(Tanzanian, male, asylum applicant, no translation, CH1)

However, some participants never talk to anyone about their substance misuse problems. For most participants, their social networks are very limited, and mostly they have friends from the same nationality or other non-Belgians.

6.6 Discussion

In this exploratory case study about substance use in people with a migration background we focused on refugees, undocumented migrants and asylum applicants. During our fieldwork we observed this to be a diverse group of people with different nationalities, languages, and ethnic, religious and cultural backgrounds (Lutz & Schatz, 2007). What they share is their (recent) migration background and the problems they face or have faced with residence documents.

Sixty-seven of 71 interviews collected by 11 different community researchers were transcribed and analysed. Some interesting results were found. First, a high rate of male respondents (84%) was reached in this sub-study, which means only 16% female respondents participated in this research. Second, the respondents came from all over the world, but almost half of them originated in one of the three most represented countries (Morocco, Iran and Afghanistan). Third, undocumented migrants and refugees face particularly difficult problems. We did not manage to recruit many asylum applicants to the study.

Regarding the patterns of substance use, alcohol and cannabis were most used among the respondents. This result is similar to the other case studies in this report. In this case study more than 50% of the participants reported recent cannabis or alcohol use. Also, recent use of cocaine and heroin was relatively high in this case study. Approximately 20% of the participants had used one of these substances within the last 30 days. Unlike the other case studies, we also included tobacco use in this part of the research because it was mentioned several times as a stepping-stone to other substances in the context of asylum centres.

Another important result, which emerged during the community advisory board meetings, is that all the substances used are of sedative and narcotic nature (including alcohol). The reason why participants use this kind of substances may be due to an attempt to escape from the reality of their current situation, and to temporarily forget their problems. Dupont et al. (2005) describe the patterns of use as “killing time”, which means that asylum applicants try to counter the psychosocial distress of the asylum-seeking process and related uncertainty about the future, and distress they feel about past trauma, by using alcohol and other drugs.

Participants' migration background is clearly of great importance in their motives for substance use. The (lack of) residence documents plays a particularly important role here – people find the uncertainty about their future very hard to deal with. This uncertainty, sometimes lasting for a long period of time, can cause mental health problems (Matthei, 2007). Moreover, a lack of residence documents also puts them in a very precarious position in their day-to-day life. In the light of the motives for using substances, other difficulties were also mentioned by the participants: the problem of finding a job, having a sufficient income, finding a decent place to live, etc. All these elements, and the fact that they are “new” to the country with few daily activities (they don't have a job and have limited social control due to small or no social networks), mean that for most of the time they have very little to do, and experience high levels of loneliness as a result.

Haker et al. (2010) emphasise that some basic conditions need to be fulfilled for asylum applicants, in particular improving their feelings of security and providing meaningful daily activities, in order to improve their (mental) health. In our research, a professional worker from one of the community organisations that works with undocumented migrants had come to a similar conclusion: in the ideal scenario, basic conditions (food, security, housing, etc.) need to be fulfilled first, before problem substance use can be tackled – which does not mean that treatment cannot work if these basic conditions are not yet fulfilled. Additionally, Haasen et al. (2004) argue that insecurity is very tough to live with, which leads some refugees to use substances as a negative coping strategy as a way of managing huge insecurity and the accompanying stress. Generally, the difficult experiences the participants have been through and the many losses they need to cope with, cause deep emotional suffering, aggravated by

their limited future perspectives, constrained social network, lack of daily activities and precarious living situation.

About two-thirds of the respondents report problematic substance use, while only one-third have ever received professional support. There is very little evidence of participants receiving professional substance misuse treatment, and four major barriers to accessing this kind of treatment were identified.

First, there is a lack of knowledge about existent services. Many respondents have no idea what kind of professional support exists for them. This result corresponds with the findings of other studies about asylum applicants, refugees and/or undocumented migrants (Teunissen et al., 2014; Lutz & Schatz, 2007; Matheï, 2007; Fountain et al., 2004), which conclude that there is a lack of knowledge among this group about the right to access health care and regarding their specific needs. Related to this topic, Haker et al. (2010) concluded that professionals who work with asylum applicants acknowledge there should be a much better information transfer about mental health care facilities.

Second, the lack of residence documents and ongoing residence procedures have a negative impact on the ability of some respondents to access professional support. Some respondents even mention that they have been refused help because they do not have the right residence documents. On paper, people without a residence permit do have some access to health care in Belgium, but only in “urgent” cases. However, there is no statutory definition of what qualifies as “urgent” (Matheï, 2007).

Third, language problems are seen as a barrier for some respondents, which corresponds with findings from earlier studies (Matheï, 2007).

Fourth, there is a lack of trust in professional organisations among some participants. Most examples we heard of concern distrust of methadone treatment. In a broader perspective, there is distrust of the medical approach where the focus is based on a description of medicines, and where there is no space for an approach that focuses on the mental state of an individual. Teunissen et al. (2014) reached similar conclusions about undocumented migrants’ lack of trust in health care, more specifically general practitioners. Burnett and Peel (2001) conclude that time, patience and a welcoming approach can break down many barriers for asylum applicants and refugees. Respondents in this research did not make many suggestions for how to improve substance misuse treatment. Nevertheless, many suggestions and ideas were supplied for stopping substance use.

The topic of substance use and addiction is taboo in this group of refugees, undocumented migrants and asylum applicants. Related to this finding, Teunissen et al. (2014) concluded that there is a taboo towards all kinds of mental health problems among undocumented migrants. Lindert & Schinina (2011) even argued that mental health among refugees and asylum applicants is a neglected area of theory and research. Users in this case study rarely talk about their use with their family or religious people. However, substance use is often discussed among their friends or peers. In some cases friends advise them to find professional support, but this is unusual. Overall, most participants have small social networks and don’t know many people from their host country. In addition, discrimination by Belgian residents was mentioned by a number of respondents. Moreover, individuals become even more isolated if they have no residence documents. The lack of a social network is self-reinforcing because of problematic substance use.

7 SUBSTANCE USE IN THE CONGOLESE COMMUNITY IN BRUSSELS

7.1 Contextual introduction

7.1.1 Migration history

The presence of the Congolese community is the result of different immigration waves, either of individuals or more collective nature. During the Belgian colonisation period, very few Congolese had come to Belgium (Etambala, 1993). Unlike workers from the other Belgian colonial states, Congolese workers were not called on to join Belgian soldiers during the world wars or to work in the mining and metallurgic sectors (Tousignant, 2014). The first significant (but still relatively limited) wave of Congolese migrants arrived after the independence of the Congolese State (Martiniello et al., 2001). During the decolonisation process, mass migration to Belgium was not encouraged, in contrast to the situation in the neighbouring countries of France and the Netherlands (Demart, 2013). In 1970 only 7,827 Sub-Saharan³¹ Africans – of whom 1,409 were students – were counted in Belgium.

By the year 2000 this number had increased to 25,833 (Mazzocchetti et al., 2012). This figure, however, only refers to people not holding Belgian citizenship. Increased immigration was triggered by political troubles and increasing poverty rates, despite – and some would argue because of – the structural adjustment programmes of the World Bank. By 2010 the Sub-Saharan African community in Belgium consisted of about 130,000 people, of which 40% were of Congolese origin (Schoonvaere, 2010). This figure includes migrants with and without Belgian citizenship. Most are first or second generation migrants: either newcomers or children of migrants (Mazzocchetti & Wayens, 2012). The first wave of migration was composed of students and some political opponents to the Mobutist regime (Demart et al., 2013).

Initially, there was no stated economic component to this migration, even if a considerable part of the student population would eventually remain in Belgium due to the deteriorating situation in their home country (Demart et al., 2013). Some Congolese came to Belgium due to their professional mobility, linked to companies they had worked for in Zaire (the name of the country during a large part of the Mobutu regime). The second wave of migration was mostly linked to instability in the region after the decline of the Mobutist regime and the replacement by the Kabila regime in the 1990s. The third wave is mostly explained by the rising poverty of the population in the Congo, civil war, the failing of state structures and the weakness of redistributive policies.

7.1.2 Religion

Religion plays an important role in the life of a lot of Congolese migrants (Maskens, 2013). Three main religious traditions can be distinguished among Congolese migrants in Belgium: the Roman Catholic faith, the protestant faith (*Eglise du Réveil*, closely linked to the Pentecostal movement) and the Kimbanguist faith (Demart et al., 2013). Moreover, regular religious practice is an important characteristic of the Congolese community in Belgium. A minority of the population is Muslim and there are also a few agnostics and atheists.

7.1.3 Discrimination

The Congolese community is one of the most vulnerable groups on the Belgian labour market. Even if they are among the highest skilled migrants (judging by the proportion of people with a university or higher education degree), they have a high level of unemployment. Among other

³¹ The term Sub-Saharan designates a synonym and a euphemism for the racial category “Black” (Martiniello et al., 2013).

things, this suggests that there is a considerable problem of discrimination in hiring processes (Martens et al., 2012). There is also a problem of access for ethnic minority groups to the housing market, as documented in situation tests in the Diversity Barometer Housing (De Witte, 2014), with a high likelihood that Sub-Saharan Africans are particularly affected.

Discrimination levels in daily life are reported to be high and are linked to a pattern of lower levels of identification with Belgian society (Demart, 2013; Garbin et al., 2013; Kagné, 2000; Manço et al., 2013; Mazzocchetti & Wayens, 2012). Despite the comparable levels of discrimination they experience, the Congolese community should not be seen as a homogeneous entity. Indeed, the Congolese community is socially and politically divided and internal distinctions related to migration trajectories are of some significance. During the fieldwork, some people underlined the fact that more recent Congolese migrants were not to be equated to people who have been in Belgium for longer periods of time. In the most outspoken cases, the new migrants are sometimes even considered to be “*racailles*” (“thugs”) by the older migrants. The interviews during the fieldwork clearly show that the respondents, especially young people, stemming from different migration waves emphasise they belong to different social classes and have different socio-economic statuses.

“[I feel] I’m a young man, I will not say a young offender, because it would be terribly wrong, but I am a young black.”
(JD, male, 22)

7.1.4 Relatedness to the general population

The colonial past is very present in the minds of the young people we met, more even than for the older respondents we spoke to. This reflects findings from earlier research (Demart, 2013; Garbin & Godin, 2013; Kagné, 2000; Maleço et al., 2013; Mazzocchetti & Wayens, 2012). They often make reference to the colonial past to underline the fact that the Belgian state exploited Congolese resources and did not sufficiently care for Congolese people. Evaluations of the Belgian state are not always positive, low identification with Belgian society is reported and the Congolese community itself is highly valued. We will come back to this issue in the section on identification.

7.1.5 Spatial distribution

Congolese people are to be found all over Belgium, with a concentration in urban areas and particularly the Brussels Capital Region (Demart, 2013; Schoonvaere, 2010). In 2008, 40 % of the Sub-Saharan people in Belgium lived in Brussels (Schoumaker et al., 2012). The presence of Congolese migrants in Belgium is often associated with the Brussels neighbourhood of Matongé (nicknamed after a neighbourhood in Kinshasa) in the municipality of Ixelles (Demart, 2013). Even if relatively few Congolese people actually live there, the area has become a meeting point and hub for this group in Belgium. The neighbourhood is even a reference point for (non-Belgian) Congolese officials or politicians. Within the Congolese community it is common for people who want to meet someone to go to Matongé. With a high and visible presence of Congolese restaurants, food shops, clothes shops and hairdressers, ethnic entrepreneurialism embodies the “Congolese” character of the neighbourhood.

More recently, the neighbourhood has also become a reference point for other Sub-Saharan African migrants. The importance of Matongé in the daily practice and in the cultural references of the Congolese community – and more generally Sub-Saharan African populations – is not reflected in the residential patterns, as official statistics do not show an overrepresentation compared to other statistical sectors in the Brussels Capital Region. Nevertheless, given the central social role of Matongé for the Congolese community, it makes sense to use it as the starting point when analysing the Congolese community in Belgium (Demart, 2013). Matongé was the starting point of the fieldwork, but we quickly extended our search for respondents,

community researchers and associated partners beyond the precise geographical area. As has been said, Matongé is a symbol, a meeting point for the Congolese community, but not a place where Congolese people live (Bensaid et al., 2015). Moreover, Matongé turned out not to have the same significance for all the Congolese people included in our sample:

“When I arrived, I knew people, but unfortunately it was difficult to find their addresses easily. I started from Matongé to recover old acquaintance from the country.”

(Richard, male, arrived in 1994, 53)

“You know, as Africans, we have an extended family, an African when he sees his brother in our language. The cousin or the nephew does not exist, we are all brothers. I see a lot of African brothers and sometimes Congolese brothers in Matongé. It is an ideal place to meet them and it reminds me sometimes my country.”

(Charles, male, 48)

For some respondents, Matongé is a symbolic place for the older generations of Congolese migrants, as it reminds them of the Congolese way of life in the Congo. But it doesn't have the same meanings for the migrants' descendants.

“We never go to Matongé [laugh]. No, actually, you must also know that there is a difference in the community itself. A very important difference is the generational difference. Parents have a greater desire to be among Congolese because they grew up in the country and they have this kind of nostalgia. They feel the need to go to the activities made by the Congolese for Congolese. They remain in Matongé all day because they have that kind of nostalgia, and this is the place that reminds them most of the country. Now, younger people want a different type of Congolese community”

(Isi, female, 27)

Furthermore, Matongé also seems to be losing some of its attractiveness for Congolese youth, even the recent migrants.

“The community is fairly homogeneous at Matongé. Well there is some diversity but it is really a neighbourhood ghetto. From what I see, there are more people of the older generation who feel strongly about Matongé than people my age. That's uncles and aunties, with a small minority from my age group. And I also want to add that it is often those who come from the Congo, who grew up here, who stay in Matongé. Come on, I feel no ownership, no ties to Matongé.”

(Babassou, female, 25, born in the Congo)

“No, except when I go home, I never stay in my neighbourhood. I spend most of my time in Flagey, because I work in Flagey and the school where I go is not far. [...] I am often in Schaerbeek, because I have many friends who live there, close to Diamond.”

(Danko, male, 21, arrived 2010)

For our study it was an entry point, but we did not restrict our data collection to this particular area.

7.2 The respondent pool

7.2.1 Socio-demographic characteristics

The Congolese sample is composed of 56 people, from 18 to 64 years old. There are 10 women and 46 men. They have different ethnic backgrounds: Baloubas, Mouloubas, Muswahilis, Mukongo, Matete, Kabinda, Murega, etc. Regarding nationality, the sample includes people of Congolese nationality, Belgo-Congolese nationality, and Belgian or other nationalities but with Congolese origins. In the last case they or their parents acquired Belgian nationality, or one of their parents is not Congolese. The heterogeneity in the parents' nationalities is partly a reflection of the colonial period and migrations from north to south and intra-African. These characteristics of the sample show that the nationality doesn't correspond totally with self-identification. It also highlights the heterogeneity of a group that is already perceived as heterogeneous in terms of social diversity, context and period of migration.

All the interviews were done in French. It was difficult to establish a precise picture of socio-demographic characteristics because the community researchers did not always follow the guidelines, and some respondents were reluctant to provide this information. We can say, however, that there is a variety within the sample. Some respondents hold Belgian citizenship or have dual nationality, while others only hold Congolese citizenship. Among those holding only Congolese citizenship, different legal statuses are represented (refugees, asylum applicants and undocumented migrants). Some respondents were born in Belgium, others in the Congo.

Even though respondents were recruited in Brussels – and more particularly in the neighbourhood of Matongé – only one of the interviewees actually lives there. They resided either in Flanders or Wallonia, often in the periphery of Brussels.

Due to the origin of our community researchers and the fact that substance use is a taboo subject, we opted not to strictly enforce geographical limitations to find respondents, as the research design originally prescribed. Moreover, even though the neighbourhood Matongé is a hub for the Congolese community the residential presence of the Congolese community is limited and the neighbourhood functions as a meeting place stretching far beyond the Brussels context. That is the reason why the neighbourhood effect – in a strict sense – is not explored in this case study. Community researchers were asked to look for respondents following a double-stage strategy: first, recruitment in their own social circles and then expanding beyond through snowball sampling.

Despite the constraints on the recruitment of respondents, the sample is useful to better understanding the determinants of substance use in the Congolese community in Belgium. First, it reflects a certain social diversity, even among hard drug users. We reached respondents from popular or middle classes, and also from upper classes.

“My mother is a nursing auxiliary and my father often goes back and forth between the Congo and Belgium... and handles a bit of business in the Congo. [...] My paternal grandfather was a Latin teacher, my father's mother was a housewife. And my maternal grandparents, I did not really know them because they were already dead before I was born so I do not really know their course.”
(Jackson, male, 29)

There is also diversity in the social status of the respondents – students, unemployed people, people in low skilled jobs and also highly skilled workers.

“Since the age of eight, I am in Belgium, in Brussels. I came with my family. Yes I knew people, and I lived in Holland. We decided with my family to come here in Belgium because my wife wanted to continue her education, that’s why we came, and I wanted to work in Belgium, that’s the reason why we came here to Belgium, to Brussels.”
(W3, male, 42)

The periods and contexts of migration are different, the respondents who are not born in the Congo came to Belgium not only for economical or war causes:

“Because at degree level and what schooling was like in the Congo, it was better for me, for what I wanted to do in the future, it was better for me to come here.”
(Danko, male, 21)

Religious practice is also varied in our sample. Some respondents practice regularly, others believe but don’t practice, and others don’t have a faith. We found that religious orientation could sometimes explain the behaviour of the respondent or their relative towards substance use.

“A very big space but it’s pretty abstract. How can I explain this, it occupies an important place in my life, I pray every night, but I never go to church. I have my own religion but it does not dictate my life, I don’t follow a code. I have my own religion that is based on the Catholic religion but on the extreme version. It has a certain place in my life, I know that there is God and that there is stuff going on with him, but I’m not religiously fanatic.”
(Danko, male, 21)

“Being satisfied is not only when you have enough to eat, a place to live and sleep or an access to health care but also the child that I have, I still have to take care of him and plane his future. His future is what? I do not have savings while I am not working. So my life is not... Anyway I’m not satisfied with my life.”
(Mister X, male, 41)

7.2.2 Identification and life experience

7.2.2.1 The Congolese identity

In our sample, the Congolese identity is associated with different characteristics, which often translate into strong social cohesion and an elevated level of social control. There is a social process of differentiation and distinction. The notion of a distinct identity exists in the Congolese population in Belgium. These characteristics are summarised by one participant as follows:

“When you visit a Congolese, you find the way... Food, the ways to talk, to dress all that, it is the same.”
(Charles, male, 48)

We will further examine respondents’ views on these main characteristics in order to better understand the manifestation of the Congolese identity, fully conscious that this is a social construct in a narrative developed in an interview context. It should be noted that some respondents emphasise that these characteristics are not the same for all ethnic groups from the Congo. First of all, some respondents consider food to be an important part of their Congolese identity.

“Yes, I have the Congolese attitude, because I always eat Congolese meals, I eat the Pundu, the madesu the chikwange, but also French fries and pizzas like Belgians. Fortunately, it is not so often. Today I ate pizza at home.”
(Chris, male, 45)

Others emphasise that clothing is an integral part of the Congolese identity. Particular attention is paid to being well dressed, in a “European way”, as well as in traditional Congolese clothes.

“It’s a cliché. Being Congolese is to be well dressed. It is a cliché.”
(Shaks, male, 21)

Also, the particular way of interacting with each other is said to be characteristic because it implies a strong feeling of brotherhood and this is defined as a mark of the Congolese community. Even when two people with Congolese origins do not know each other, they will embark on a conversation:

“I describe, the way in which we live, the way, when we meet, when I see the person I automatically know that it is a Congolese even if he has not already [spoken]... We don’t know each other, but his gestures, his way of speaking, the tone, everything. I know he comes from such a region in a province, and so on, and then the way he greets me or I welcome him, the way we exchange ideas, the way we speak and on.”
(Charles, male, 48)

Furthermore, a number of respondents emphasise that the Congolese identity is a set of values and traditions:

“So being Congolese for me, even though I was not born in the Congo, my parents have given to me some traditions, some cultures, etc. Being Congolese is not forgetting where we come from and knowing our roots.”
(LA, female, 22)

“Being Congolese is [laugh] firstly loving music and the atmosphere that we love it... How to say it... It’s very important, the respect for... not only the generations before but mostly adults. There is a discipline we receive from an early age to become a man... A man with a capital M.”
(Mister H, male, 22)

“Personally, I always feel solidarity towards Congolese people because we have the same origins. I would feel as close to a Belgian if you hurt him. But if I hear something racist, of course I do not like the racist term, I would say if I hear something disgusting about a Congolese, a black man or another community I would feel solidarity with this person of course, I would react because it’s like they are saying it to me.”
(Jackson, male, 29)

Even if the Congo is a vast country, the Congolese identity seems to be stronger than the local and tribal identities:

“My mother comes from Batandu, not far from Kinshasa, near Matadi, and my father is Musi Gombe mu Kongo [Low Congo]. Both are Bakongo, I’m mu Kongo and foremost Congolese.”
(Richard, male, 53)

Not surprisingly, the link with the country of origin is also an important identity-building feature for people of Congolese origin:

*“Being Congolese, in my mind, I belong to a country, I am the son of that country.
That’s a pride”
(Charles, male, 48)*

Furthermore, some respondents take pride in the history of the country of origin as an identity marker, also embracing a pan-African reference:

*“No, no joke, there is also a very strong history. I think immediately of Lumumba, representing the whole of Africa. Not to brag, my country is full of a great wealth of raw materials. There is also very wide cultural diversity because there are more and more cultures, which settle in the Congo – Pakistani, Belgian, Chinese, etc. Also, strength of character. This is a very African feature, in general.”
(Nzema, male, 42)*

Religion, however, clearly does not produce a consensus to define the Congolese identity, given the important religious diversity among the Congolese population in Belgium and, indeed, in the Congo itself. However, there seems to be a reference to an overall Christian identity, surpassing divisions between, for instance, the Roman Catholic Church and Pentecostal Churches, which flourish widely.

*“For me, no, but I still feel that when you’re a Christian Congolese it is like a standard. And when I was there, it was everywhere. Schools, trucks with verses written on them, churches everywhere. So, I feel that it really belongs to the culture.”
(Neko, female, 20)*

Some respondents refer to the history of colonisation to explain why they don’t feel Belgian.

*“No, I mean, Belgium colonised the Congo, it would be ironic to feel Belgian. No, I do not feel Belgian.”
(Danko, male, 21)*

Colonisation is also invoked to explain the generational gap in the Congolese population between those who have experienced and interiorised the colonial way of thinking, and the young generations of Congolese people, through the first and the second generation of migrants who didn’t grow up with the idea that everything was better in Belgium.

*“Here, the Congolese are too much concerned about the appearance, in the bling bling, while there is nothing behind. And it is done to hide this kind of angst. Because it must be said that the Congo was colonised by Belgium, which was at that time a very poor country. It was the Flemish who were there; Flemish in Belgium who were less than nothing, worse than the Walloons now. Workers who arrived there and stirred things up. They made you think that you were nothing, that Belgium was everything and that the Congolese were nothing. So imagine this colonialist mentality that put you down for years and years, which continues. And you arrive in Europe, which you are told is like heaven, you realise that in fact you came all that way for nothing because in fact Europe is not so wonderful. Because in fact you may not succeed in becoming a doctor because you are not the right colour, good financial returns. Because you left thanks to your little family who helped you and say ‘Well it will bring us money’. And you arrive and you see that it’s hard, you become depressed. And a lot of Congolese are depressed, that’s why they hang out in Matongé and they drink beer all day or they stay at the hair salon and don’t do a damn thing. I’m not saying they depend on the Public Centre for Social Welfare, but they have completely lost hope of fighting.”
(Isi, female, 27)*

Having a family in Belgium doesn't stop people from passing on their ethnic identity to their children – the second generation is also considered to be Congolese.

“No, they are Congolese, even children born Congolese, who were born here, who grew up here. When you ask them, they introduce themselves as Congolese, even if they are Belgians, this is normal, Belgium is their country, Congo is the country of their parents.”

(W5, male, 40)

Other respondents, however, clearly state they do not feel entirely Belgian and instead identify as being Congolese:

“I'm not comparing the Belgian mentality and that of my country, but I must say that I don't feel Belgian. I can even say that my score out of 10 for 'feeling Belgian' would be 6/10. Not to mention my origins. I say this without comparing attitudes. But if today I return to my country and was asked the same question, 'How Congolese do you feel?' I would say absolutely 10/10, therefore 100%.”

(Mr X, male, 41)

Discrimination is one of the reasons why respondents do not feel Belgian. Unemployment is also a factor.

“Honestly, no. Domestically, I joined the army here, I did the babysitting service, I worked as a storekeeper and today I find myself unemployed and this is when we do not feel Belgian. In my job research, it happens often because recruiters cannot distinguish the accent but when I am physically present the mood changes, that's where I think some people in Brussels have small minds. [...] Some people look at us in a strange way, they take everybody and put them in the same bag. If a child has stolen, they consider that all Congolese are thieves; if a child sells marijuana, they think that all blacks do, it's the evil that lives with this mixture and without distinction as one is black, one is Congolese and, automatically, it is all bad.”

(Richard, male, 53)

Not all members of the Congolese community stress positive aspects. Indeed, the image of the Congolese identity and community is also quite negative among some of its members. A negative view of the own community also exists among the respondents:

“Well there are 'drunkards', alcoholics then, they have red hair, green, blue. They dress badly, they smoke hemp so, uh... These are things that I don't tolerate. They are now in the process of copying people, movies and things like that. I... They make me ashamed. Being black, it is shame. They are shameful with what they do...

Yes because it is shame for our Congolese children now. Before, there was education, you would never have seen your child walking round like the men, smoking... But now it is fashionable. They must have four or five earrings, piercings, tattoos and all. All that, it annoys me so... I pray that my children don't do that... Thank you.”

(Cécile, female, 50)

“Honestly, a bit messy. A messy community. Like, they do not really know what they want in life, their goals, most of the time. And it is not very united, rather dispersed. [...] I was raised in the Congolese culture. I do not forget where I come from. And most of the time, young people who have grown up here forget where they come from. There are parents, aunts and uncles who still have a sense of

belonging. There are a few who have grown up here who cannot even speak Lingala or do not even know Semolina or Congolese music. I'm really a minority, I live more in the Congolese lifestyle than most of my generation."
(Neko, female, 21)

"We are not united. Here in Ixelles, there was a guy who tried to create a sort of association to allow the Congolese to organise themselves, to be like other foreigners who are here, but unfortunately it did not work, but there is still a Congolese community."
(Richard, male, 53)

Some respondents even claim this negative image of the Congolese community – or even the pan-African community – is a reason to avoid too intense interaction with other people from a Congolese background.

"No, the Congolese community, we are all brothers, but it does not interest me to go into the Congolese community because there are always problems between us, the African brothers. There is jealousy, there is a difference here compared to white. Living as Africans, but we live in Europe. That is why, to avoid it, I cross the street. In a coffee bar or at a party, I avoid it all the time, it always creates problems. This is why I am not interested in being with our brothers all the time."
(Chris, male, 45)

"No, it's totally the opposite of the Congolese lifestyle in general – those who came more recently, they have a different mentality, unlike us who were born here, the mentality is totally different. I do not feel at all like them, I feel completely different, the priorities, the focus, the logic and thinking are completely different."
(Broken Heart, female, 27)

"Since my parents are gone, I hardly spend any time with Congolese people."
(Neko, female, 20)

7.2.2.2 The Congolese identity in daily activities

Almost all respondents maintain contact with the country of origin, even if some have never visited it; many of them still have some family living in the Congo. Developments in communication make it easier to maintain a link with the country of origin, family and friends.

"I am always pleased to receive news of my country, so every day I use the Internet. I'm glad I have always news from my country."
(Mr X, male, 41)

This, however, does not mean that transnational contacts lead to frequent trips, as the financial cost of air travel is a prohibitive barrier (Manço et al., 2013). Contact with the country of origin and with relatives is maintained or re-built thanks to modern communication technologies. Some respondents say they use the Internet to learn about Congolese culture and news.

Interviewer: "Do you often go back to the Congo?"
Respondent: "No, it's mainly because I don't have the financial means. I only went back once, when I was 13. But I feel still I belong to the country. I have a lot of contact with my grandmothers, my aunts and uncles."
(Babassou, male, 25)

Even if people with Congolese origin or citizenship in Belgium have a strong Congolese identity, there is also a feeling of exclusion in the Congolese community, because of the domination of a regional group:

“There is a Congolese community in Belgium. I frequent other communities because I feel rejected by the Congolese community, in particular Kinshasa [native of Kinshasa]. I tend to make ties with other communities and not my own community.”
(Bob, male, 20)

7.2.2.3 Feeling Belgian and Belgian citizenship

As with the Congolese identity, participants in the study did not identify a single Belgian identity. It is defined by the consequences it should produce. For some, there is a big difference between being Belgian and feeling Belgian.

“We are Belgian on paper; being Belgian brings benefits, but it does not change our personality. I remain Congolese except on paper [...] I am Belgian, of Congolese origin. By our skin colour, one feels that one is not totally Belgian and so I feel Congolese [...] I’m not too close to the Congolese community as to feel Congolese one must have spent at least a few years in the Congo and be born there. But when you’re born here, except the language Lingala, if one has experienced anything of the country, it does not feel Congolese. I feel in between.”
(Broken Heart, female, 27)

Belgian society still doesn't consider or include people with Congolese origin among its members. There is a general feeling that leaving a country of origin should only be done to escape a difficult situation – this is the only legitimate reason to accept someone's presence in Belgium.

“When I meet someone they always ask, ‘Did you come here as a refugee?’”
(Gérard, male, 58)

“We will not say there is a difference but the fact of being born here, we see that there is a difference of dialogue between parents and children. Here, for example, I see that he has some education, perhaps indeed the Congolese, but there is still a western side to it. There are ‘taboo’ subjects in the Congo that are not treated the same way as here. That may be the only difference I find between a Congolese born here in Europe and one born in the Congo.”
(Meroe, male, 25)

Participants say that the racism and the discrimination are clearly an obstacle to taking on a Belgian identity.

“In my opinion, being Belgian would mean that we can walk about without being stopped by the police with trivial and ridiculous questions because of my skin colour or the origin of my parents. For example, what surprises me is that I have suffered, I don’t want to victimised myself, but I suffered a reverse racism more or less. Often, racist believes that your parents live in a particular place in these awful conditions. But I have often been told, ‘Oh that’s weird, you don’t have a black accent,’ but this is stupid because anyone from Brussels has an accent, from Marseille has an accent, but we do not say a white person has an accent. What is the meaning of the Belgian guy? So the person says they do not realise it is offensive. But me, personally, I feel Belgian.”
(Jackson, 29 male)

“People who live in Brussels are a bit too pessimistic and a bit racist.”
(Fabio, male, 42)

With regard to identification with Belgium and Belgian society, a number of respondents identify themselves as being Belgo-Congolese, stressing a “hyphenated” (dual) identity, or they identify with the multicultural character of the city-region of Brussels:

“Listen, I feel Belgo-Congolese. I could not say I’m 100% Belgian because I also have another cultural background, it was certainly instilled here but there is a lot of space in my personality. And I do not feel completely Belgian because there are things that a Belgian might say (when I say Belgian I mean Belgian blood or descent) or could afford to do that I do could not. Because I have this Congolese heritage that doesn’t fit, and I have to adapt. I have to adapt both personalities.”
(Isi, female, 27, parent born in Congo)

“I still consider myself to be a Brussels citizen because there is multiculturalism in the city of Brussels. So I don’t really distinguish a ‘Brussels strain’ or a ‘foreign Brussels’. I really consider myself ‘Brussels’ because it is also a cosmopolitan city. I learn a lot from this culture of diversity.”
(Babassu, 25, born in Congo and arrived at 1 year old)

The discourse about the Belgian identity of the respondents is not always coherent, as the following comment shows:

“Yes, I feel Belgian. [...] Being Belgian means being integrated, participating in society and knowing the rights of a Belgian. For me, that’s being Belgian. [...] I speak as a Congolese, I have Congolese friends, I also think as a Congolese, I eat Congolese food. That is why I said I have Congolese blood.”
(W3, male, 42)

Perhaps less surprisingly, identification with Belgium and feeling “Belgian” is highest among people who have obtained Belgian citizenship, even if in this case reference to a typical “Brussels” identity is sometimes apparent. For some people of mixed Sub-Saharan African and European origin, blood ties seem to play an important role in self-identity.

“Well I am Belgian, because my father is Belgian... that is the origin. It is the father who had the child, I have the blood of my father so I am Belgian.”
(Cécile, female, 50)

Interviewer: “Are you very attached to this community?”
Respondent: “No. Finally, it depends. If ever there is something going on in the Congo, I feel really concerned. In the sense that the Congo is still where I come from. So there’s still this little side ‘I belong to that country.’ But not here in Belgium, not at all.”
(Neko, female, 20)

Others feel like a citizen of Brussels (*Bruxellois*); the residential identity is stronger than the Belgian identity.

“Well it’s weird, even though I have lived three-quarters of my life here, I really do not feel Belgian. Because being Belgian, for me, by definition, is to feel Flemish,

Brussels and Walloon both. I just feel Brussels, so I do not feel Belgian.”
(W2, male, student, 28)

For some, even if they have a clear preference for an African identity, being born in Belgium and holding Belgian citizenship leads to a patriotic identification with the country:

“It means belonging to the Belgian homeland. Represent Belgium in an ethnic conflict. Of course, I am African, but I find that I am Belgian, and I am proud to be Belgian.”
(Reyce, male, 23)

When asked about the sub-identity of feeling a Brussels citizen – which is often an important identity marker across groups living in the Brussels Capital Region – a number of respondents are somewhat ambiguous.

“Personally, it depends. I think I don’t have to worry too much because I try to integrate myself and I also work. I believe they have a good opinion about me.”
(Titi, female, 49)

“I think that in Brussels there are many people like me who are not from here, so I think they see me as one of them.”
(LA, female, 22)

“The Brussels residents... Honestly, I never paid attention to what they think of me because since I was in Belgium I first lived in Wallonie in Liège. After that I moved to Brussels. When you have just arrived, you always tend to see people in a different light. But personally I can never judge the Brussels residents about that. I built, I have good relationships with people, even people who do not know me, I can initiate a conversion and it’s fine.”
(Mr X, 41)

The Brussels citizen is sometimes seen differently from his co-nationals.

“I think that the Brussels citizen is someone who is open, compared to a Flemish, compared to a Walloon. Open because of all the multiculturalism that is around, there are many people from different backgrounds, all are Brussels citizens. I meet people from diverse backgrounds, but all meet, recognise we are from Brussels, it is essential for me.”
(W5, male, 40)

Language is often mentioned as an important identity marker, most often referring to a reality of multilingualism. Respondents often emphasise that they live in a multilingual environment and switch routinely between different languages:

“At home we speak our native language, Swahili. Therefore, I speak Swahili with my partner but if we want to address children, we do it either in French or Flemish. With friends? In French, we speak French. But when I’m with my friends from my country, my compatriots, we speak Lingala.”
(Mr X, male, 41)

The migration trajectory and its impact on social status is, for some respondents, more important for identity issues than identification with Belgium or Congo. A number of respondents state that they have experienced status loss and reduced social mobility as a result of migration:

“Well when I was in Congo I was a queen. I didn’t do the cleaning. And now I clean to earn money. But there are people who lack all that, so that’s how it goes.”
(Cécile, female, 50)

“I would say that for me it is difficult because I am unemployed, my wife works, she has small jobs, it is 27 hours per week, which is not enough. At this point, it’s really complicated. When I started working in Belgium, I was independent, I did some lumberjack training, I was cutting wood. I was my own boss and I employed people. I have a problem with budgets. And also, my last child is hyperactive, very active, he must move all the time, and all that made life complicated.”
(Richard, male, 53)

Another respondent highlights some pressure she experienced from her parents in relation to her choice of studies:

“No, there are certain things I would change anyway. I would go back and I would not have studied political sciences. I would have done fashion or anything that is art. Instead, I followed my parents’ wish. Although I managed the course and have excellent grades, I don’t think I chose the right subject for me. Now, I feel more accomplished because I have my internship in England and I think I’ll finish and leave. I will finally be able to do what I like – get in touch with people, fashion, design. In the wonderland – England has always been the country of my dreams.”
(Neko, female, 20)

Taking all this together, it is safe to say that multiple processes of identification and differentiation are present within the Congolese community. As a result, not all Congolese respondents actually feel they are fully part of the Congolese community. Respondents often put strong emphasis on having a Congolese or African identity, and the specificities of the Congolese community are routinely stressed, but this does not necessarily lead to absolute identification. ‘Hyphenated’ identities (Belgo-Congolese) are embraced, but tensions in combining multiple identities are also highlighted. These conflict-prone identification processes are reported by the users of different types of alcohol and drugs among our respondents.

An important conflict-prone element linked to identification processes is articulated in the statement to “behave like Belgian people”.

“As a fake African, literally. [...] Because everyone has always told me I am not Congolese and I am Belgian. Whether members of my family, at school, in Brussels all the time. [...] Basically it’s because I do not fit the typical stereotype and I think that I behave a little more like a Belgian.”
(Neko, female, 20)

A famous expression – “I am a Bounty” – is used by this young respondent to describe this kind of “white” behaviour. It echoes the statement by another (somewhat older) respondent who used to spend time with people from the fashion and night scene, including a number of Belgians.

“As a ‘Bounty’ [black outside, white inside] ... it’s cliché, because it’s sad, because in our community the fact that you’re well educated and do not scream loud, or you’re quieter, down, you speak well. And so I am told that I am a Bounty”
(Babassou, female, 25)

Participants also stress that this process of differentiation between Congolese born in the Congo and those born outside is also at work in the Congo, and not just in Belgium.

“At the beginning, I was tired because it’s weird to hear that. And besides, when I went to the Congo it was the same thing, I was treated as European. At first I took it badly and then finally I said that deep down I was Belgian and that was it.”
(Neko, female, 20)

“Behaving like a Belgian” is, however, not really socially valued in male groups in the Congolese community in Belgium. Indeed, it is considered to be a kind of betrayal or disloyalty to adopt the values of the state that colonised your country of origin.

“It really depends. My story and the history of this country make it difficult for me to say that I feel Belgian, I think. Because I grew up in the Congo, totally, and it is quite unpopular at home... when one arrives here, one claims to belong to the country that colonised us. It’s pretty unpopular. I have been here for three years, I lived for 18 years in the Congo so I do not feel Belgian. But for a Mexican, yes, it could happen. It does not shock me either. I can’t say that I feel Congolese because I have not been there for many years. I feel I am a person of the world.”
(Chaka, male, 27)

Respondent: “In Congo I would say 1 or 0.5 because I had the chance to have financial resources. Congo is a very poor country. And here, we feel the differences of money, so I would say 3–3.5. The difference in social and economical status is less visible here, but they are also sensitive. When you say you were in a Belgian school there and you come to do your studies, there is already a little luxury in their eyes. People who are not from the Congo can’t be, we would notice but we know that it is a luxury.”

Interviewer: “Do you feel close to members of your community in general?”

Respondent: “Here, yes. I would say 3 because, like I said, I do not speak much Lingala, I feel we not have the same ideas sometimes. For example, this can happen in the daily lives of people, music as a whole. At school, for example, we listen to a lot of American rap, in the end it’s really like we’re the small Belgium in Kinshasa.”
(Jess, female, 20)

“I speak French at home and I speak Swahili with the family. But I prefer to speak French because I want my children being integrated.”
(Cécile, female, 50)

Some respondents say they have experienced discrimination and ethnic segregation created by Belgian society. Among our respondents, participation in civil society is often limited to Congolese associations, with associative involvement mostly being directed towards the country of origin:

“This association is mainly to get news of the country. We exchange news from the country almost every month... we intervene when it is necessary, for people who suffer with us.”
(Mr X, male, 41)

Moreover, the Congolese associations don’t give the impression to the Congolese community in Brussels that they are as organised as the other migrant associations. Some of our contacts in the Congolese community observe that there is mistrust even between associations with a Congolese dimension and that there are consequent difficulties in cooperation.

“Yes, we are not united. Here in Ixelles, there was a guy who tried to create a sort of association to allow the Congolese to organise, so we can be like other foreigners who are here, but unfortunately it did not work, but there is still a Congolese community.”
 (Richard, male, 53, arrived in 1994)

The Congolese population is socially diversified and live in deprived conditions or are unemployed. The social difficulties they experience don't promote their well-being and their self-esteem and the positive image of the Congolese population compared with other migrant population.

“I would say I have an average quality of life, I'm not poor, I eat my fill. Are you satisfied? No, I'm not satisfied. When someone depends on the Public Centre for Social Welfare, one is never satisfied.”
 (Broken Heart, female, 27)

“I do not like it that we mess with our own heads, we are colonised by the Belgians, the Flemish. We, the Congolese, we take ourselves for idiots but we are not idiots.”
 (Fire, male, 32)

7.3 Nature and patterns of substance use

The respondents either use one, two or three of the substances targeted in the research design: cannabis, alcohol, cocaine, crack (purified cocaine), heroin, methamphetamine, Xanax. It should be stressed that we expected to encounter some difficulties in working with community researchers to undertake research into this taboo topic, and we were aware that it is difficult to target the Congolese community for research. However, we had not anticipated that the fieldwork would be difficult to the degree it was. We cannot stress enough how challenging the fieldwork has been. A lot of people who were contacted in the framework of the project refused to take part in this research project. Eventually the community researchers did not bother trying to keep track of the number of refusals, focusing instead on (rare) successful contacts.

Self-declared substance use is only an indicator of the main substances used in the Congolese population. These numbers don't provide any information on the frequency of use and the problematic nature of the use. In addition, table 22 doesn't give information on the respondents who use several substances (i.e. alcohol and cannabis, or alcohol and cocaine). Tobacco was initially excluded from the list of substances investigated, but some respondents declared it as main substance used. As a result, the number of people who declared tobacco use is underestimated. Because of the difficulties experienced, both with the work with student community researchers not really interested in CBPR processes and with lack of trust among respondents, data regarding substance use in the past 30 days were not systematically collected, whether because of the community researchers' oversight or due to respondents' failure to answer.

Table 22: Self-reported main substance use in the Congolese sample

Substance	Total
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Alcohol	27
Tobacco	2
Cannabis	21
Heroin	2
Cocaine	4
Crack	1
Xanax	1

There were a number of reasons for the high refusal rates and difficulty with recruiting, including: a fear of being reported to the police or judicial services; a fear of creating a bad image of the Congolese community; and a resistance to – or misunderstanding of – the research categories (“No, I am not a real addict”, “No, I am not a problem user”). In addition, the research topic and the focus on the Congolese community were not always clearly understood. Some respondents don’t recognise themselves in the research category of “substance user”, because they associate this term with people who are addicted to hard drug. They didn’t really understand the mix of the different substances and difference in the frequency of use, and the lack of nuance between recreational and problem use. Even if this is disappointing, this research project can only be considered to be a first step in a more in depth research agenda into substance use within the Congolese community and should be read with the necessary caution to avoid over-interpretation.

Nevertheless, we do believe it is an important step forward, as an exploratory study into a difficult topic regarding a relatively under-studied ethnic minority community. Making use of community researchers was sometimes as much a hindrance as an advantage to the research process, because considerable effort had to be put in to training and socialisation of the community researchers to “play the game” of the research objectives. To cite but one example, when this report was being finalised a community researcher who had abandoned all contact with us unexpectedly delivered five interviews (the findings of which have not been included in this report) without having informed us that he was still on board. Overall, the interviews that were conducted show different kinds of use in terms of frequency, of substance nature, and of the self-qualification of use.

Due to the differences in social acceptance of the different substances within the Congolese community, the following section is structured by the types of substances used by our respondents.

7.3.1 Alcohol

There were both irregular and regular users of alcohol among the respondents.

7.3.1.1 Social acceptance

Overall, consumption of alcohol seems not to be considered a (potential) problem, and is a normal social practice among a number of the Congolese people interviewed. The same attitude towards alcohol exists in the dominant culture of Belgium.

“The drugs and all those things which are related to the drugs are not part of my education. So I do not touch it. But, for alcohol, it is different. I’m not drunk, but I love to drink mojitos, rosé, red wine, white wine. Especially the mojitos. But it is often at the weekend, when I go out with friends. It’s really social. After, it depends. For months, I can say once or twice a month at home with my father, drinking wine. But being drunk, I have never experienced this. Usually I drink in the evening, but I have never been tipsy or drunk.”

(Babassou, female, 25)

“I always find it odd when I see black people smoke a cigarette. I say, ‘What are you doing?’ We feel that it is not right.”

(Olivier, male, 33)

Alcohol is socially accepted for women and men, so there is no particular gender dimension here. An interaction effect with religion is, however, to be observed. We will come back to this point later. Overall, consumption of alcohol is seen to be fairly normal and is largely downplayed, as the following extracts show.

“I don’t know how often I drink alcohol. But I only drink when I go out. It costs too much.”

(Neko, female, 20)

The following quote clearly shows that there is a different perception of substances in the Congolese community. As in the receiving society, alcohol use is socially legitimate, while other substances are far less accepted, but this also depends on consumption levels. This respondent, for instance, states that alcoholism would be regarded by parents as more problematic than cannabis consumption. But social acceptance of the recreational use of alcohol is diffused throughout the various social classes and levels of education.

“The use of alcohol is a common practice, everyone consumes. Alcoholism is frowned on. My parents would rather I smoked joints than became an alcoholic. After that, it depends on what city you live in, too.”

(Neko, female, 20)

However, it should be stressed that this perception of alcohol clearly depends on the religious orientation of the individual. Only the atheists and Roman Catholics among our respondents consider the use of alcohol to be totally unproblematic. They report it as a commonly acceptable and very widespread practice in the Congolese community. Those who lived in the Congo also told us that in the Congo drinking alcohol is very widespread. Some respondents report that they drank less in the Congo because they had less money to spend on “those kind of things” than in Belgium. Some alcohol users began to drink in Belgium, while one had never drunk alcohol in the Congo. Strikingly, protestant male alcohol users report that their life partners do not approve of their alcohol use and urge them to stop as soon as possible. Indeed, within the Pentecostal movement alcohol consumption is frowned upon. There seems to be an interaction effect between religion and gender here.

Alcohol seems to have a more positive image than cigarettes, which are also classed as a drug by the respondents.

The harmful effects of alcohol, i.e. drunken behaviour or vomiting, are often associated with not eating enough to support alcoholic drinks.

“I would say, yes, it is problematic as I do not eat well and I eat too much, it creates problems with my liver, liver cirrhosis.”
(Fabio, male, 42)

Among the alcohol users, some felt that their social situation was worse in Belgium than it had been in the Congo. There is no specific link with their legal status (asylum seekers, refugee or having dual citizenship) or the frequency of their use:

“When I was in Congo, I lived better. Here, we experience miserable living conditions.”
(Fabio, male, 42)

Some suggest that financial, marital and psychological problems are possible causes of alcohol use.

“However difficult life is in the Congo, a householder may not have the money to feed his family but he will seek by all means to find a way to buy alcohol... Almost all, more than half of Congolese, consume alcohol, in my opinion because they are suffering. Many escape into alcohol when they have problems and stuff. Even here in Belgium, for example, you’ll see almost all of those, people who consume alcohol, have a serious problem with a partner or serious financial problems. So what are the problems that cause people to seek refuge in this stuff, so why do the Congolese consume alcohol? It is because of poverty and to try to find a solution that they consume a lot of alcohol.”
(Mr X, male, 41)

7.3.1.2 Desired effects

The use of alcohol is a commonly accepted social practice in the Congolese community. Some users describe the desired effects of alcohol.

“It reduces stress, so there are periods when I really need to try to feel better, here. [...] I think that yes, it can be a problem. [...] Often when I’m depressed I take it and that’s it, I’m still drunk, especially when I take a lot, so here goes.”
(W2, male, 28)

The older Congolese and those who work report that they often drink with other Congolese friends. The younger Congolese also stress the importance of social drinking, but emphasise they also drink with friends of different origins and with Belgian people. Alcohol use is routinely described as a means to relax and reduce stress after work, and as a social lubricant during regular meetings with friends in bars. Some respondents, however, also mention that alcohol and tobacco are used to reduce stress in the face of problems, such as uncertainty linked to their residential status:

“A long time ago, I used to smoke occasionally, but it was very rarely... Because when we have problems we said, taking a particular substance, perhaps this could provide a solution to this. I started smoking occasionally because I had serious problems with respect to the regularisation of my stay. And then I felt every time I smoked a cigarette it would comfort me...”
(Mr X, male, 41)

7.3.1.3 Problem use

Given the high social acceptability of alcohol, it is sometimes difficult for people to recognise or accept that they have problem consumption patterns. Alcoholism is a taboo topic and respondents state that family members routinely prefer to downplay or disregard problem behaviour. Some respondents suggest that there is a particular cultural component to this, in which one prefers to externalise the sources of problems – also referring to the malignant effects of curses and spells – rather than admit to personal (and interpersonal) responsibility for behavioural patterns.

“Yeah alcohol, there is a real consumption. Now it also depends, as I said, on the generations. The older generation, I do not know much about their consumption, except those who stay all day long in Matongé, but they are exceptions. The African and Congolese community are communities in which parent–child relationships are very remote. So, for example, I have white friends who have seen their parents drunk at dinner and they just laugh. At home, it is taboo. The figure of authority is not the same, there is a distance in discussions between parents and children. Now, even, in my family, there are subjects that my mother made sure to talk to me about, but there are some subjects that we do not discuss. So about alcoholics, we know they exist because I have already experienced that in my extended family. You see that the person is not well, but Africa also has a different way of looking at problems. Many people will say, ‘This is sorcery, a spell cast on me’ instead of saying that there is really a psychological problem.”
(Isi, female, 27)

The misuse or problem use of alcohol is a taboo subject. Consequently, it is difficult to speak about problems with relatives or parents, because they don't understand the causes and the effects. This difficulty is not specific to alcohol misuse and could be explained by the young people's behaviour not meeting their parents' high aspirations for them, and parents feeling that their children are ungrateful. Some say that they find it difficult to live up to their parents' expectations.

“It is not that it provides an advantage but it brings a state of well-being, it disconnects us, but we know that it is not good for health. [...] No, not at all because it's taboo. You would not discuss it with your parents among us Africans, one cannot confide in them. [...] When I got pregnant, my parents kicked me out, I found myself alone, I was depressed, and that's how I started drinking because when drinking it feels a little disconnected, and I kept wanting to drink to stay in this disconnected state. I started at the age of 22 years.”
(Broken Heart, female, 27)

Some male respondents have recognised that their alcohol use is problematic. In this context, the following comment is interesting as it underlines the trouble caused by alcohol, but it also reflects that a similar level of daily use may be interpreted as being problematic for some respondents, and unproblematic for others:

“I can say that this practice is problematic for me because sometimes when I get home from work, I take a few drinks sometimes I'm drunk, I sleep and then in the morning when I wake up I am tired when I go to work, so there, uh, it's not going, I began to have headaches, I get them at work so it is a bit difficult.”
(SK, 39, female with children in Congo)

In the case of alcohol misuse, warnings by family members or friends do in some cases trigger behavioural change:

“Yes, my sister who was there, my nieces who saw that I was really drunk, and it is from there that it taught me that alcohol is dangerous. I now began to manage.”
(Chris, male, 45)

“Some of my friends began to tell me to reduce because they found that I was drinking a lot and it is not good for health. They saw me often drunk, that friends told me to be careful. I was busy with the child when I was drinking a lot and it was really a problem.”
(Broken Heart, female, 27)

Some, but not all, alcohol users have asked their priest for help, but this is not the case for all alcohol users who are religious.

“If it feels like I have become a slave to alcohol I could go to church for assistance to try to stop. But for now I drink when I feel like I really need to relax. But if I start to get worse I could ask for help from the church.”
(Cécile, female, 50)

7.3.1.4 Negative consequences

The problem use of alcohol causes problems in couples, and its use is sometimes associated with the unemployment.

“I fight to stop drinking, smoking, etc. I had reached a level where my little brothers gathered me in the street, I awoke in the morning, I was quick to seek work and do my things. But since the interims closed, I spent my time with friends and drink until 4am. Currently, I try to make sense of things. When I lived with my ex-wife and my child, it was complicated... I do not consider myself an addict but in the eyes of others, I was a drug addict.”
(Chaka, male, 27)

Amongst the negative consequences of alcohol use are financial problems and risks for society, especially when the user drives.

Interviewer: “You lost a lot of money?”
Respondent: “Yes, a lot, and also an accident.”
Interviewer: “A car accident?”
Respondent: “Exactly.”
(W2, male, 28)

Alcohol dependency and frequent consumption is in some cases triggering theft and delinquent acts, as one of our respondents admits, and this can be a stimulus for the individual to reconsider their behaviour and consumption patterns:

“If you have no money, how can you drink? You cannot drink alcohol so you will always have problems or you’re going to a store to steal, so there is not much. This happened to me one day, for years I did not even have a sip, but I wanted to drink. I went rushing into a store and they arrested me and from there I said even if I have nothing I cannot rush into a store to drink alcohol.”
(Chris, male, 45)

The negative consequences don’t always lead participants to stop drinking, even following car accidents, because they are seen as the consequences of other people’s negligent behaviour.

“It was when I lost a friend, unfortunately, who died, it was at this point that I thought. It was the weekend of my birthday. He died at 21 years old and I had just turned 21. He had gone to a wedding, and after an argument with his girlfriend he left, he was so drunk that the car was overturned. Now he’s dead! At 21! When I see today, now that I’m 29, and I see a man of 21, I tell myself that he’s still a baby.”
(Jackson, male, 29)

7.3.2 Cannabis

7.3.2.1 Social acceptance in the Congolese community

Even though the use of marihuana has been decriminalised in Belgium, it is still illegal in both Belgium and the Congo. Matongé is a well-known place to buy marihuana and reports on drug-selling in the neighbourhood often appear in the press. The majority of dealers in the area are “black”. Dealing is often visible and consequently is widely known about within the Congolese community. The community representatives suggested that we go to Matongé to find Congolese users. But even if Matongé is a place to find dealers and buy marihuana, users do not automatically stay in the neighbourhood to use the substance, and therefore they are not that easy to contact there. Use of cannabis is perceived in a variety of ways, according to our respondents. In some families it is largely condoned, while in others it is a taboo topic and practice.

The social acceptance of cannabis in Belgium is, however, reported to be different to the situation in the Congo. Indifference and passive acceptance is said to be more common in Belgium than in the Congo.

“Yes, but hidden. [...] This is where I distinguish between my country and my host country, as at home, for example, someone who smokes in the street, but this is frowned upon here, the youth of today smoke in the street, this is normal, there are people who say ‘Yes, it is like grass, that’s something natural’”
(Titi, female, 49)

“I can tell my mother, ‘So one day I drank two glasses, I stuffed my mouth’, but if I tell her that I smoked a joint she would call all the social services to analyse me, to know what she did wrong.”
(Babassou, female, 25)

Among cannabis users we find a social diversity and a variety in generations. Cannabis use even affects the army, an important component of the Congolese state. This means that cannabis use is not socially restricted. Cannabis use among our group of respondents is not limited to the young, as older respondents holding regular jobs also report consumption, and are sometimes indirectly encouraged by colleagues:

“No, people did not warn me, this is a coincidence. One day I tried my workplace, there were colleagues who smoked it and I said to myself, why shouldn’t I try it, and I smoked and I had difficulty working, and I told myself that it still caused me harm.”
(Titi, female, 49)

This is, obviously, not a particular characteristic within the Congolese community, as there is also a wide variety of user profiles in the dominant group of the receiving society. Our

respondents do report that in most cases the family does not foster or encourage the practice of cannabis consumption:

"[M]y father, he always tells me he prefers me to drink than to smoke anything."
(Kingston, male, 23)

"I do not speak to my family since I already know their views on it and it will be frowned upon. So I do not talk about. I think for them, it would be problematic, I do not speak, it is taboo so that's my little secret."
(Titi, female, 49)

"So... it is a bit complicated for me and then beyond that, I do have drug problems, we can say it like that, but I do not think it's that, but the people around me think it's a problem... I do not see where the problem is. It's still something I would like to improve, though, because it hurts people around me."
(LA, girl, 22)

When cannabis users are older, they try to keep their use secret, even from their wife:

"I use the weeds, marijuana, hashish, cannabis. I smoke two or three times per day. I am safe, my wife does not know that I smoke, it made no impact on me because it is not too much."
(Richard, male, 53)

7.3.2.2 First use

For some recent migrants who were cannabis users, their use began in the Congo. This indicates that their first cannabis use is not related to their migration experience or contact with Belgian society. The following quote demonstrates that cannabis use in the Congo is not recent and began before the decline of Mobutu's regime.

"I started smoking (cannabis) at the time when I joined the army and my father decided that I should go to the army. I was 18, almost 19 years, it was in the Congo. The first time it did not make me good, I felt bad, but I am afraid that I smoked again, until the end of my military training. When I became head of my section, I started. But when I arrived in Europe, at first I did not smoke for fear of being arrested. But then when I came to live in Brussels, I started smoking. It was my elders in the army who initiated me in hemp. Here, I smoke with buddies, three or four."
(Richard, male, 53)

Others first smoked cannabis in Belgium. First use in Belgium doesn't only occur among young people of lower classes, but also in more privileged areas and social classes. The following quote is from a man living in this kind of area:

"I'm one of those people who will try at least one drug to see what happens. Weed I had taken when I was 17 to 18 years old, all the people around me were smoking, that was in the Walloon Brabant, they were all white. And they were smoking regularly. I told you that when I smoked, I never finished the evening so I quickly realised that it was not for me. But the first time, I was 14 and this is when you try weed for the first time and you do not know if you're under the influence or not. And you invent attitudes to it. And then we had to wait until we were 17 to 18 years old and, because we hung out with people who regularly smoked, we knew we

could smoke when we wanted but we did not do it all the time.”
(Mac, male, 33)

Some cannabis users begin smoking it before they start drinking alcohol, but in many cases alcohol consumption precedes cannabis consumption.

7.3.2.3 Desired effects

When commenting on the significance and desired effects of cannabis consumption, a variety of described and researched effects are mentioned. Some present marijuana use as part of youthful rebellion or a passing practice, linked to being young.

“No, because my parents never knew I smoked weeds and they were not even concerned. With this kind of stuff, we often pay attention to the persons we do not know. None of my relatives knew apart from my closest cousins, otherwise, regarding adults, no, no.”
(JL, male, 23)

Others emphasise it is used to enhance or produce a state of relaxation.

“Because it calms me down a bit, it put me at ease, if I may put it like that, sometimes when I am a bit upset or when I am not well, I smoke. I smoke because it relaxes me, it helps me escape.”
(Kingston, male, 23)

The need to “escape” is not related to the age of the respondents. This particular respondent, for instance, states he began to smoke in his thirties.

“I started when I felt bad, I have a good group of friends who have tried to help me and I thought ‘Oh that’s good’. With groups of friends, it helped me a lot to escape, to walk, I felt really... I forgot a lot of things that hurt me, and then I thought that with this I can be better. Finally I found that it was good.”
(Charles, male, 48)

“I have smoked since the age of 19 and I think I’ve tasted all the pleasures; it is time I stopped. For two years I stopped using during the holidays. Summer vacation with the kids because I do not need, I stop everything. I start smoking again when I’m in Brussels because it’s surreal, because I am Congolese, because to deal with all the contradictions, I need to make my core self more elastic. And I have an elastic core so I smoke a little joint and it makes me well when it’s good grass.”
(Nzema, male, 42)

Respondents are nevertheless aware that this quest to “escape” and “relax” brings health risks. The following interviewee states he primarily sees a health risk linked to the combined used of tobacco:

“Problematic, I would not say that, but it is true that a joint a day, it corresponds to smoking seven times per week, it corresponds to 31 smokes of weed in a month. Smoking weed 35–40 times a month, in view of my health, it’s true that it’s not very good, that’s why I do not put a lot of tobacco in, I try smoking a pure, good pot but

I still smoke and it is not good for health.”
(Kingston, male, 23)

“I may have sleep disorders or neurological disorders. But that’s since I was little, I have paranoia, I do not like the dark and crowds, stuff like that. That’s paranoia, excessive melancholy, and I think when you smoke, you are free to choose.”
(Danko, male, 21)

This respondent, however, finds justification for his cannabis consumption in its perceived positive effects:

“The marijuana makes me think a lot, too. It is a way to escape. It is like a little therapy for me, when things are not going well, just to be comfortable when in the evening I’m tired, I have a little joint and it’s always fun here.”
(Kingston, male, 23)

It is clear most respondents see cannabis consumption as relatively harmless. Even if it is less socially accepted than alcohol, it is not perceived as highly problematic.

Interviewer: “Is the use of substances common in your community?”
Respondent: “Yes, anyway.”
Interviewer: “Is this a problem for you?”
Respondent: “No, because I can smoke with other people in my community so no, it’s not really a problem.”
Interviewer: “How is it perceived in your community?”
Respondent: “It’s a sin. [...] As I said, they consider it negatively, they do not find it normal to smoke and also say, since we’re pretty religious, well it’s still a problem”
(LA, female, 22)

As is often the case with cannabis consumption, it is usually associated with social use among friends, which can downplay potential problems:

“It is clear that when we are with friends, we smoke more, as I said, when in the evening, we therefore smoke more and it affects my use, it is clear, yeah.”
(LA, female, 22)

7.3.2.4 Problem use

The cannabis and alcohol users do not usually consider themselves to be “addicts”, given the assessment they make of the frequency of their use:

“I’m not a junkie and I smoke a joint a day late in the evening, before sleeping or whatever or watching a short film.”
(Kingston, male, 23)

In the case of problem use, where respondents report periods of excessive and problem use of cannabis, unemployment is often cited as an important factor:

Respondent: “It was more cannabis and I associated it with alcohol, when we were partying. There was drug use, alcohol consumption so it was really... I had a period in my 20th to 23rd years, where it was really steady, it was almost problematic in that period. [...] Regularly, I used to smoke a joint after two to three

hours, when I was no longer high, I had to smoke again, so it made me easily by four or five days.”

Interviewer: “What situation or what circumstances led to this?”

*Respondent: “Lack of work.”
(Titi, female, 49)*

“When I was 16, I started smoking every day because I was living with friends who were selling drugs; we smoke here and drinking has increased because here in Europe, I am not busy, I am unemployed, I’m not working, I start to beg for cigarettes.”

(Bob, male, 20)

7.3.2.5 Experience of negative consequences

Almost all of the alcohol and cannabis users stress that relationships with their families are good and normal, including those who no longer live with their parents in the same household. However, occasionally a respondent did point out that cannabis consumption led to problems in relationships:

“This is problematic because at home when you arrive, you smell, when your wife asks you ‘What do you smell of, what do you do?’ You try a little lie, then it’s trouble, there no peace and then, you get home late because you spend time with groups of friends and forget that you have left a woman in the house and you go home, there are only problems. Cannabis is the problem. There is no peace. [...] That’s when I saw that my behaviour began to change at home. Insults, shouting, getting home late, stealing from my wife’s bag...”

(Charles, male, 48).

Furthermore, cannabis use could also lead to problems with the police and judicial authorities.

“Judicial, since I was arrested for cannabis. Yes, good, I must say it was long ago, when I was young at the time and we could not use drugs as such, so I still had some problems.”

(Titi, female, 49)

“ Well it’s not good, so this hinders me.”

(Olivier, male, 33)

Some male cannabis smokers don’t accept that women also smoke cannabis; there is a gender dimension in the social acceptance of cannabis use:

“It is not normal for a woman smoking pot.”

(Fire, male, 32)

7.3.3 Hard drugs

Carrying out interviews with regular users of hard drugs was challenging, particularly with regard to heroin users. None of the community researchers or research interns involved in the project was able to locate and recruit heroin users. The lead researcher had to develop a strategy that mobilised her own extended social networks, making use of a snowball sampling approach to try to identify potential interviewees. Once identified and recruited, these users repeated several times that they found it particularly hard to talk about an issue they considered to be a personal matter, and when speaking about their first use and the reasons for use

respondents usually became very emotional, which hindered the remaining part of the interview. Another difficulty has been to actually meet these participants once appointments had been fixed, and then to complete an interview with respondents who had agreed to participate and turned up at an agreed time and place of meeting. The urge for and pursuit of the substance often made it difficult for respondents to stay focused and concentrate. Unfortunately this did not always guarantee high-quality interview material. However, a number of tendencies can be highlighted.

In the case of the regular hard drug users of crack, cocaine and heroin, the narratives of the respondents show a particular pattern. Relationship problems, separation or an emotional breakdown were said to have corresponded with or triggered either first use or the intensification of hard drug use. Nevertheless, the interviewees do not go so far as to suggest their regular use is linked to one single cause; rather, they say it is the result of an accumulation of several different factors. Sometimes particular traumas are, nevertheless, singled out. One of the respondents linked use to their experience of child abuse and violence. None of the respondents identified ethnicity or culture as having any causal effect. Even if they have frequent contact with the Congolese community, these are not their only social contacts, especially in relation to their drug consumption.

These hard drug users stated that they not only use with other Congolese people (origin or citizenship), but also with other Sub-Saharan African people or people of Moroccan, Belgian or Turkish background. They often also sell drugs to organise and fund their personal use. Talking about this proved to be a difficult task, and one can understand this when focusing on the life stories of those respondents who provided us with a more in-depth view of their use of hard drugs and related lifestyle. One of our female respondents admitted she prostitutes herself to pay for her substance use, while male hard drug users were often also active as dealers. The female respondent was supposed to have stopped using and opted for substitution treatment, but appears to have continued using heroin. She does, however, signal a clear willingness to stop using heroin and other substances in order to try to rebuild the relationship with her son. As a reason for her drug use, she refers to emotional problems she had in her relationship with her mother. She has spent a considerable period of time without a fixed place to live, but now she has found an apartment and is able to pay for it on a monthly basis. If we had met her in other circumstances and at another time in her life, holding the interview would have been problematic.

The first use of hard drugs is difficult to interpret here because of the lack of information and the difficulty in conducting the interviews with hard drug users, who are constantly seeking the substance and do not have a lot of time between two uses. Moreover, the question causes an emotional reaction, and is the moment when they say they have to go. That is why the following quote is from an ex-user.

“The lack of money, parents had their problems, and I could not support myself. But I had bad relationships outside, I fell into robbery and as I was not near my parents I let myself be led by those friends who do not necessarily wish me well. For example, regarding the alcohol, I drank Gordon: 10% alcohol, at least four per day. [...] I lived with friends, I smoked and drank, we were all in the same frenzy; even when I was living alone, they had to smoke with me after I began to sell, and there I was, I had the money and I consumed a lot.”
(Chaka, male, 27)

The hard drug users recognise the negative consequences of their substance use more easily than the positive ones.

“The weed, I smoked a lot and I sold weed and cocaine, I took and sold heroin, I sold but I have not taken alcohol, etc. Currently I still consume weed but others, I put a stop because it was no longer going. [...] I was consuming 20 grams of weed per week; 10, 15, 20 joints per day, it was non-stop. Cocaine, I was using 5 g per

week, heroin was when I had nothing and I was missing it... these were great moments of sweating, anxious moments, I scratched, I felt bad about myself, and I really was like shit, I was running away from people's eyes, I felt spied on, looked at, I was in a paranoid delusion. [...] I do not know, I think it was to escape the problems and all that goes with it. The thing is that the problems, they are still there."

(Chaka, male, 27).

Some hard drug users express regrets about their living conditions in Belgium as migrants.

"A lot of things go wrong in my life, except health. Life is very difficult here in Europe. When one is in Africa, we think Europe is paradise, life is easy. Once you arrive you realise that it's the opposite. Everything we do, white complicate us, and make us feel like a shit, it's really boring. [...] If I was asked to go back five years ago, my life, it would be very different, there are choices I made in my life that I regret. When I was in Africa, while watching TV, I thought Europe was paradise but when I arrived I realised that this is not the case. I had to abandon my studies to come to Europe but if I could do it again, first I would finish my studies and go to the university."

(Bob, male, 20)

Hard drug use in the Congolese community is not easily discussed. As with other kinds of use problems, it is a taboo subject and is perceived as a weakness in the user, making them feel guilty in front of their relatives.

"Especially not in my family, we don't even talk about smoking a cigarette, I hide. In the Congolese community"

(Chaka, male, 27)

Religious practice has helped some respondents to stop using:

"Actually for six or seven years I was not even at home, I went out and slept anywhere. I slept at my friends' houses, anywhere I found a place to sleep. I was too much in the mood, so high that I could not get off. And then towards the end of 2014 my mother took me to my pastor saying she's tired. She was extremely worried about my substance use. They prayed for me and I remember a sentence my pastor told me: 'Persevere, persevere.' So I told myself that I will try to persevere. I said, I'll stop for three months and if it does not work I'll go back to where I was. I held on and I liked it, I really tasted something new and it was good. I really felt that I was speaking, God spoke to me and I decided to repent and then I stopped my old life. I even stopped going to my friends, I changed situation since evil communications corrupt good manners, so even if I had the desire to stop smoking, to stop using drugs, the desire to stop drink or do anything I wanted, the fact of hanging out with my friends encouraged me to take drugs, to smoke."

(Mwana, male, 26)

7.3.4 Prescribed medicine

Only one respondent reports the use of medicine (in this case Xanax). The respondent has had severe problems with mental health that led her to leave the parental home, but she did not want to give any details to the community researcher who interviewed her. She seems to be very introverted and doesn't feel she belongs to the Congolese community. Obviously we are not dealing with a statistically representative sample of respondents, but the relative absence of references to misuse of prescription medicine is striking.

7.4 Use of treatment and other facilities

Judging by the responses provided by our respondents, information about treatment or facilities related to drug or alcohol use is certainly available, but it does not seem to penetrate all sections of the Congolese community. Some young respondents have parents who have encouraged them to stop smoking cannabis, even enrolling them in a cannabis clinic. But a lot of respondents associate help services only with psychological services for hard drug users, which means that they don't know about other types of services that are available. However, users seeking a solution do not appear to trust the collective therapy approach. Some alcohol users recognise they have problem use but at the same time feel they are able to manage their problem on their own:

“No, I do not have any motivation because I know how to handle my business.”
(Chris, male, 45)

Respondents were most willing to approach medical settings to find help to stop drinking, and it seems to be held in particularly high regard in the Congolese community:

“Maybe if a doctor tells me to stop drinking, maybe I would look for help to stop drinking, but for now I know how to manage my situation so there are no worries. No, it's not hard – it's easy. Maybe if you go to a doctor, he examines you, he finds that you are ill, you have a health problem, you are forced to ask for help so that you can stop using alcohol. Some people fail because they are addicted, so that is why, they cannot stop, and they can die like that. If the doctor says you need to stop drinking because you have liver cirrhosis and you, you do not stop, you continue to drink in secret and then what happens? You will fall sick, you die, so everyone knows about his or her affairs. Me, if a doctor tells me to stop drinking alcohol, I would do my best to stop drinking.”
(Chris, male, 45)

Some hard drug users access treatment services, but do not necessarily stop using as soon as they go to these services. Guidance is provided in prison to direct hard drug users to the services that are available to help them. In the interviews, it is important to distinguish between those who do not know the range of existing facilities and treatment, those who know but do not want to use them, and those who have tried them. An additional distinction should also be made according to the type of substance use.

As far as alcohol use is concerned, it is clearly often difficult for users to recognise a potential problem, as alcohol use is highly associated with festive practices and events. Furthermore, consumers often state they manage their consumption patterns as they “never feel really drunk”. Given that alcohol consumption is legal and social acceptance is high, problem use is easily downplayed. However, some pressure does seem to be present linked to alcohol consumption when people are embedded in a social network in which religion plays an important role.

Cannabis consumption is perceived differently. While alcohol is more openly consumed and discussed, people generally turn a blind eye to cannabis use. Several young respondents state it would be difficult to discuss cannabis use openly with family members and they therefore prefer to avoid discussing it. Even if several respondents state that cannabis is disregarded as relatively harmless, they also say that open consumption of cannabis tends to be frowned upon within the family and the wider community. Given negative associations, people tend to avoid discussing it.

The taboo on hard drugs is even greater. The taboo is actually so powerful that we had considerable difficulty in finding users and even more so in convincing them to participate in the study. Community researchers also proved to be quite reluctant to probe and address the issue, or met with resistance when seeking support in locating potential interviewees.

Respondents, and particularly parents, often do not know about the range of existing facilities for support and treatment. Judging by the interviews, the lack of knowledge of services that can provide help is not limited to issues of alcohol or drug use, but is part of a broader pattern of poor knowledge about the assistance that is available within children's education. Furthermore, parents prefer to handle delinquent behaviour by their children through repressive or traditional solutions. Especially in the case of hard drug use or severe patterns of drug addiction, a common response seems to be family rejection (following a number of trials to convince them to stop) or silence, while it is also reported that one often simply prefers to deny the problems and not discuss or hear about them. Blaming problems on external sources, such as witchcraft or evil spells, seems to be one of the strategies to deal with cognitive dissonance on this level.

The experiences of young people who know and have been enrolled in treatment facilities and care structures are not always successful. A case in point is one young Congolese respondent who was pushed by his parents to seek help but dropped out of treatment as he was afraid the service would reveal other personal problems. This person did embark on a treatment trajectory but did not participate fully, partly because when re-establishing friendship ties with his personal social network he routinely resumed old habits of consumption.

7.4.1 Specific barriers

Once people are aware of the existence of care and treatment services, a number of specific barriers to accessing the treatment are highlighted by respondents. The taboo surrounding drug use and dependency is highlighted as a major obstacle. One commonly cited reason is the fear they will not be able to find a trustworthy person who will be able to really help:

“I think for a person who really wants to talk about it, it is a bit difficult because you have to see that we must speak of it. Everyone is not open to such things. I find that asking for help, it might help, but in my case I do not think it will. I turn more to friends that also consume. I see myself turning to the wrong people to tell me what to do.”

(Meroe, male 25)

Although the family is very important in the Congolese community, not all subjects are easy to discuss with family members. People don't always feel able to confide in their parents about their problems or worries. Parental expectations towards children are very high. Children often try not to worry their parents. When disappointment occurs, it is also really hard to face, especially when the parents sacrifice a lot to provide welfare and education for their children.

“I think the end of this debate is that it could be discussed at home but I have a kind relationship with my parents in which such conversations should take place only if – in any case it is me who said it – only if a serious thing happened or what... for example, if a cousin overdosed. [...] my friends, I can tell them about the family. I talk to my friends about this because I feel extremely bad about my family's disappointment in me. So I think the family will speak to them if it goes wrong. If I go for help and in the end I failed and it was no help, I will clearly go to the family. But before that I would do everything to handle the problem in silence.”

(Mr H, male, 22)

“Yes, I can talk among Africans but after there is always this distance with parents, so there is a way to do it, it is true that we also Belgian, it is here, we can talk, etc. With parents there is always a way of approaching subjects. There are topics that are not necessarily taboo but are difficult to deal with.”
(Jackson, male, 29)

The taboo is reinforced by fears for the imagined negative effects of social control by the family and the larger community, even if the unspoken truth is that use is also a part of reality in their own social network. The taboo persists because visible substance use is associated with the educative failure of the family:

“Now how this is perceived by my community, it is still taboo. For the reasons I have said, and because I think that people did not want it to rub off on them actually. Because we must be realistic among us Africans, we are responsible for our image and also that of our parents and our family too. So when we do something wrong it not only falls on us but also on our family, our friends. I do not know how to explain. For example, here you can say, ‘What a girl, she sleeps left to right.’ Yes, ok, Westerners will easily make the difference, saying ‘It is she, you are you.’ Among Africans is different. And while we’re here, there’s always that little thing to say ‘Did you see your buddy? He was found completely flared, this and this. You hang around with them, um yeah but hey I’m different, yeah, yeah that’s it.’ That may be why people do things more quietly.”
(Isi, female, 27)

When substance use problems occur, the main attitude seems to be to keep the problem secret among a few people, and sometimes to avoid any kind of discussion about it.

“Alcohol, yes, it is very, very taboo, even in my family. Because until now, it is as if my brother came out a little too much, he drank too much but it was not that, he even drank in his room... but it was hard to see the problem in front of you, I find. And we had to take drastic measures to prevent him drinking – we used to have bottles at home, for us it was very common, and we began to remove them. And yet it was as if it was not a problem, as if it was a punishment. It was hard to put words to these situations. Because it’s taboo. In our mind, we did not say that it can become a problem, we did not think it, anyway.”
(Jess, female, 20)

In addition to the prejudice that drug users are mainly young males, another common belief is that the more highly educated will be discreet and hide consumption, while vulnerable and poorly educated people are thought to consume more openly. The use, when it becomes visible is hence equated to social devaluation:

“It’s not widespread, I can say in all towns we have, speaking of Kinshasa is not in all municipalities where... you’ll see, there are two categories, there is the category where people who are poorly educated, who consume but discreetly hidden. There is also another category – children who are unable to get out because the family is behind, so they use this drug then, since we found it easily and it is cheap, even their parent no longer know how to have the upper hand because children consume every day and they trivialise the thing.”
(Titi, female, 49)

Consequently, a blind eye is turned to actual practices, consumption patterns are downplayed and people stress that frequent use does not equate to a genuine “addiction”. In the following excerpt the young person stresses that his cannabis use should not be a reason to label him as an “addict” needing support:

“Because, for me, it worked, so here goes. But I do not know for me if I was addicted as some are but that’s why I managed to get out, so I have succeeded, so why not?”
(JL, male, 23)

Shame is reported to be a major obstacle in asking for assistance or even discussing potential problems with friends or relatives, perhaps because use is socially conceived of as a rational practice that could be stopped:

“Never. I cannot. Not even talk about it, because it’s a shame.”
(Charles, male, 48)

A fear of being the subject of gossip within the community thus constitutes a major barrier to establishing contact with service providers. Several respondents state they would not wish to be put in a situation where they might meet someone or be seen by someone from the community:

“Because when you go, you’re afraid to meet people you know, you see these people and you say to yourself, ‘Oh, they’re going to talk about me, that I am this, I am this’, that sometimes that makes it a bit complicated to go.”
(Charles, male, 48)

“I believe that there is nobody who I have talked to about it as I am doing here. I never talked about it. You still have to say one thing, it’s still embarrassing, it’s shameful, the use of cannabis. When we have to talk to someone, it’s still annoying [...] The fear of being seen. Why? Because we are always embarrassed, we reach a point where you say, I’m already gone very far and I personally believe if I want to stop, I will stop myself. I do not think it’s a problem for me since, in addition, cannabis is not a hard drug, I do not think being dependent so it makes me feel good, I smoke until today so I do not need help, I do not find help.”
(Titi, female, 49)

For some respondents there also seems to be a certain level of mistrust of care facilities, as they do not rule out the possibility that caregivers might report illegal activities or the use itself to the police and judicial authorities:

“Never, I cannot do that because there is the risk that they might denounce me, he can talk to me, I do not trust him.”
(Charles, male, 48)

Some respondents consider help services as more adapted for people with white culture.

“Among my friends, there is nobody who has asked for help. Detoxification is the white stuff is not for us blacks.”
(Bob, male, 20)

“Psychologists? That too is a question of whites. No, psychologically, I prefer to talk to my friends.”
(Olivier, male, 33)

As a consequence, the preferred solution to dealing with consumption issues or addiction is to focus purely on treatments available in the “normal” medical sphere, such as general hospitals:

“Yes, when you ask to go further in the sense that sometimes you need aid, good, you’re going to the hospital for blood tests, sometimes you meet someone like a psychologist to talk a little with you, someone assisting you psychologically and socially and that makes you good.”
(Charles, male, 48)

Some of the respondents also seem to think they do not really need help when deciding to change their habits and seem to underestimate the effort that is needed to the habit or to overcome the difficulties:

“I never asked for help because I still believe if I want to stop, it’s my personal decision.”
(Titi, female, 49)

Finally, a number of respondents point to their perception that there are no prevention or care services in their country of origin. While some respondents think there are no prevention or care services because substance use would not really be seen as an issue, others stress that the taboo is so great that care services will find it difficult to convince potential “clients” to take the step to seek assistance:

“Me, I think if today there were services like in the Congo they would have almost nobody going there. Because, even here it’s very difficult for someone to agree to go to a service like that. There needs to be people behind the person with advice, saying ‘Listen, we can help you at the centre’ and all that. But initially the person refuses. And in the end, she accepts. So it is very difficult.”
(Mr X, male, 41)

The overall effect of the taboo and double standards regarding substance use is that there seems to be a lack of knowledge and information about both the prevention and symptoms of problem alcohol and drug use. Routinely in the narratives of our respondents, “real” problems with drugs and alcohol are equated to problem situations of youngsters, particularly those having scholarly problems. As a consequence, the relevance of prevention and care seems to be seen as a niche issue that doesn’t necessarily personally affect them.

During the fieldwork, the only civil society association we encountered trying to explicitly work on the prevention of drug use among youngsters used a prevention DVD produced by the Church of Scientology. It can be pointed out that this association was recently removed from the list of associations eligible to receive public subsidy. As is the case for quite a number of African associations, it was deemed to lack a sufficient degree of professionalism to receive public support. During the fieldwork we came across similar prevention material issued by the Church of Scientology in the waiting room of a Congolese doctor of Matongé. The doctor informed us that he had stopped delivering substitutive treatment because his patients felt insecure. He justified the presence of material from the Church of Scientology by saying it was the only source of information he could provide to patients. He reported that representatives of Scientology came over on a weekly basis to bring new leaflets on the dangers of drugs and had observed that patients actually read and retain these leaflets. Discussions with other Sub-Saharan African doctors in Matongé revealed that their knowledge of drug use and drug users among their patients is quite limited, if not non-existent.

7.5 Discussion

This case study does not show any specific patterns of alcohol or drug use within the Congolese community. Nor does it point to a specific way of dealing with alcohol and drug use

in this diaspora. We did not encounter any reference to a strategy of sending problem users to the country of origin or efforts to handle addiction in alternative ways as compared to the substance misuse treatment centres in Belgium. The sample reflects the social, generational and migrant heterogeneity of the Congolese population living in Belgium.

Arrival in Belgium isn't one of the causes of the first use of alcohol or cannabis. On the contrary, first use of alcohol and cannabis could also have occurred in the Congo before leaving and during adolescence. Some people say that the migration experience, including the willingness to stay with Congolese people and discrimination, is one cause of regular and recreational use. In these cases, the substance use allows them to escape or reduce stress. The need to handle stress by using alcohol or cannabis is not specific to a particular trajectory and is mentioned by students, unemployed people and those with a job.

We observed that social acceptance of cannabis use is quite high among some groups and members of the Congolese community. Alcohol addiction is difficult to admit to because the boundary between social practices, which consist of drinking when meeting friends (Congolese and others), and alcohol addiction is narrow.

What seems to be specific to the Congolese community and population is the large taboo regarding drug and alcohol use. That is why it was so difficult to talk with our participants about (problem) use and the help that is available, which is not well known among the Congolese community. Nevertheless, it is not possible to claim that there are no problems related to levels of alcohol and drug consumption within the Congolese community. We found several respondents reporting seemingly problem substance use, not only among youngsters.

Finally, it is important to underline that we found only one Congolese association that deals with drug problems of young Sub-Saharan Africans in Brussels, among the 600 associations identified in Brussels. This organisation has reduced its activities due to a lack of public funding. Our research demonstrates the absence of useful information about substance use in the Congolese community in Belgium.

The following recommendations are made specifically for the Congolese target group, based on the information collected through the interviews of users undertaken by the community researchers and the academic researchers, complemented with insights collected through contacts with multiple representatives of Congolese associations, local services, existing facilities in Brussels and Liège and Congolese doctors in the Matongé area. We wish to highlight the following points.

There is a need for active prevention relating to the risks of substance use and for information on the available care and treatment facilities in the areas and spaces where Congolese people live and spend time. Knowledge about drug and alcohol use and misuse is clearly restricted in and through Congolese associations and strategic meeting locations. The fact that the Scientologist prospectuses about drugs and alcohol were the only information we came across during our fieldwork, and that they were actively read and used, points to the urgent need for (perhaps targeted) information. These practices could help to sensitise the families and friends of substance users to recognise and interpret the behaviour of problem users and give them adequate resources for exploring alternatives to conflict or inertia in addressing their challenges.

There is also an urgent need to find (and maintain) Congolese community actors interested in, and willing to handle, the drug and alcohol use issue, not only for young people but also for adults. On a more general scale, this requires more organisational support for Congolese civil society actors. We had great difficulty in finding (and keeping on board) a civil society community partner for the CBPR exercise, and this reflects the fact that a lot of Congolese associations do not have a professional – let alone permanently viable – approach or

(infra)structure currently allowing for effective partnerships with community outreach, with regard to substance (ab)use issues or about any other issues. Indeed, the limited resources we were able to provide seemed to be the only financial support at their disposal, and we constantly had to explain, ensure and negotiate that they would only be used for the project and task at hand.

DRAFT

8 CONCLUSIONS ACROSS THE CASE STUDIES

In this research we intended to answer two main research questions by means of four case studies in the Turkish community in Ghent, Eastern European communities in Ghent, asylum applicants, refugees and undocumented migrants, and the Congolese community in Brussels:

- (1) *What is the nature and what are the patterns of substance use in four populations?*
- (2) *What are the expectations and needs of the four populations towards substance abuse treatment care?*

Additionally, we identified sensitising concepts in literature (conformity pressure, social and recovery capital, the urban context, ethnic density, acculturative stress and discrimination and ethnic identity) that might be significant in the social mechanisms underlying substance and treatment use. We also identified three types of barriers to treatment in literature: barriers at the (1) system and society level, (2) provider level and (3) individual level.

In what follows we will link these research questions to the sensitising concepts defined in the literature review. We will complement these mainly theoretical concerns with new findings in our data. Furthermore, we will compare the potential barriers as identified in literature to our empirical findings in the four populations. What follows is a cross-case comparison: it is the result of comparing the case studies and not a meta-analysis of primary data in the four cases.

8.1 Nature and patterns of use

In total we analysed 247 transcribed interviews with individuals describing themselves as migrants or belonging to particular ethnic minorities. Our samples consisted of: 55 users and seven family members of users from the Turkish community in Ghent; 62 users from Eastern European communities in Ghent; 56 users from the Congolese community in Brussels; and 67 users primarily identified as asylum applicants, refugees and undocumented migrants. In the Turkish population sample and in the sample of asylum applicants, refugees and undocumented migrants about two-thirds of the respondents describe their substance use as problem use. In the Eastern European sample only one-fifth describe their use as problematic, while one-quarter of self-described non-problem users state that their family members do find their use problematic.

Regarding the substances used, all four populations used the same “top three” substances as the general population (Plettinckx, 2015) with alcohol and cannabis in either first or second position, and cocaine in third place (tobacco was excluded). Also, we reached a relatively high number of primarily heroin users ($n=25$), mostly in the Turkish target group and the group of asylum applicants, refugees and undocumented migrants by means of purposive sampling. The use of sedative (prescribed) medication and antidepressants is quite high in all populations apart from the Congolese. The use of “downers” is prevalent in all populations. Regarding “uppers”, cocaine was the only drug to be fairly common in all populations; this ties in with the observation of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) that cocaine is Europe’s most commonly used stimulant (Goulão, 2015). Furthermore, the use of ecstasy, speed, LSD and Piko (methamphetamine, or crystal meth) is mentioned in individual cases and mostly in recreational settings.

8.1.1 Reasons for continued use

The user careers of our respondents are very diverse. Some do not describe their use as problematic. These respondents mainly situate their use in recreational settings and are less inclined to give a reason for it. Some participants note that they started using recreationally in the home country but that it became problematic after arriving in Belgium due to migration experiences and/or the consequences of migration (social isolation, not speaking the language, etc.). Others note that they started using during their migration to Belgium (mostly fleeing their home country) or when incarcerated in prison. Others note that they in fact came to Belgium to reduce or stop their problem use in the home country. However, these are individual cases and the vast majority of participants in all populations situate their use in Belgium (because most of them have been living here for over five years, and a majority have a family history in Belgium that stretches over several generations).

The reasons we found for continued and problem use are quite different and well defined among the populations. In what follows we give the two most common reasons for continued use in the respective populations.

In the Turkish community in Ghent:

- (1) marital problems and other family discord (sometimes caused by arranged marriages);
- (2) early life experiences (such as the insecurity of possibly returning “home” and discrimination in school).

In Eastern European communities in Ghent:

- (1) financial and work-related problems (caused partly by discrimination in the labour market);
- (2) family problems (mostly caused by having family abroad and divorce).

Among asylum applicants, refugees and undocumented migrants:

- (1) the lack of residence documents and consequent feeling of insecurity;
- (2) the migration history and consequences of migration, such as loneliness.

In the Congolese target group no specific reasons were given for problem or intensified use.

8.1.2 Help-seeking behaviour

In our interviews we can clearly distinguish between those respondents who do not know what services are available for substance abuse treatment, and those who know about these services but do not want to make use of them because they do not find their use problematic or because they mistrust the services.

Generally speaking, very few participants have used formal treatment support. In the Turkish and Congolese communities several users believe that their use is “their own problem” and that they “have to” deal with this problem themselves. In the Turkish target group and the group of asylum applicants, refugees and undocumented migrants, one in three of the problem users has accessed formal treatment services. Less than one in seven of the Eastern European respondents has accessed formal and informal treatment support. This partly ties in with the observation of a professional in a heroin substitution centre who notes that Eastern European users are hard to reach. Therefore we also include other services that are not treatment abuse related in this target group. The most mentioned services in the four populations are the following:

- In the Turkish target group: in-patient treatment centres, specialised psychiatric centres in hospitals, heroin substitution centres, independent psychiatrists or psychologists, outreach services (mobile team and crisis team).
- In the Eastern European target group: general practitioners, psychologists, emergency care, trade unions and associated health funds, Public Centre for Social Welfare.

- In the group of asylum applicants, refugees and undocumented migrants: heroin substitution centre and Free Clinic.
- In the Congolese target group: general practitioners.

The “treatment gap” might in reality be larger, taking into account that many of the participants in our research do not consider themselves problem users. It is worth noting that the Eastern European participants most often made a direct request for help from our community researchers; these were all requests for psychological help.

8.2 Mechanisms at work in substance and treatment use

8.2.1 Taboo, shame and (ethnic) conformity pressure

In our literature review we introduced the concept of (ethnic) conformity pressure as a mechanism possibly influencing views on substance use, individual expressions of substance dependence and treatment strategies. (Ethnic) conformity pressure (Van Kerckem et al., 2013) is created by the norms and values identified within the (ethnic) boundaries of certain (ethnic) groups. The taboo surrounding substance use was most prominent in the Turkish community in Ghent and in the Congolese community in Brussels, albeit in different ways. In the Congolese community the existent taboo made it hard to conduct the research, find community researchers and recruit participants. In the Turkish community this first barrier was seemingly overcome by recruiting community researchers who explicitly aimed to remove the taboo because of personal experiences with substance use in the family. However, the interviews revealed that some of the community researchers reinforced the taboo during the interviews. Still, they gave us an insight into how this substance and treatment use interferes with ethnic conformity pressure in the community.

The interviews in the Turkish community in Ghent demonstrate a close interlinking between being Muslim, using substances and belonging to the community. Our participants often felt they were the only ones responsible for their problem use because drug use is considered *haram* (forbidden) in Islam. Many of the participants have lost contact with their family network and avoid meeting members of the community, or choose not to visit mosques so that they are not confronted with the stigma that goes with substance use. Some respondents moved neighbourhoods or cities to avoid confrontation with community members and family. Many respondents also say that when substance use is talked about in a religious context, it is mainly a reflection of why it is forbidden, instead of how to deal with it when confronted with it. Many of our Turkish participants who consider themselves problem users feel excluded from their community because of their use.

In the Congolese community the taboo on substance use also has far-reaching consequences. Fear of being gossiped about in the community is one of the reasons why people feel ashamed about asking help if needed. Furthermore, it results in a fear of not being able to find a trustworthy professional. Also, an image seems to be reinforced in the community that a drug user is a socially deviant, economically devaluated person. The perceived social control by the family and the community leads to a lack of knowledge and information about both prevention and the symptoms of problem alcohol and drug use.

Both the Turkish community in Ghent and the Congolese community in Brussels are well established, closely knit networks where a lot of people know each other. The ongoing structural discrimination of individuals who are part of these communities reinforces ethnic boundaries, creating ethnic conformity pressure. A thematic search in the interviews with Turkish and Eastern European communities in Ghent and asylum applicants, refugees and undocumented migrants confirms that discrimination is the topic that was mentioned most

often in all interviews. Both in the Turkish and the Congolese communities we cautiously assume that ethnic conformity pressure in combination with ongoing discrimination has a detrimental effect on dealing with substance (ab)use.

Asylum applicants, refugees and undocumented migrants are a more diverse group, and their feeling of belonging is often more related to the family in the home country and small groups of peers in Belgium, the host country. Therefore, stigma and taboo are less prevalent among these individuals. However, participants belonging to this target group say that they would never tell their family in their home country about their problem use, which causes extra psychological stress and social isolation in these individuals. The same goes for many of our Eastern European respondents. They are less embedded in a well-defined “community” but do state that they would not talk about their use with family members in their home country. Furthermore, Muslim asylum applicants, refugees and undocumented migrants also say that they are ashamed of their use because of their religion.

8.2.2 Lack of information and language skills

When comparing our four populations, we note a large difference between the level of awareness of existing substance abuse treatment services and centres. In Eastern European communities in Ghent, the Congolese community in Brussels and asylum applicants, refugees and undocumented migrants, several problem users explicitly state that they do not know where they could go if they required help for their addiction problem. This could partly be explained by the fact that in some of the countries of origin such services do not exist. Furthermore, it is clear that most of the respondents in the target groups of Eastern European communities, and asylum applicants, refugees and undocumented migrants do not speak Dutch sufficiently to easily access Belgium’s complicated health care system.

For the Turkish community in Ghent we cautiously state that the taboo on substance use has a greater impact than the lack of knowledge about existing services. However, once a person has made the decision to seek help, they seem able to find adequate treatment. The problems this group encounters regarding what constitutes adequate treatment are quite similar to those in the general population. For example, patients rarely get to choose a particular treatment centre for intake, even though different treatment centres apply different treatment models to which individuals will respond differently. Furthermore, some of the Turkish respondents also mention that specialised psychiatric centres in hospitals often treat addiction with medication and do not treat the psychological aspects. These respondents’ criticism of existing treatment care is significantly more in-depth and demonstrates a better knowledge of treatment possibilities than in the other three populations.

Language-wise, Turkish people say that they prefer to speak their own language at treatment centres. Also, they would rather visit psychologists and psychiatrists of Turkish descent than what they conceive as “Belgian” psychologists and psychiatrists. Participants explain that this is not only because of the language, but is also about a different understanding of family structures and the importance of family ties in their lives.

8.2.3 (Ethnic) identity, acculturative stress and discrimination

Within the framework of a critical ecosocial approach (Krieger, 2012) to health and discrimination, we explored how (ethnic) identity formation, acculturative stress, structural and perceived discrimination interact and relate to substance use in our populations. We intended to map the degree in which participants in our research feel exposed to perceived discrimination and how this relates to their ethnic identity and the nature and patterns of their substance use.

Balanced identity formation is key to psychological stability and can influence patterns of substance (mis)use. Although this is only one possible risk factor, it is worth mentioning that in our four samples we discovered several individual difficulties in defining certain aspects of one's identity and that these stories share some parallel features across the populations.

First of all we should mention that the reasons for migration and the migration experience are often the cause of mental problems such as depression and post-traumatic stress disorder. If these issues are not dealt with adequately, by means of psychological support, they can cause individuals to self-medicate by means of substance use.

Furthermore, the identity constructs in the Turkish community in Ghent and the Congolese community in Brussels are quite similar. On the one hand, all respondents refer to what we might call an imagined community of Turkish/Congolese with specific characteristics. On the other hand, many respondents explain that they do not completely relate to this community because they are "different" in some way or another (because of substance use or other reasons). Still, many of these respondents feel Turkish/Congolese rather than Belgian. Feeling Belgian in this case is mostly related to the formality of having a Belgian passport. In a considerable number of cases respondents account for a certain degree of reactive ethnic identity: they feel Turkish/Congolese rather than Belgian because they do not find access to what they perceive of as "Belgian society" (e.g. education, labour, housing), or because they have had negative experiences of racism and discrimination. Most of the participants describe a dual feeling of relatedness to being both Belgian and Turkish/Congolese.

All except three Eastern European respondents state that they do not feel Belgian at all. Some of them explain that they cannot feel Belgian because they do not speak the language, have not been here long enough or because they do not have a job. Most of these respondents do not feel negative about this. In line with existing theories on first generation migrants, only a small proportion of the Eastern European migrants display reactive ethnic identity formation because of negative experiences with Belgians. Some of the respondents also note that they do not know how to feel, and describe a dual feeling of relatedness to being both Belgian and Bulgarian/Slovakian/Roma.

8.2.4 Social and recovery capital: isolation and social networks

In our literature review we found that bonding capital/embeddedness and relations within the ethnic group can be a protective factor for better self-rated health through risk management and solidarity functions (Kozel & Parker, 1998 in Woolcock, 2000). Nevertheless, bridging capital/embeddedness and relations between ethnic groups outperforms bonding capital when related to self-rated health (Kim et al., 2006), positive civic values (Geys & Murdoch, 2010) and subjective well-being (Hooghe & Vanhoutte, 2010). Furthermore, we introduced Cloud and Granfield's definition of recovery capital (2008) as the internal (individual) and external (ethnic and other group-related) resources that can be drawn upon to initiate and sustain recovery from alcohol and other drug problems.

Two important observations are made in our four case studies. First, we notice that the social network of most participants consists primarily of individuals with the same ethnic background. The asylum applicants, refugees and undocumented migrants are surrounded by individuals with a similar legal status. Second, many substance users, both problematic and non-problematic, tend to surround themselves with individuals with similar use patterns as their own. We can assume that the combination of only having one's own ethnic group as a reference group, in combination with allying primarily to a user group or groups can create double alienation from general society, which causes low recovery capital and is an impediment to finding help when needed.

8.2.5 The urban context and ethnic density

We suggested that the physical living conditions and locations of our respondents might influence their perception of substance use and access to treatment services. To our knowledge, no studies related to neighbourhood ethnic density and health and substance use have been conducted in the Belgian context so far.

Unfortunately, based on our four case studies, we can make no conclusive statements concerning this topic. None of the respondents can, as a community member, be pinpointed to a particular area. Although studies have demonstrated ethnic density in the urban area of Ghent in the Turkish community, a reduction in density in these neighbourhoods has also been documented more recently. Also, some of our respondents had moved neighbourhoods because of social control. Eastern European respondents are situated in smaller enclaves in the city of Ghent but the effect of this on substance and treatment use cannot be identified from our case study. The Congolese participants are very dispersed in and around Brussels.

Lastly, for asylum applicants, refugees and undocumented migrants the atmosphere of living in an open or closed asylum centre, being homeless or living in squatted houses can have an effect on substance use but this is very much dependent on the specific context. Based on the reports of some Eastern European respondents we presume that precarious living conditions also impact this target group. Some undocumented and refugee participants residing in an asylum centre mention that they started using, mostly hashish, with colleagues residing in the same asylum centre, all of whom are awaiting the outcome of their asylum procedure.

8.3 Specific barriers to treatment

The participants mention several barriers to treatment. In the literature review we distinguished between three levels of barriers, at the (1) individual, (2) provider and (3) system and societal level. However, these barriers often overlap in the stories of our participants. In many cases, individual barriers are attributed to societal constraints and/or past experiences with substance abuse or other (mental) health services. Provider-level barriers consist of attitudes of individual health professionals and structural constraints such as budget cuts and policy changes.

Although individual users and substance abuse service providers are independent agents with their own freedom of action, we maintain a sole rational choice theoretical perspective when analysing barriers to health care. In a critical analysis of our interviews we observe that many of the perceived barriers are structural (see *infra*). Most of the barriers mentioned by participants have already been cited when explaining the social mechanisms feeding into substance and treatment use because of the close interlinking of the individual, provider and structural barriers. Those factors are not included in these social mechanisms but are encountered as stand-alone factors, and will be discussed below.

8.3.1 Individual barriers: cultural and religious representations of substance abuse

Research has stated that some people with a migration background have a medically oriented view of substance use (Vandeveldt et al., 2003). We found that this statement needs some nuance. For example, Turkish respondents define problem use by means of physical dependence and seemed to underestimate the social causes and impact of substance dependence. Nevertheless, several mention they have discontinued treatment in specialised psychiatric departments of general hospitals because it was too focused on a medical approach. It appears that several of these negative experiences relate to (general) mental health care rather than to specialised drug treatment. Furthermore, a large proportion of the

Eastern European, mostly Bulgarian, respondents expressed a need for psychological support. Also, a number of respondents in the group of asylum applicants, refugees and undocumented migrants requested psychological guidance.

The search for alternative treatment methods is quite limited in our populations. A small minority of Turkish users mention imams and hodjas when explaining which treatment methods they had already made use of. Also, in the Congolese community we heard second-hand of the intrusion of Scientology-inspired methods of treatment. However, our study confirms that the use of such treatment is similar to the general population's use of alternative treatment as documented by Derluyn et al. (2008) and Oliemeulen and Thung (2007).

8.3.2 Provider barriers

We can only report in a limited way on provider-level barriers. The majority of our respondents have no experience of substance abuse treatment. Furthermore, an in-depth analysis of provider-level barriers would imply in-depth analysis and comparison of data within users, clients in treatment, treatment providers and individual professionals.

A commonly heard critique from participants was that general practitioners are not able to help sufficiently in cases of substance (ab)use related problems. Taking into account that general practitioners are the first medical professionals that people turn to for addiction problems, this statement should not be taken lightly. We will come back to this issue in our recommendations.

The need for cultural responsiveness and transcultural competences among professionals is not a subject we talked about with migrant and ethnic minority users, and they did not bring up the topic themselves. Some Turkish respondents feel that family members are not sufficiently included in treatment, whereas Eastern European respondents and asylum applicants, refugees and undocumented migrants believe that medical issues receive too much attention and they are more in need of psychological support.

During our fieldwork, several key figures in treatment centres confirmed that since they had to dismiss the outreach worker in their centres (e.g. because of lack of funding), the number of migrant and ethnic minority clients had fallen to zero. One staff member mentioned that the number of migrant and ethnic minority clients has reduced drastically since one of the key bridging organisations in the Ghent municipality (the NPO De Eenmaking) ceased to exist in the city's drug scene. Initiatives that lower both the symbolic and physical threshold of substance abuse treatment are urgently needed (Noens et al., 2010; Walleghem, 2013).

Considering that people with a migration background more easily find access to out-patient care when compared to in-patient services (Derluyn et al., 2008), the emphasis on low-threshold initiatives broadens the scope of prevention, treatment and harm reduction in migrant and ethnic minority users. In this sense, outreach work responds to our observation that the needs of people with a migration background (such as psychological support) all too often are not met by health services.

Lastly, there is little expertise on creating accessibility and intercultural policies in substance abuse treatment centres. We barely heard of such targeted diversity policies during our fieldwork. Nevertheless, good practice and expertise on the implementation of such policies do exist, for example in the domain of elderly care and education, but also in substance abuse treatment centres such as De Kiem (Gent), Katharsis (Genk) and De Pelgrim (Oosterzele).

8.3.3 Societal and systemic barriers to treatment

We can only report on societal and systemic barriers to treatment by comparatively analysing the life stories and user careers of our participants to their legal and socio-economic status. Consequently, we ground this part of the report mostly in literature. Derluyn et al. (2011) Missinne & Bracke (2012) stress that people with a migration background (especially those from Turkish, Moroccan and Southern European origin) run a higher risk of depression and chronic stress disorders when compared to the general Belgian population (Suijkerbuijk, 2014: 215). Moreover, Derluyn et al. (2011) stress that there is a significant link between socio-economic status and health on the one hand, and vast socio-economic insecurity for people with a migration background on the other.

These socio-economic (mental) health determinants (A. Kamperman et al., 2003; Knipscheer & Kleber, 2005; Marmot et al., 2008) seem to be underestimated both at client, community and institutional levels. In the life stories of our participants we conclude that their general socio-economic status is more influential than the fact that they belong to an ethnic community or have a migration background, when it comes to both the reasons for substance (ab)use and the perceived barriers to treatment. Including these factors (employment, housing, labour) in dealing with substance (mis)use in ethnic minorities ties in with the health model of Dalghren and Whitehead (Dahlgren et al., 1991) who propose that education, culture, employment and community factors play an important role in (mental) health and consequently substance (ab)use.

Therefore, it is vital to tackle, at a structural level, the disparities people with a migration background are confronted with in education (Agirdag et al., 2011; Boone & Vanhoutte, 2014), employment (Verhaeghe, Van der Bracht, et al., 2012) and the local housing markets (Verhaeghe et al., 2015). Furthermore, undocumented migrants have lower access to the health care system and National Institute for Health and Disability Insurance services (Spoel in Suijkerbuijk, 2014: 76).

Also, the Belgian mental health care landscape and substance abuse treatment services are very dispersed. Vulnerable groups in society have less access to these structures and this affects people with a migration background. In this context Derluyn et al. (2011: 4) identified three more at-risk groups among people with a migration background: irregular migrants and asylum applicants, individuals with mental health problems and women. In our study these groups also seem to be particularly vulnerable to substance abuse and finding adequate treatment.

9 RECOMMENDATIONS

We will divide our recommendations into macro-social (recommendations 1–20) and meso-level recommendations at local policy (recommendations 21–33), treatment (recommendations 34–45), and (ethnic) community (recommendations 46–52) levels. This division allows us to point out some generalisable needs for vulnerable (user) groups and more specifically migrant and ethnic minority users, and the specific needs in treatment and reaching out to people with a migration background. Some of the characteristics of users, substance (mis)use and barriers to treatment as mentioned in this report could well be identified in other vulnerable user groups. The problems vulnerable (user) groups are confronted with are intensified among people with a migration background.

In our recommendations it will become clear that we argue for more integrated care for all patients at all service levels, bringing together services by means of case management and taking the general socio-cultural background of all patients into account. Considering the current European migration flows, the issue of substance and treatment use in people with a migration background will need to be prioritised on federal, local and treatment centre policy agendas. We have based our recommendations to a large extent on the European ETHEALTH project (Derluyn et al., 2011) on fair health policies for people with a migration background and on “Witboek over de toegankelijkheid van de gezondheidszorg in België” (RIZIV, 2014). Furthermore, our recommendations have been fine-tuned by professionals in out-patient services, municipal socio-cultural outreach services, heroin substitution centres and professionals working with undocumented migrants in governmental agencies.

9.1 Macro: system and societal levels

At the federal and community policy levels we propose some recommendations specifically related to countering racism and discrimination, enabling research on substance use and treatment uptake among people with a migration background, creating efficient networks of practice and expertise, fostering information and prevention activities and tackling specific problems in the most vulnerable group of asylum applicants, refugees and undocumented migrants.

1. Creating binding obligations for mental health care and substance abuse treatment centres to pay attention to diversity.
2. Encouraging local networking between services within the framework of PSY 107 projects and reforms of mental health care:
 - Link local heroin substitution centres to one another;
 - enable referral from out-patient heroin substitution centres to in-patient treatment;
 - provide funding for outreach workers in in-patient addiction services;
 - link the reduction of in-patient psychiatry to an extension of frontline services (e.g. community health) to cater for mental health needs.
3. Introducing courses that promote cultural competences as a mandatory part of the education of practitioners in mental health care.
4. Encouraging research into migrant and ethnic minority health status and health care.
5. Combating labour market discrimination and ensuring existing anti-discriminatory legislation in companies is applied.
6. Taking into account the specific educational needs of migrants and ethnic minorities, especially first-generation migrants, but preventing the creation of education ghettos and discouraging the systematic orientation of migrants and ethnic minorities in specialised schools.

7. Identifying migrants and ethnic minorities in a systematic health care register to enable better monitoring, for example by consistently linking data from the social security database *kruispunt databank sociale zekerheid* to the e-health platform.
8. Encouraging public health authorities to join (inter)national networks to promote intercultural health care.
9. Increasing the representativeness of the national health survey in the health care sector by involving and defining people with a migration background.
10. Limiting the impact of austerity measures on the funding of health interventions and specifically drug-related initiatives, drug-related research and prevention activities and on professionals working with vulnerable groups (Suijckerbuyck, 2014: 237) by:
 - eliminating waiting list problems in the Flemish general welfare centres (CAWs) and mental health centres (CGGs);
 - stimulating research on and use of heroin “user spaces”;
 - restarting the Central Registration Points (CAPs).
11. Considering the specific topic of substance and treatment use in migrants and ethnic minorities in the (community) safety contracts and in metropolitan policy.
12. Allocating a more proactive and transversal role for Unia, the Interfederal Centre for Equal Opportunities, so that it can combat discrimination in all layers of the society even more effectively.

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

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

In what follows we formulate concrete recommendations for the levels of local policy-making, treatment, and ethnic communities.

9.2 Meso

Sensitising for social health determinants and enabling access to substance abuse treatment services both in the communities and in treatment will be a necessary step for successful prevention and intervention. This entails improvements to practice and policy at three levels: the local policy level, the treatment level and the community level.

9.2.1 The local policy level

Creating networks and links between treatment centres, social services, families, communities and community organisations is beneficial and can, in the long run, reduce some of the barriers and difficulties mentioned in this report. The creation of local welfare practitioner groups such as *Welzijnsoverleggen* and *buurtteams* in Ghent municipality and thematic, focused networks around a specific problem (such as access to treatment services for people with a migration background) can be useful. Focused needs assessments in delimited areas and populations will be necessary for the creation of successful initiatives (see *infra*). The following recommendations are aimed at sustainably tackling substance and treatment use disparities in people with a migration background by means of local (municipality) policy measures:

22. Creating flexible, proactive, low-threshold, locally embedded intermediary primary health care services (RIZIV, 2014: 12).
23. Encouraging each health professional, health service and socio-cultural service to develop action plans to meet the specific needs of people with a migration background.
24. Sensitising and training general practitioners about substance (mis)use in people with a migrant background, drug treatment services and referral systems, for example by using the “me-assist” tool, working with the expertise of FedAsil and/or the example of CAD-Limburg.
25. Providing an intercultural worker for support in the development of a diversity policy in substance abuse treatment centres to make them more accessible to people with a migration background, e.g. based in the independent municipal integration agencies in Flanders (*Externe Verzelfstandigde Agentschappen*).
26. Developing and providing culturally competent mental health services, especially in urban centres in all the regions of Belgium.
27. Providing adequate information to people with a migration background about substance abuse treatment centres and distributing it via locations where the target groups will find the information (e.g. Public Centre for Social Welfare, Public Employment Service, health insurance funds, local shelter initiatives, etc.).
28. Improving collaborative links and referral between mental health services, street-based social work and socio-cultural organisations.
 - Collaboration between mental health services and social outreach services (e.g. mobile teams and Dienst Outreach Stad Gent, mental health centres, heroin substitution centres).
 - Collaboration between integration (e.g. IN-Gent), social (Buurtwerk & Dienst Outreach werk) and mental health care services (mobile teams, crisis teams and also, e.g., Villa Voortman).

Quantitative analysis in closely knit migrant and ethnic minority networks confirms that interventions and policies that leverage community bonding and bridging social capital might serve as a means of population health improvement (Kim et al., 2006), and that this is specifically true in community mental health services (Priebe et al., 2011). Professionals in treatment facilities affirm that closer contact with the communities might reduce communication difficulties by helping to lift the taboo and by increasing people’s confidence in services (Chow et al., 2010; Meys et al., 2014). More specifically, close contact with community organisations and creating win–win situations between these and social or health professionals and organisations can be used to set up durable relationships between prevention and information initiatives and also to enlarge the perspective of professionals working with these groups.

29. Stimulating the implementation of a dedicated, harm reduction oriented drug strategy with specific attention to people with a migration background.
30. Considering mental health as a main activity and priority of the primary health care services (e.g. Medikuregem).

As has been highlighted in national and international literature, there is an acute need for holistic interventions and co-operation between social and mental health services in urban areas (Laudens, 2013; Rask et al., 2015). We have encountered several of these initiatives, including the recent collaboration between Ghent's social outreach service and the public welfare centre service *OpStap* that aims going in search with ex-users of day-time activities, former NPO De Eenmaking linking Turkish and Moroccan users to treatment centres and out-patient center Villa Voortman, which offers day activities for users with a dual diagnosis. Still, we notice that socio-cultural and mental health outreach services often work parallel to one another when they could in fact be functional communicating bodies. More specifically, these networking initiatives at the local municipal level could include:

31. The creation of a platform for transcultural/culturally sensitive mental health care for knowledge sharing and dissemination, which can also possibly function as a contact point for family members and users.
32. Entrusting the Public Centres for Social Welfare with the social support of clients to decrease the burden on social services in hospitals, for example by means of training employees concerning substance (ab)use related problems and substance abuse treatment services (cf. the expertise in the mental health centre Eklips).
33. Stimulating regular contact with the general practitioner in the target group.
34. More intensive follow-up of users during and after incarceration and treatment (Tieberghien & Decorte, 2008) via the staff of CAPs, judicial assistants, Public Centres for Social Welfare and/or other judicial and medical services.

Additionally, we also stress that harm reduction initiatives such as heroin substitution centres and Free Clinic reach a large number of clients with a migration and/or ethnic background. In addition to being very accessible we should mention that such initiatives are referred to as low-cost and high-impact interventions (HRI in Favril et al., 2015). Nevertheless, these organisations are faced with serious reductions of employees. Therefore we appeal for further investment in these low-threshold harm reduction interventions.

The community advisory board of the Turkish and the Eastern European communities also stress the importance of (1) intensifying collaboration between social and health outreach work, (2) diversifying the staff of outreach services, (3) the existence of "bridging" services such as "De Eenmaking" (see supra) and (4) "psycho-education" within the communities.

9.2.2 The treatment level

Paradigms on health care for people with a migration background are dominated by the culturalism/anti-differentialism debate. The main question is to what extent facilities should recognise and incorporate "the other's" differences in their services (Derluyn et al. 2008: 83). This question can be extended to ask whether the risk factors and determinants for substance use in people with a migration background differ substantially or, on the contrary, if they demonstrate manifold similarities to risk factors when compared to native populations (Viruell-Fuentes et al., 2012).

Noteworthy in this debate is that specialist services (Fountain & Hicks, 2010) and parallel networks (De Gendt, 2014; Verhaeghe, Van der Bracht, et al., 2012) have emerged because

of the historic failure of generic services. Domenig and colleagues (2007) discusses the fact that mainstream services could use the existence of independent specialist services as a justification for not developing their own service responses. Migrant and ethnic minority users rarely see the existence of specialist services as a solution to the services' lack of cultural competence (De Vylder, 2012; Fountain & Hicks, 2010). Still, we should of course acknowledge the usefulness of the temporary existence of bridging services such as Moslim Advies Punt in Ghent.

Derluyn et al. (2008) conclude that services should introduce transcultural awareness at the operational level, not only by means of a single employee with a migration and/or ethnic background, but also by introducing processes at all levels of the facility. Further, the fact that individual determinants of problematic substance use often have a larger impact than cultural determinants should be taken into account in individual care trajectories (Derluyn et al., 2008; De Vylder, 2012: 4–5).

The treatment of migrant and ethnic minority users should not be an isolated action within treatment services, but needs to form an integral part of the “interculturalising” (Van der Seypt, 2013) of substance abuse treatment centres, prevention and harm reduction initiatives. The configuration of residential care and the attitude of professionals in substance abuse treatment could be tackled via intercultural policy measures within the institutions, as in the examples of elder care and educational centres. Such projects have been initiated by, for example, in-patient and out-patient centre De Kiem and Katharsis. We echo the call we have heard several times in the field to create supported platforms, networks and policies for transcultural awareness within treatment and other mental health care centres by means of team training and explicit all-encompassing policy measures within the centres.

35. Structural integration of preventive activities into the existing mental health care services by means of diversity policies.
36. Adopting proactive initiatives to provide comprehensible and adapted information on the health care system for people with a migration background, strengthening especially the role played by the health insurance funds, public welfare centres and trade unions (for Eastern European populations).
37. Increasing the accessibility of, and encouraging collaboration with, interpreters and intercultural mediators.

9.2.2.1 Cultural “responsiveness”

The degree to which service planning organisations and professionals in health care respond to the challenges posed by the diversification of the European population is discussed under many guises. Service providers do generally agree that cultural responsiveness, competence, sensitivity and appropriateness are necessary for meeting the needs of heterogeneous client groups. The diversity in naming this capacity results in a very varied way of putting it into practice.

The employment of staff with a migration and/or ethnic background is one way of dealing with cultural diversity in services. This practice proves to be helpful in understanding some of the client's culturally oriented or grounded needs (such as the importance of family problems in one's life and in addressing specific needs in service planning policies), but also implies a fear of a confidentiality breach and stigmatisation (Fountain & Hicks, 2010). Further, this practice does not answer the cultural capacity needs in service planning of organisations generally.

Culturally responsive organisations are dependent on the majority of staff having the capacity to reach and support individual clients from all layers of society. A greater affinity with and empathy for the situation of people with a migration background is necessary to, on the one

hand, fully understand the specific vulnerabilities of migrant and ethnic minority users, and, on the other, to organise prevention and harm reduction for this group. This implies the need for:

38. Increasing knowledge and awareness of culturally specific components in health care delivery, in an attempt to improve the accessibility of mental health care and substance abuse treatment services to people with a migration background (e.g. based in Trimbos Institute's "Cultuursensitief addendum bij de multidisciplinaire richtlijn schizofrenie").
39. Taking into account, as much as possible, the context of the client in the delivery of health care facilities, especially in specialised psychiatric departments in hospitals.
40. Psycho-education to increase self-reflection as an important instrument in the treatment process (Chow et al., 2010) (e.g. the Mind-Spring project³²).
41. Fostering contacts and networking with community members and socio-cultural organisations by means of stimulating outreach work on the different levels of substance abuse treatment services, but also in prevention and harm reduction services.
42. Involving close family members in treatment, for example by means of multidimensional family therapy (Litle et al. in Alegria et al., 2011), multisystem therapy or triologue therapeutic settings, which could result in higher treatment completion rates.
43. Implementing targeted information and prevention initiatives for reaching hard-to-reach target groups as well as dealing with problems that affect specific groups (e.g. the Mind-Spring project for and by asylum applicants, refugees and undocumented migrants).
44. Taking into account the medical perspective on addiction that some people with a migration background have (Broers & Eland, 2000) may open pathways to more durable treatment solutions for particular users.

Cultural sensitivity should consist of basic knowledge of cultural backgrounds, intercultural communication, acculturation processes and **cultural perceptions of substance dependence** (Broers et al., 2000).

However, cultural sensitivity does not only imply understanding specific cultural traces, such as taboo and stigma. It also implies a greater understanding of the interconnectedness of socio-economic factors, psychosocial stress, discrimination and the migration background (Otiniano Verissimo et al., 2014).

45. Eliminating distrust of treatment centres while building a relationship of trust with the client (especially among stigmatised target groups, e.g. Roma).

Increasing cultural sensitivity can in this perspective be seen in the context of creating more accessible substance abuse services (Jackson et al., 1997), and consequently implies some basic requirements at the structural and organisational level of the services, such as sufficient financial resources, time, staff and service planning. Creating culturally sensitive treatment facilities and interventions not only implies the full optimisation of the staff's competences, it also requires (Van der Seypt, 2013: 101) (1) an integrated policy perspective of the facilities by means of a policy plan on accessibility and diversity (possibly supported at the municipal local level), (2) an organisational environment that appreciates diversity and diversity in society, (3) promoting equal opportunities for all staff members and (3) diversity in the staff members.

9.2.2.2 Targeted initiatives

³² The Mind-Spring project offers psychological support, empowers the target group by including them in the actions and reduces their social isolation

The lack of knowledge about substance abuse treatment services and the effects of substance use are two reasons why migrant and ethnic minority users are under-represented in drug treatment facilities (Derluyn et al., 2008). Some people with a migration background are in contact with very few organisations and count on a limited number of organisations for many aspects in their lives (e.g. health funds and public welfare centres). Therefore, information initiatives, first-line prevention and reference mechanisms in these organisations can be pivotal. General practitioners and public welfare centres are the organisations that were mentioned most in the Turkish and Eastern European populations. Trade unions and their associated health funds were mentioned by many of the Eastern European participants. These could be valuable partners in prevention and referral to treatment.

46. The implementation of targeted information and prevention initiatives for reaching hard-to-reach populations and dealing with problems that affect specific groups, such as the Mind-Spring project for asylum applicants, refugees and undocumented migrants.

9.2.2.3 Local needs assessments

The execution of this study by means of a community-based participatory research design has proven successful at some levels and less successful at others. CBPR has enabled us to include the perspective of the communities themselves as well as experts in the field, and to discuss this taboo topic and raise awareness about the issue among the community researchers. Only the Congolese community seemed to be less accessible when compared to the other communities. Working with co-ethnic researchers should, however, be done cautiously. In assessing the needs and tailoring interventions for people with a migration background, it should be stressed that they do not have the same needs and that these interventions will not have the same impact on all individual group members (Sloboda et al., 2012).

47. The implementation of participative engagement and research methods in future projects and research calls and in local government and social and health care service practice (such as local health care centres). (Favril et al., 2015; Laudens, 2013; Piérart et al., 2008)

9.2.3 The ethnic community level

Although communities and community organisations could take a larger role in sensitising their members to some specific risk factors for substance (ab)use barriers to treatment, the role of these organisations should not be overestimated. Parallel to a UK-based study on substance use in ethnic minorities, we notice that community organisations “see the delivery of drug information, advice and treatment as primarily the responsibility of statutory drug services. [...] This reflects the view among some organisations that their members may object if they became involved in drug service provision.” (Fountain, 2009: 4-5). We primarily observed this phenomenon in the Turkish and Congolese communities. Some recent initiatives could, however, be extended.

48. Prioritising information initiatives about the risk factors for substance abuse (such as marital problems, economic problems, a taboo on addiction, insecurity caused by the asylum procedure or not having documents at all, coping with discrimination, etc.) rather than about substance abuse per se. Mosque associations could contribute to this, e.g. the successful Tupperware formula (Laudens, 2013).

We noticed that the collaboration with Free Clinic and the Mind-Spring project for asylum applicants, refugees and undocumented migrants was less complicated. These organisations do not identify with a specific ethnic group and consequently do not maintain the taboo

surrounding substance use. On the contrary, they share the goal of lifting the stigma and taboo surrounding substance use and treatment.

49. Extending the tasks of the existing emergency telephone helpline of the Muslim Executive in terms of addressing questions about mental health care and substance abuse issues.

By analysing the perspective of Turkish problem users we suggest that the concept of *haram*/forbidden is too static in the Turkish community in Ghent and is directly related to exclusion from religious communities. We therefore appeal for:

50. Opening the discussion in mosque associations and Islamic education as to the interpretation and use of the dynamic concept of *haram* in Muslims' lives.

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10 LIMITATIONS

The CBPR model offers the ambitious possibility of bridging evidence with policy-making and is aimed at tackling health disparities in disadvantaged groups. Following the example of similar research by the Centre for Ethnicity and Health (UK), this design was deemed appropriate for the analysis of substance use service disparities in these groups. This research was policy-oriented and grounded in the fact that people with a migration background are under-represented in treatment facilities both in Belgium (Vandeveldt et al., 2003) and in Europe (Fountain et al., 2004). The greatest challenge in CBPR is to advocate for the participation of community members in all stages of the research cycle (Simon & Mosavel, 2010).

A first difficulty that arose was finding a suitable community organisation in each of the populations. The position of these (ethnic) community organisations in society largely affects the role they can play in this type of research design. In this case, the community organisations received limited to no funding, which made it hard for them to engage in the research project in addition to managing their priority tasks. Furthermore, the organisations showed little enthusiasm for promoting a project on substance use because they did not want to cause the stigmatisation of their communities, and were unwilling to be associated with the topic of substance abuse within the groups they “serve”.

Looking at the methodology of this study, the project made a significant effort to implement CBPR principles. Nevertheless, community researchers are, arguably, best placed to conduct qualitative semi-structured interviews about this topic. Although a nine-hour training session was provided and the project assistants conducted intensive personal follow-up of the researchers, they were not trained sufficiently to tackle the manifold difficulties that are common in conducting this type of research. They appeared insufficiently prepared to put their own normative framework aside during the interview (e.g. they sometimes upheld stigmas and taboo during the interviews) or to stay motivated after dealing with problems such as respondents not showing up, asking for help or being under the influence of substances during the interview. Community researchers also experienced some difficulty accessing interviewees from outside their own peer groups (Salganik & Heckathorn, 2004; Schonlau & Liebau, 2012). As demonstrated in other research (Simon & Mosavel, 2010), this form of “insider” recruitment resulted in not reaching certain subgroups (cocaine and heroin users) as a result of biases on the part of community researchers. Additionally, although community researchers were involved in setting up the interview guide, some did not feel completely comfortable using it and handled it more like a questionnaire.

The shared sense of belonging between community researchers and participants often resulted in participants not sharing everything because of the fear of gossip, or because certain statements were not explained enough during the interview due to a shared understanding (which hampered analysis by an “outsider” researcher). The fact that the participants of this study belong to an ethnic minority is a substantial challenge for the data collection. Ethnographic researchers such as Deutsch (2008) and Hagendorn (2008) point out that people with an ethnic background, especially those involved in gangs and/or substance use, are very sensitive to how they are perceived by others and are easily affected by discrimination or stigmatisation.

A last difficulty concerns back-translating the interviews. Co-ethnics have the advantage of conducting the interview in the mother tongue. However, this has the disadvantage of creating a need for back-translation (Mosavel et al., 2005), which seriously jeopardises verbatim transcription and rich linguistic description (Winchitz, 2006).

The CBPR design is designed to assist communities in effecting social change. The usefulness of this model in the current research context was suggested by the fact that migrants and ethnic minorities are hard-to-reach groups for the average middle-class academic, and because local

needs assessments in this tradition have proven to be useful in defining and tackling specific needs in vulnerable groups (Castro et al. in Alegria et al., 2011). However, the context in which this research took place did not allow us to remain loyal in all aspects to the rationale of the research design. More specifically, serious difficulties were encountered in involving the populations in all phases of the research cycle and consequently in facilitating true engagement and agency.

Engaging communities in both tackling and studying unequal social outcomes is quite complex. The combination of trying to overcome and disentangle the social mechanisms underlying these disparities has been found to be problematic in several aspects. The engagement of community members and community organisations is not value-free: each of the actors involved in this project has ambitions (e.g. changing the community rather than studying it, earning some extra money, analysing scientifically) and preconceptions (e.g. pejorative understanding of substance use). These notions and ambitions do not align well with the ambition of social sciences and policy-oriented research, and this was clearly the case in this study.

Working with ethnic community organisations is especially problematic because it entails focusing on only one ethnic group, while in Ghent, for example, no less than 157 nationalities are distinguished. Therefore, for the matter of enhancing access to substance abuse treatment, it might be more useful to focus, rather, on a locally embedded community organisation such as a local health care centre that serves the majority of residents of a specific neighbourhood, instead of an ethnic community organisation. Participative research in such an organisation could result in a win-win situation both for the neighbourhoods and for the centre, which could make it easier to assemble a community advisory board and engage people in the research, as well as sustainably bring about change.

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11 FUTURE RESEARCH

In Belgium, public agencies are prohibited from collecting data on ethnicity (Derluyn et al., 2011). This hampers the study of substance and treatment use in people with a migration background. Therefore, we appeal for the registration of at least some standardised data about these populations to enable future research. Furthermore, it might be useful to improve the statistical power of the National Health Interview Survey, not only in terms of the studied number of respondents (a number, some argue, that is too low to be representative) but also by administering subgroups of people with a migration background.

In our study we made the specific choice to study four populations. However, studying differences between groups risks overlooking an even greater variation within the group as well as shared characteristics and outcomes across groups. Therefore, we believe future research might benefit from the subdivision of people with a migration background not only by their ethnicity, but also by factors such as their residential status or their language skills. This would ensure that the ethnicity aspect is not over-emphasised in the study outcomes. In this context, Kamperman et al. (2007) state that a rigorous division between people with a migration background who do and do not speak the host country's language in the study of the accessibility of health care could give us new insights. Our study seems to confirm that large differences exist between these groups. Furthermore, distinguishing between generations and resident status might be useful.

Our main emphasis was on the perceptions of users with a migration background. However, our study demonstrates that structural factors such as disparities in health but also employment, housing and education contribute to detrimental health behaviour and possibly to substance use. More research is thus needed on the implications of federal and community (health) policies on people with a migration background.

A large majority of our respondents are over 18 years old. Taking into account that adolescence is a critical stage in the identity-forming process and the initiation of behavioural health problems as substance use initiation (Brooks, 2002 in Alegria, 2011), special attention to this group is needed in future research.

It could be interesting to use longitudinal analysis to reconstruct treatment trajectories of people with a migration background. This could also give us greater insight into how perceived discrimination is dealt with over time, a topic that is currently under-studied.

Our study confirms Kamperman et al.'s (2007) statement that most accessibility problems are concentrated in frontline care (general practitioners). Consequently, a specific study of this type of care might be of use for increasing the access to substance abuse treatment for people with a migration background.

Also, a global mental health assessment of asylum applicants, refugees and undocumented migrants within and outside the reception centres might be useful for targeted mental health initiatives for this group.

Finally, although we agree with Patel (2000) that community engagement and participatory policy-making should be encouraged in community organisations and local governments, and could inform evidence-based policy at the organisational level, it might not be the best tool for studying the issue of service disparities to inform governmental policy. Although working with co-ethnic informants from all layers of society (as opposed to only working with key stakeholders in the communities) is most useful in this type of research, working with them as researchers turned out to be problematic.

Future, participative research in the area of substance use and service utilisation aimed at informing governmental policy in improving service accessibility would benefit from working with co-ethnics as partners and informants, combining various qualitative (participative observation and other fieldwork) and quantitative methods, and needs to be preceded by a systematic review of interventions to uncover what works, for whom, in which context (Pawson, 2006). In-depth qualitative analysis of best and promising practices, in combination with systematically studying interventions aimed at increased accessibility of substance abuse treatment, could inform better policy-making and evidence-based intervention, and can consequently and consistently enable both the studying and tackling of unequal social (service) outcomes.

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DRAFT

ANNEX I: INTERVIEW GUIDE

- Always start the interview with a short introduction to the research.
- This interview guide has several themes. Each of these themes is connected to the substance use of the respondent and the way the respondent copes with it in his or her life (within the perspective of his or her neighborhood, family, belief, self-appreciation, etc.) and the reasons and motivations for going in search of help.
- According to the characteristics of the respondent, different themes can be used as an entrance to open the conversation on substance use, taking into account that this is a sensitive issue. You can choose yourself in what order you go through the different themes.
- It's important to use what we call probing questions to reach the core of the interview:
 - Why do you have this opinion?
 - How come? / What are the reasons you do or don't use treatment or other services? / ... for substance use not being up for discussion? / ... you have a negative view of aid/treatment services? / ... ?
 - Can you give an example of the opinion you just gave? / ... of the feeling you have? / ...?
 - Can you tell me something more about this?
- Based on the questions asked in the interview, we want to get information on the following research questions:
 - What types of substances are being used?
 - Why is the respondent using substances?
 - Which requests for help are not answered for the respondent?
 - What needs exist in the community?
 - What can be done better?
 - What experiences with treatment or aid services does the respondent have?
 - Why doesn't the respondent use particular types of help?
- We want to communicate the answers to these questions to service providers and key figures in the community, to help them cope better with different types of substance use.
- You will notice that there are a few standard questions in the interview; these are to be filled out in the booklet. After the interview you should hand in the booklet to the academic staff.
- You will notice that the word "substances" is often used in this text. Once you know what substances the person is using, you can replace this word by the type of substances that are used (except for the theme "substance use in the community"). We try to avoid the word "drugs" because it has a negative connotation and does not seem to include all substances (sleeping pills, alcohol, etc.)
- If the respondent suddenly behaves different or communicates in a non-verbal way, please write this down in the interview guide, or in your transcription.
- If you consciously choose not to ask a particular question, explain why briefly in your transcript or in the interview guide. If you choose not to talk about a particular theme, it is important for us to know what your motivation is.

Introduction

- This is a research project conducted by Ghent University and the Université Libre de Bruxelles about substance use in ethnic and cultural minorities.
- In this research we are particularly interested in the voice of the communities themselves.
- Anonymity is very important in this research. Your name will not be used in any way, and nobody will know that you have been interviewed within the framework of this research.

- “Substances” is a very broad concept in this research. By using this concept we refer to legal as well as illegal substances. Furthermore, we are interested in problematic as well as recreational use.
- This interview will take about an hour, up to an hour and a half at longest. We will talk about 12 themes. If you don't want to answer certain question this is not a problem.
- If you wish to see the transcript of your interview afterwards you can always ask me or the project assistant (mentioned in the info leaflet)
- The audio record will only be used by myself and the academic staff and will be destroyed after the research.

After the introduction it is important you ask explicitly whether the respondent has any further questions and whether the respondent agrees with the interview. The answer to this question should be recorded and is an informed consent for participation in the research and the use of the information that is gathered, as mentioned in the info leaflet.

PART 1: OPEN INTERVIEW

IDENTITY

Date of the interview

Place of the interview (city, location)

Starting hour of the interview

Gender

Language of the interview

START OF THE INTERVIEW

- How old are you?
- Can you describe the situation of your family?

- Do you live alone, with others, how did you live in your home country?
- Do you have any children?
- Which nationality do you have?

HOW DO YOU SEE YOURSELF?

I'm going to ask you very shortly some questions to help us understand how you see yourself in our society, which people are present in your life, and what is the most important in your life.

- What language do you prefer to speak?
- What language do you use to communicate with your family?
- What language do you use to communicate with your best friends?
 - Why do you use this language?
- What does being a "Belgian"/"Flemish" mean to you?
- What do you think of the Belgians in your neighbourhood?
- What does it mean being (your own nationality/ethnicity) to you?
- What is the nationality of your three best friends?
- Which community do you feel most connected with? (nationality, ethnicity, ...)
 - Why do you feel connected with this community?
 - What does this community mean to you?
 - Is this community present in the city/village where you live?
 - Why? Why not?

ETHNIC IDENTITY (3 statements)

- *Do you feel at home in your "ethnic community"?*
 - *In other words: If you look at how people from your ethnic group live here, is that comparable to your life? If you're in the company of people with the same background, do you feel related to these people?*
- Can you describe what it means to be part of your ethnic community?
 - *In other words: Do you think it is possible to describe your ethnic group? Can you describe your ethnic group? Do you feel like you know enough about the history of your family / community / peers?*
- Do you feel a strong bond towards your ethnic community?
 - *In other words: Do you seek much contact with your ethnic group in everyday life? Do you actively seek out people of your ethnic group?*

GLOBAL LIFE SATISFACTION (5 statements)

- Can you name the three things in your life that are most important?
- Why are those things most important to you?

"Imagine a staircase with stairs numbered from 0 to 10. Suppose we say that the upper step is the best possible life for you and the lowest step is the worst possible life. If the upper step is 10 and the lowest is 0, at which step do you stand?"

(fill out) number:

- Can you explain why you chose that number?
- To what degree are you satisfied with your life?

- In which life domains would you describe your life as (almost) ideal?
- In which life domains would you describe your life as less ideal?
- Do you feel like you have accomplished the most important things in your life?
- What would you change, if you could do it all over again?

PERSONAL SUBSTANCE USE

- Which substances do you know about? Do you use them? In what frequency?

Which substances	Ever used (yes/no)	Age at first use	Used more than 3 times this year (yes/no)	Used in the last month (yes/no)

- What would you tell me about your substance use?
 - Can you tell me more about how you came into contact with these substances?
 - What was your age at that moment, approximately?
 - Under what circumstances was that?
 - Were there people around you (friends, family...) who used these substances?
 - What type of substances did you come across?
 - Was this one single time?
 - How did you feel about that?
- At what age did you start to use these substances more regularly?
 - Which substance do/did you use in a more regular way? How frequently? (per day, per week, usual pattern, maximum, minimum quantity)
 - What circumstances led to this?
 - How did you feel about that?
- In what situations/circumstances do you use substances?
 - Do you use with other people?
 - With whom? Why?
 - Are/were there any circumstances that had an influence on your substance use? (financial, mental, or social factors)
- How do you feel about your own substance use?
 - What kind of feeling does this substance give to your life?
 - What is the function and meaning of this substance in your life?
 - How does your substance use today differ from your use in the past?
 - Would you describe your substance use as problem use?
 - Does your environment (family, friends...) describe your use as a problem?
 - Does your environment in your country of birth describe your use as a problem?
- If there is problem use:

- Do you still know the specific circumstances of it becoming a problem?
- Do you still find it to be a problem?
- When did you realise that it was a problem?
- Are there people who told you it was a problem? Who? In what context?
- What are/were the negative implications of your use? (health, mental, financial, legal and social implications)

SUBSTANCE USE IN THE COMMUNITY

Try to ascertain the relationship between family, friends and the community in the life of the respondent. We will not obtain objective knowledge here, but we want understand the opinions, views about substance use and motivations.

- Does substance use frequently happen in your environment?
 - Do you think this is a problem?
 - And is it perceived/recognised as such within your environment?
 - What is the reaction of your environment to substances?
 - How do they deal with substance use?
- Does substance use frequently happen in your country of birth?
 - Do you think this is a problem?
 - And is it perceived/recognised as such over there?
 - What is the reaction over there to substances?
 - How do they deal with substance use?
- With whom do you talk about your substance use?
 - Do you talk about it with family or friends?
 - Do you speak about this with your family?
 - Do you speak about this with your friends?
 - Are there other people you can talk to?
 - Who can you contact to talk about substance use?
 - What reactions do you get?
 - Do you talk about it with someone from your religious community?
 - Do they speak about this in the religious organisation?
 - Can you speak with someone in full confidence about substance use?
 - Who can you contact to talk about substance use?
 - How do they look at substance use within your belief?
- (If) you say you are religious, how do you see your use from that perspective?
 - How do you feel substance use is perceived within your religion?
 - Do other fellow believers have the same opinion about that?
 - Can / will you turn to your religion for solutions to this issue?

AID

- Have you ever tried to look for help?
 - What was your motivation to seek help?
 - When did you try this and why?
 - Did you find the help you were searching for?
 - What expectations did you have about this help?
 - What were the difficulties you encountered?
 - How did you experience this help?
 - Was it hard to find help?
- Do/did you get support in seeking help from your environment?

- Are there people within your environment who want you to seek help?
 - If yes, about what kind of help are they talking about?
- Did they offer you help themselves, or did you asked for it?
- How do you experience this help?
- (in cases where treatment was received)
 - Did the treatment programme correspondent with your expectations? Why? Why not?
 - Have you completed / continued this “treatment”? Why? Why not?
- (in cases where treatment was not received)
 - Why didn't you use the treatment offer?
 - What do you know about treatment?
 - Why haven't you searched for help / don't you search for help from the treatment or other services? (referring to barriers: both practical barriers and cultural barriers)
- Can you describe the ideal treatment / help?
 - What help that you have ever received has helped you the most? (both within the treatment/care services, and outside treatment/care services)
 - Why was this approach so effective? Which aspects were most helpful?
 - How do you believe that the existing services could be adjusted to correspond to your needs?
- Do you know how substance use is dealt with in your home country?
 - Are there specialised services?
 - If yes, do people use these specialised services?

MIGRATION BACKGROUND

- Can you tell me a bit more about your family and life in your country of birth?
 - Where did you live?
 - In which village did you live?
 - Who did you live with?
 - What was the reason to move?
- Can you tell me more about your migration history?
 - How long do you live in this town?
 - How long have you been living in Belgium?
 - Do you have family living here?
 - If yes, why did you / your family move to Belgium?
- Are you often confronted with your migration background in everyday life?

FAMILY

- Can you tell me something about your family?
 - Do you live with someone?
 - Are you married? Do you have children?
 - Do you consider problems in your family as your own problems?
 - How do you feel in your family?
 - What role does family play in your life?
 - Do you have contact with your parents?
 - Do you have brothers and sisters?

BELIEF OR RELIGION

- Is religion important in your life?
- To what extent is religion important in your life?
 - Do you practise your religion?
 - Is there a representative in the church / mosque / ... that you really trust?
 - Do you see yourself as a member of the religious community?
 - Is it important to you to be a part of the religious community?
 - Do you feel connected to the religious community?
 - Do you spend time with members of the same religious community?

LEISURE TIME

- What do you do in your free time?
 - Do you have any hobbies?
 - Are you a member of an association? Which association? What does this association do?
 - Which places do you frequent most often? (in the neighbourhood, in the city, ...)

NEIGHBOURHOOD AND CITY

- Can you tell me something about your neighbourhood / asylum home ?
 - Which places do you frequent most often? (recreation, shopping, care, family, ...)
 - Why do you live in this neighbourhood?
 - Do you like to live here?
 - Why (not)?
 - Do you feel home in this neighbourhood / asylum home?
 - Why (not)?
 - Is this a safe neighbourhood / asylum home?
 - Why (not)?
 - Are you active in community work or other activities in your neighbourhood?
 - Does your family also live in this neighbourhood? How did you end up here?
 - Which welfare organisations do you know in your neighbourhood?
 - Do you use them?

I think we've covered all topics, do you want to add something?

IDENTITY

12.1.1 Initials	
12.1.2 Age	
12.1.3 Gender	12.1.4 M / F
12.1.5 Language of the interview	
12.1.6 Marital status	Single / Living together / Married / Widow(er) / Living with parents
12.1.7 Number of children	
12.1.8 Nationality	
12.1.9 Nationality of mother & father	
12.1.10 Nationality of grandmother & grandfather	
12.1.11 Ethnic origin	
12.1.12 Education	
Profession of mother (or guardian)	
Profession of father (or guardian)	
12.1.13 Profession in country of birth	
12.1.14 Profession in host country (Belgium)	
12.1.15 Type of residence permit	
12.1.16 Dutch: writing	12.1.17 1 2 3 4 5
12.1.18 Dutch: speaking	12.1.19 1 2 3 4 5
12.1.20 Dutch: comprehending	12.1.21 1 2 3 4 5
12.1.22 City and neighbourhood	

12.1.23 Date of the interview	
12.1.24 Location	
12.1.25 Duration	

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ANNEX II: BOROUGHS IN GHENT MUNICIPALITY

