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# **Migrants, asylum seekers and refugees: an overview of the literature relating to drug use and access to services**

Background paper commissioned by the EMCDDA for  
Health and social responses to drug problems: a European guide

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# **Migrants, asylum seekers and refugees: an overview of the literature relating to drug use and access to services**

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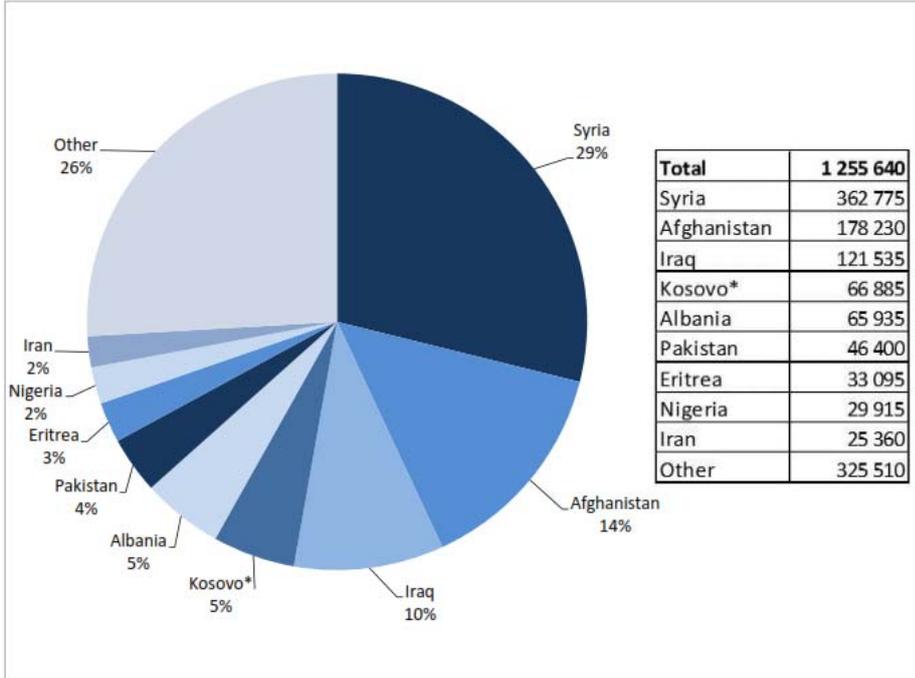
This paper was commissioned by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) to provide background information to inform and contribute to the drafting of Health and social responses to drug problems: a European guide.

This background paper was produced under contract CT.16.SDI.0141.1.0 and we are grateful for the valuable contribution of the authors. The paper has been cited within Health and social responses to drug problems and is also being made available online for those who would like further information on the topic. However, the views, interpretations and conclusions set out in this publication are those of the authors and are not necessarily those of the EMCDDA or its partners, any EU Member State or any agency or institution of the European Union.

**1. Current context: recent migration to the EU**

A beacon of hope to many at its inception in 2010, the Arab Spring has evolved into violent conflicts in several countries, with Syria being the worst-affected. That and several other political, humanitarian, economic and environmental factors have triggered the recent high numbers of migrants seeking refuge in the European Union (EU). Even though the majority of forcibly displaced individuals are hosted in their home countries or within the region (e.g. in Pakistan, Iran, Turkey and Lebanon), nonetheless unusually high numbers of migrants have moved to Europe in recent years. During the recent peak, in 2015 and 2016, over 1.2 million people applied for asylum in the EU in each of these years (Eurostat, 2017a), approximately double the number who did so in 2014, sparking political controversies as European societies struggled to agree on how to manage the migration flow. The migration issue divides European citizens, who have differing views on what constitutes an effective and right response. The recent Brexit vote in the United Kingdom is taken by some to be an example of how migration issues have had a negative impact on the popularity of the EU project as a whole.

**Figure 1: First-time asylum seekers in the EU Member States by country of citizenship, 2016**



\* Kosovo under UN Security Council Resolution 1244/99.

Source: Eurostat, 2017b

During the migration peak in October 2015, more than 200 000 refugees arrived in Greece by sea (UNHCR, n.d.), mainly Syrians, Afghans, Iraqis, Somalis and Eritreans fleeing their home countries because of (ongoing) conflicts that have put strain on domestic asylum systems (FRA, 2016). After the so-called Turkey deal in March 2016, the number of refugees arriving in Greece by sea fell significantly. Ongoing conflicts in Afghanistan, Sudan, Somalia and Iraq, abuses in Eritrea, and poverty in Kosovo, West Africa and Albania are also driving people to leave their homes and countries. In the past four years, most applications for asylum in Europe were made in Germany (1.2 million), followed by Sweden (329 000), Hungary, Italy, France (each around 260 000) and Austria (178 000) (Lucify, n.d.). The

likelihood of having an asylum application approved differs significantly among European countries (Eurostat, 2017a). Some authors assume that this mass movement of refugees creates opportunities for criminals to open a new drug trafficking route. The evidence for this assumption is, however, rather meagre (Van Hout et al., 2016).

In 2015, most first-time asylum applicants in the EU-28 came from Syria (363 000 or 29 % of all applicants). Afghan citizens accounted for 14 % of applicants and Iraqis for 10 %, while Kosovars and Albanians each accounted for 5 % and Pakistanis for 4 % (EMCDDA, 2016). In 2016, the situation was more or less similar, with over half of asylum seekers coming from Syria, Afghanistan and Iraq (see Figure 1). However, some notable changes from 2015 occurred in the applications per EU member state. The numbers of applications in Scandinavian countries and Holland and Belgium were much lower than in 2015. Germany, Greece and Italy had a sizeable increase in applications compared with 2015. Six out of ten applications were made in Germany (Figure 2). At the end of 2016, 1.1 million applications were still pending in the EU as a whole (Eurostat, 2017b).

Historically, the number of asylum applications in the EU has never been as high as it has been recently, although there were earlier peaks in 1992 (672 000 applications in the EU-15 <sup>(1)</sup>), when Member States received many asylum applicants from the former Yugoslavia, and in 2001 (when there were 424 000 applications in the EU-27 <sup>(2)</sup>). By 2006, however, the number of asylum applications in the EU-27 had fallen to just below 200 000.

Even leaving aside the recent migration peak, it is worth mentioning that, since 2007, several EU countries have been dealing with significant intra-European migration flows that also pose serious challenges for European drug treatment and general health policies.

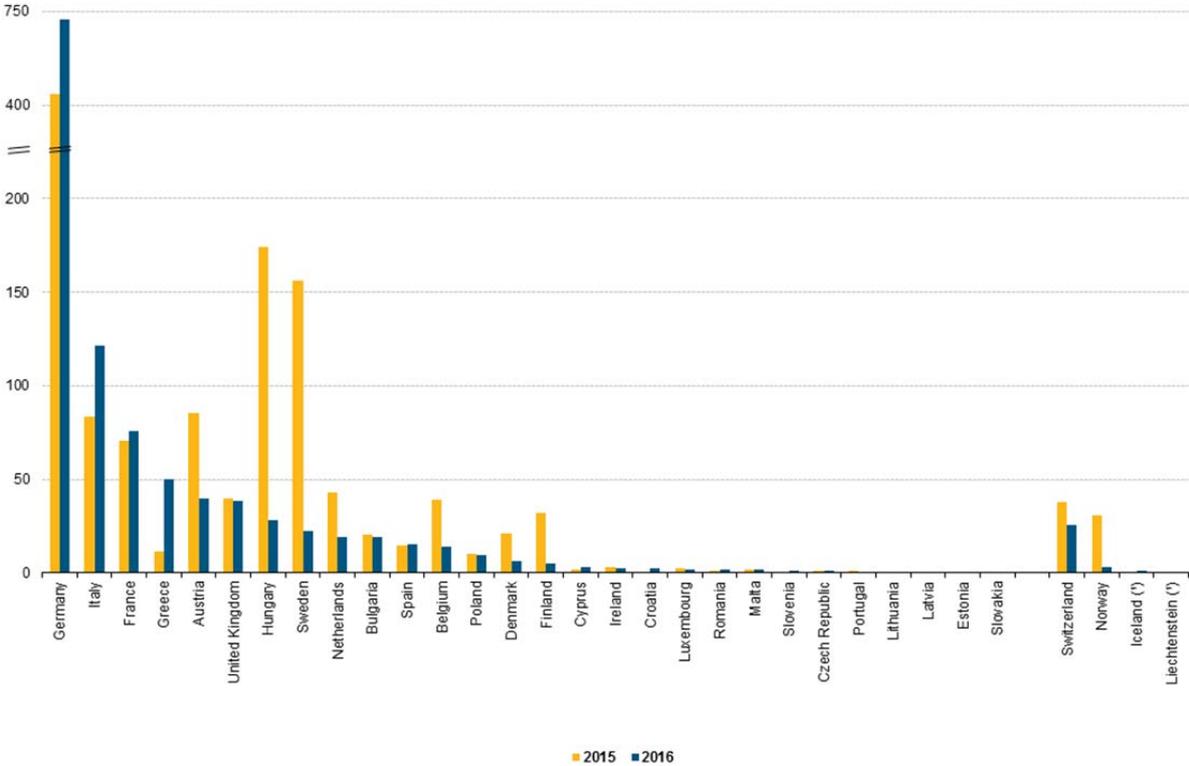
It must be considered evident that the validity of research on migrants in the past is limited when applied to the current population of asylum seekers. Period and cohort effects and differences in cultural values and practices, as well as reasons for migration, may affect the generalisability of past research on health, healthcare utilisation and drug use. Other reasons for a lack of external validity are the use of varying instruments and questionnaires, and differences in the registration procedures for people with a migration background across EU Member States.

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<sup>(1)</sup> <http://ec.europa.eu/eurostat/statistics-explained/index.php/Glossary:EU-15>

<sup>(2)</sup> <http://ec.europa.eu/eurostat/statistics-explained/index.php/Glossary:EU-27>

Figure 2: Number of (non-EU) asylum seekers in the EU and EFTA Member States, 2015 and 2016 (thousands of first time applicants)



Note: the y-axis is interrupted with a different interval above the interruption from that below it.  
 (\*) 2015: not available.  
 Source: Eurostat (online data code: migr\_asyappctza)  
 Source: EMCDDA, 2017a ([http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum\\_statistics](http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics)).

**2. Definitional issues: migrants, people from ethnic minorities, asylum seekers, etc.**

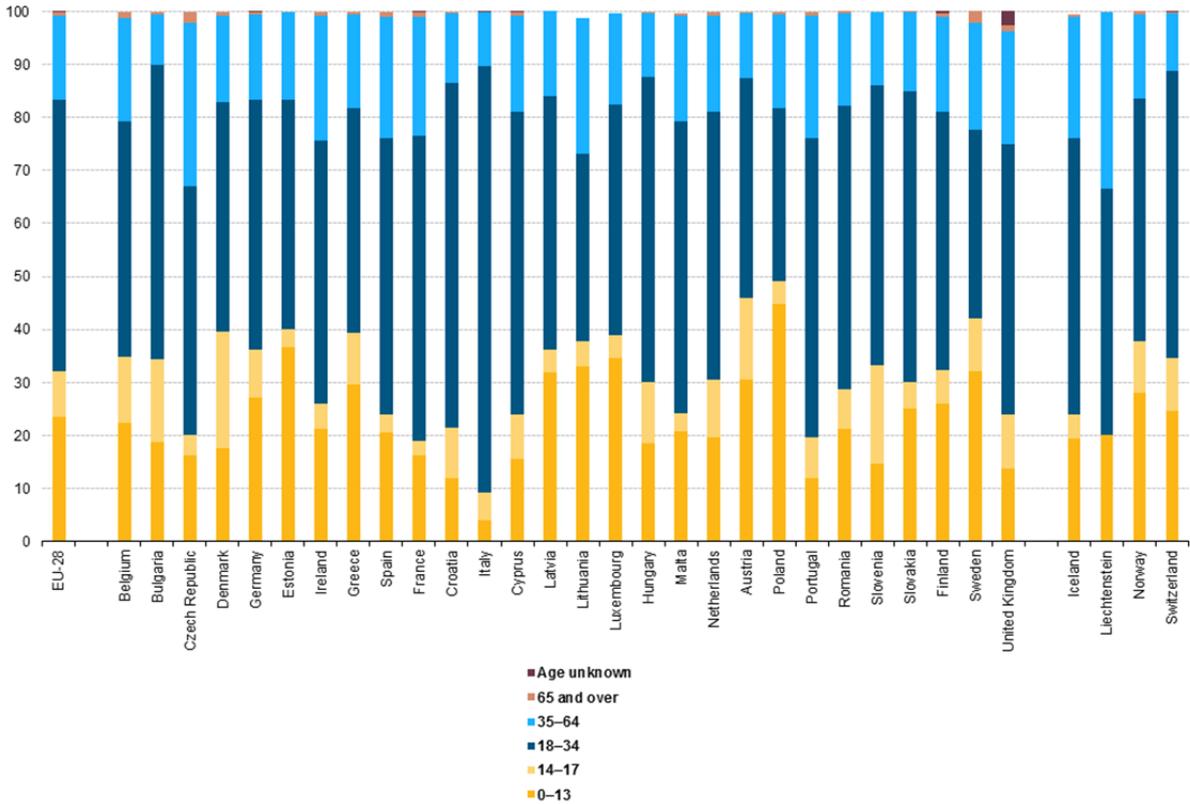
When describing the health issues of people moving to Europe, it is important to define or describe more clearly the different categories of people covered by the term ‘migrant’. Research studies refer to and cover several categories of migrants, such as immigrants, economic migrants, labour migrants and student migrants, refugees, internally displaced persons, unaccompanied minors, *sans-papiers* (undocumented migrants) and asylum seekers. In this report, the main focus is on the category of migrants who are fleeing from persecution, seeking international protection and in the process of claiming their refugee status. Without going too deeply into legal definitions, ‘international protection’ refers to a legal status given by a state on its territory to a person unable to live safely in his or her country of residence, in particular to those in fear of being persecuted for reasons of race, religion, nationality, membership of a social group or political opinion. The objective of the Asylum Procedures Directive (Directive 2013/32/EU) was to establish common procedures for granting and withdrawing international protection across Member States. Legally, a person who has received international protection in one EU country is considered a refugee, a legal status based on the 1951 Refugee Convention (Hondius et al., 2000). Under EU law, a person’s right to access healthcare services varies depending on their legal status (see

Section 6). A relevant legal distinction in this respect is made between an applicant, a refugee and a person in the situation of ‘withdrawal of international protection’. Data about applications for international protection and on decisions taken on such applications are published by Eurostat.

Countries define migrants (not necessarily specifically asylum seekers) in many different ways, such as by country of birth (of the person or of one of their parents), nationality or duration of stay (Rechel et al., 2012). This renders the monitoring and comparison of research and statistics on health problematic. Furthermore, a focus on asylum seekers or applicants, as in this report, limits the available data considerably.

Most recent asylum seekers are relatively young. In the EU, just over 80 % of first-time asylum seekers in 2016 were younger than 35 years old, with over half being between 18 and 34 years old; in Italy, the percentage of asylum seekers in this young adult age range was as high as 80 % (Eurostat, 2017a). Over 70 % of all applicants are male (Eurostat, 2017a) (see Figure 3).

Figure 3: Distribution by age of (non-EU) first time asylum applicants in the EU and EFTA Member States, 2016 (%)



Note: due to the use of rounded figures in these calculations the sum of all age groups does not always equal 100 %.  
 Source: Eurostat (online data code: migr\_asyappctza)

Source: Eurostat, 2017a

### 3. Health status of asylum seekers

Not all people under serious threat in their country are able to travel. As shown in Figure 3, over half (51 %) of asylum seekers in the EU in 2016 were young adults, while about one third were children (under 18 years of age) (Eurostat, 2017a). The relative youth of migrants is one reason for what is known as the ‘healthy migrant paradox’: most migrants are in relatively good physical and mental condition, particularly as regards chronic conditions (Mladovsky, 2007). However, asylum seekers are a specific group in which the healthy migrant effect may be reduced owing to the situation from which they needed to flee, their journey and/or unwelcoming host societies.

Owing to the (often) dire living circumstances in refugee camps and conditions on migration routes, infectious diseases such as tuberculosis, hepatitis A infections and injuries seem to be more prevalent among asylum seekers than other migrant groups. Many asylum-seeking children are not vaccinated, as children resident in the EU are, against, for example, measles, meningitis, polio and diphtheria. However, a Dutch study concluded that the rates of infectious diseases were no reason for alarm (van Duijnhoven et al., 2016). In addition, it is important to note the wide variation in health indices among asylum seekers of different ethnic backgrounds. For this reason, generalisation may be problematic. One has to keep in mind the lack of data on recently arrived asylum seekers, and the fact that most data on health status and healthcare access date from before the 2014 immigration developments <sup>(3)</sup>.

### 4. Asylum seekers’ drug and alcohol use

In a systematic review on alcohol use among forcibly displaced persons, Weaver and Roberts (2010) concluded that ‘the evidence base was extremely weak, and there is a need to improve the quantity and quality of research about harmful alcohol use by forcibly displaced persons’. In their study, they found only 10 studies that met their criteria (i.e. provided specific data on forcibly displaced persons), with only one study reporting on a sample of internally displaced people in Europe, dating back more than 15 years (to the time of the Yugoslavian crisis). In fact, most studies identified in the search carried out for this report found a similar lack of data and problems with data collection on migrant and/or ethnic groups. The main problems noted were that these groups were poorly mapped and too heterogeneous to enable generalisations about addictive behaviour. Furthermore, there seems to be a need to further differentiate subcategories according to migration background.

In the literature, several circumstances have been noted that could make migrants more vulnerable to substance use or misuse. Traumatic experiences, unemployment and poverty, loss of family and social support, and a more lenient normative setting have been named as factors in alcohol and drug use. Horyniak et al. (2016) found that drinking to cope with trauma, drinking to cope with boredom and frustration, and drinking as a social experience

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<sup>(3)</sup> More information on European action on health inequalities can be found on the website of Chafea, the Consumers, Health Agriculture and Food Executive Agency of the European Commission: <http://ec.europa.eu/chafea/news/news448.html>.

were important drinking motivations for African migrants in Australia. In a commentary, Pearce et al. (2004) convincingly argue that the social situation of migrants and people from ethnic minorities, and the differences between immigrant groups or groups with specific ethnic backgrounds, are more important determinants of health outcomes than genetic or 'racial' make-up. In terms of Zinberg's trilogy of 'drug, set and setting' (1984), research seems to indicate that setting factors are more important than set factors in explaining the drug and alcohol use patterns of migrants.

Research studies provide a mixed picture, reflecting the diversity of groups and situations studied. On the one hand, some found high levels of cultural or ethnic identity, particularly as in being of 'non-Caucasian' descent, to be associated with heavier drug use (James et al., 2000). Conversely, being a devout Muslim seems to be a protective factor when it comes to substance use and misuse (Dupont et al., 2005). Moreover, the time spent in hostile conditions in the host country after migrating was found to be associated with increased drug use. Additionally, children of parents who were less well acculturated or integrated than they were found to have higher risks of juvenile drug use and misuse. (Alaniz, 2002; De La Rosa, 2002; Caetano and Clark, 2003; Salant and Lauderdale, 2003). The increased vulnerability of people from ethnic minorities to becoming involved in illicit drug use is often found to be aggravated by poor knowledge about and access to drug treatment services (Fountain et al., 2004). A lengthy procedure for obtaining a permit to stay can be associated with a higher use of mental health and drug addiction services; however, the use of health services seems low compared with the prevalence of psychiatric disorders (Laban et al., 2007). The availability of specialised staff and treatment services is limited, as is that of screening procedures (FRA, 2017).

Alcohol and drug use depend on, among other things, motives and purposes for migration, whether or not people have lost their family leaving their home country, whether or not they have lost possessions and status, and the experiences they have when integrating into a new culture in terms of language, employment, access to care and the nature of that care (Westermeyer, 1996; Spooner, 2005).

In general terms, people from ethnic minorities were found to drink less alcohol than the majority population. There seems to be another 'refugee paradox' here: although refugees experience more mental issues, they are substantially less likely than native-born refugees to develop problems with alcohol or illicit drug use (Salas-Wright and Vaughn, 2014). Ethnicity and alcohol and other drug use do not have a straightforward or uni-directional relationship, however, and multiple differences between different ethnic groups can be observed (Dupont et al., 2005).

In the research literature, as is not uncommon generally in research on substance use, the concepts of substance or drug use, problem use, and misuse are not very well defined or clearly operationalised.

## 5. Risk and protective factors

In the current migration situation, the risk and protective factors in Table 1 may interact in complex ways to produce the varying use pattern of individuals. Migration background and type of substance used will probably affect the influence of those risk and protective factors.

**Table 1: Risk and protective factors**

<b>Risk factors</b>	<b>Protective factors</b>
Being single	Being a devout Muslim
Coming from an alcohol culture (e.g. Yugoslavia), a khat culture (e.g. Somalia) or an opium culture (e.g. Iran)	United with family
Boredom, unemployment	Integration into the new society in terms of language, employment or other activities
Traumatic experiences	Good physical and mental condition
Poverty	Early identification of mental health needs and availability of psychosocial services
Poor knowledge about treatment services	

Sources: Westermeyer, 1996; James et al., 2000; Fountain et al., 2004; Pearce et al., 2004; Dupont et al., 2005; Spooner, 2005; Mladovsky, 2007, Horyniak et al., 2016.

Some of the differences in risk of developing substance use problems may result from genetics (Edenberg, 2007), but they are more likely to result from aspects related to cultural, religious and ethnic identity. Strong feelings of ethnic identity, sustained religious values or strongly maintained family habits may discourage alcohol drinking, yet in such cases the risk of involvement with alcohol increases following societal integration processes (Hurcombe et al., 2010).

Although prevalence is relatively low (Salas-Wright and Vaughn, 2014; Haker et al., 2016), forced migrants may be at risk of substance use disorders for reasons including coping with traumatic experiences, comorbid mental health disorders, acculturation challenges, and social and economic inequality (Lindert et al., 2008). Drug and alcohol use patterns often reflect standards, values and traditions from the country of origin (Westermeyer, 1996). A decade ago, Dupont et al. (2005) hypothesised that, post migration, the cultural practices and expectations of the country of origin tend to continue in the host country, and that these factors are more significant than past trauma in accounting for alcohol and drug use patterns in the asylum seeker population. However, practices usual in the home country may not be sustainable in the new European context. Living circumstances, the availability of the substance in question and changes in the structure of everyday life may impose a change in use practices that in turn may lead to consequences differing from those that would result from continuing the practice in the home country.

The most important setting factors seem to be the boredom and the uncertainty about their application for refugee status that characterises life for asylum seekers in their new home countries (Dupont et al., 2005). Boredom and unemployment, together perhaps with undiagnosed depression, may cause asylum seekers not only to continue patterns of drug

use brought from their home countries but also to intensify them. An obvious example of this pattern can be found in Somali khat users moving to Europe. Khat use is popular among Somali refugees (its use is minimal among second generation Somalis). Problems related to khat use, although fairly uncommon in Somalia, begin appearing because users have to change their habits. Owing to the availability of a fresh supply of khat leaves later in the day, users may start much later in the day than in Somalia, where khat use is more integrated into daily routines. They may stay up all night using khat, with few direct social consequences, since many are not working, sometimes resulting in grave physical complications (Corkery et al., 2011). This change in, and sometimes intensification of, a traditional pattern has also been observed in opium-using Iranians (Dupont et al., 2005). When these users move to Europe, traditional Iranian opium practices have to be adapted to market conditions in countries where heroin is more easily available than opium. While few of these asylum seekers used heroin in Iran, traditional opium users are vulnerable to becoming heroin users in Europe, where they have more limited access to opium. This involves a greater risk of drug dependence and greater utilisation of addiction care. Another example of a culture-specific adoption pattern of substance use is described in a Swedish study of Afghan refugees aged under 18 (Reza, 2014). Tobacco and drug use were found to be higher than among the reference Swedish population, but alcohol use was much lower.

## **6. Access to healthcare**

The aforementioned study by Rechel et al. (2012) noted that limited formal registry data on healthcare utilisation by migrants are available in the EU. Nielsen et al (2009) found that hospital data, including data on mental health admissions, were available in 11 countries, but even in this batch direct comparisons were problematic because of the diversity in the definitions of migrant status. Even fewer countries collected data on care in outpatient settings, which are important for a general assessment of access to mental healthcare.

Until a few years ago, newly arriving or undocumented asylum seekers were usually entitled to healthcare only in case of emergency, acute disease or pain. Cuadra (2011) noted variations in the services provided, however, with 10 countries providing not even emergency care to undocumented migrants.

Recently, under Article 19 of the Reception Conditions Directive (Directive 2013/33/EU), asylum applicants have become entitled to necessary healthcare, which must include at least emergency care and essential treatment for illness, as well as necessary medical or other assistance for those who have special needs.

Healthcare entitlements for those who have not submitted an asylum application is regulated at national level. In 2011, the European Union Agency for Fundamental Rights (FRA) published an overview of such healthcare rights under national law in the then 27 EU Member States (*Fundamental rights of migrants in an irregular situation in the European Union* (FRA, 2011a)), outlining in a separate report practical obstacles that migrants may face in accessing those services (FRA, 2011b). FRA has also published a report concluding that 'providing timely access to health screening and treatment [is] cost-saving compared to providing medical treatment only in emergency cases' (FRA, 2015).

Dauvrin et al. (2012) report that the Ethnicity and Health (ETHEALTH) group established by the Belgian government formulated 49 recommendations to the public authorities to reduce health inequalities affecting people from ethnic minorities (not necessarily asylum seekers or refugees). The ETHEALTH group argued that many improvements are possible and feasible, even when 'migration issues are sensitive'.

A Dutch study noted that newly arriving asylum seekers had more mental health problems than refugees (migrants with a formal status), yet utilisation of care was similar (Gerritsen et al., 2006).

A Europe-wide study on depression in migrants showed that immigrants and people from ethnic minorities experience more depressive symptoms than non-immigrants in several countries (Missinne and Bracke, 2012). Socioeconomic conditions and experiences of ethnic discrimination are important risk factors for depression. A striking result was that migrant status seems to be irrelevant once the other risk factors are accounted for.

After acquiring official refugee status, refugees in most EU states have the same access to healthcare as other residents. However, some studies report lower rates of healthcare utilisation, particularly with regard to mental healthcare (Lindert et al., 2008). This low healthcare utilisation results from a lack of knowledge of the healthcare system in the host country. However, low levels of cultural competency and a lack of language and general communication skills are also often seen as the main reasons for this under-utilisation, alongside general characteristics such as being female, older and poorer. Higher levels of acculturation and lower levels of cultural traditionalism seem positively related to use of mental healthcare services (Laban et al., 2007; Lindert et al., 2008).

A recent Dutch report, based on three different sources, concluded that the objective and subjective health of asylum seekers is lower than that of the residential population, a gap that widens with age (Treurniet and van Oers, 2016). Physical healthcare utilisation was higher among asylum seekers, but mental healthcare utilisation did not differ. Interestingly, subjective health seemed to increase during the years after acquiring refugee status.

A systematic study (Fazel et al., 2005) found that more than 90 % of all migrants with potentially traumatic war experiences seem to cope well with this. About 9 % developed post-traumatic stress disorder.

## **7. Responses and preventive interventions**

Drug policies in EU Member States are of a general nature and do not specifically target migrants' or asylum seekers' use of substances.

Perhaps the only exception is khat. Based on results from a study instigated after complaints from within the Somali community, the Dutch government decided in 2013, as one of the last governments in Europe to do so, to introduce a legal ban on khat production and trade. An evaluation in 2015 concluded that, compared with the situation at baseline, overall khat use had declined; however, problematic use had increased (Korf et al., 2015; Nabben and

Korf, 2017). Other consequences of the ban were a tenfold increase in price, a decline in quality (associated with a shift from fresh leaves to use of dried leaves or khat powder), and an increase in alcohol use. The authorities reported, furthermore, that trade had become less transparent. Before and after the ban, the most prevalent problems were family disruption and sleeping problems. After the ban, heavy khat users reported financial issues. The decision to ban the khat trade fits in with the typical western response to drug use. It is also an example of how a traditional practice becomes untenable after migration. Prohibition and curtailing availability obviously affects use, but the questions remain of whether or not such measures are necessary and whether or not they are the most effective means of preventing negative consequences.

Khat has been criminalised also in the United Kingdom, against the advice of the Advisory Council on the Misuse of Drugs (ACMD, 2013). In its report, the Council recommended not changing the status of khat to a controlled substance under the Misuse of Drugs Act. The Council recommended including khat in local needs assessments, as well as in local generic substance misuse education and prevention initiatives, and providing culturally specific and tailored treatment responses.

In a critical discussion of the discourse on khat use in Scandinavia, Nordgren (2015) notes that khat misuse is associated with unemployment, lack of integration and relationship issues among Somali immigrants. In the study, he analyses material from six projects, arguing that 'an overreliance on cultural explanations overlooks socioeconomic issues and that the focus should be on potentially problematic patterns of khat use rather than Somali immigrants in general'.

A recent European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) study on drug prevention found that not all EU countries had developed specific interventions targeting minority ethnic populations, as suggested by the EU drugs action plan for 2009 to 2012 (EMCDDA, 2013). The motivation for the interventions that were implemented was to increase awareness of the specific vulnerabilities of these groups and the greater extent of social exclusion and marginalisation in them. Interventions consisted of information provision on drug use, on its risks and on drug and alcohol treatment services, often using peer educators. A later report presented prevention profiles of the Member States, with preventive efforts targeting migrants mapped as very extensive (Cyprus, Luxembourg and Norway), extensive (Croatia, Germany, Greece, Italy and the Netherlands), limited (Austria, Belgium, the Czech Republic, France and the United Kingdom) and rare (Bulgaria, Estonia, Ireland, Latvia, Lithuania, and Slovakia) (EMCDDA, 2015). Most often, efforts are aimed at preventing young people using substances. Ploeg (2015) summarised the problems with the implementation of specific policies mentioned in Reitox country reports to the EMCDDA: the lack of a general policy addressing specific migrant health issues; cultural barriers, as evident in language problems and differing understandings of addiction; and staff readiness and competence to work with immigrants. More general issues raised were a lack of resources, a lack of information on migrants' drug and alcohol use (i.e. a lack of monitoring), and a lack of efforts to ensure migrants' integration.

## 8. Implications for policy and practice

A conclusion that can be drawn is that substance misuse is not prioritised in delivering healthcare to newly arrived asylum seekers. Rates of substance use are generally low, although the diverse backgrounds of asylum seekers and migrants generally make it difficult to paint a full picture of the situation regarding substance use and misuse among these groups. The limited availability of mental health and addiction services for traumatised or otherwise mentally ill asylum seekers is obvious. Several studies and commissions have suggested improvements in terms of access to healthcare, screening for mental health problems and training staff.

The issues raised in this report and that by Ploeg (2015) demonstrate a need for further information and research on tailored treatment and prevention efforts. Research should investigate the hypotheses presented here about how practices, cultural expectations and use patterns of the country of origin and the host country interact post-migration.

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