REPORT

BEYOND BORDERS: EXPERIENCES OF MIGRATION, DRUG USE, HEALTHCARE AND SUPPORT

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Content

Executive summary

Aim and objectives

The overarching aim of the SEMID-EU project is to enhance the well-being of Persons with a Migration background Who Use Drugs (PMWUD) and live in vulnerable situations and to mitigate associated risks and harms. Part of the project aimed at developing an inclusive understanding of local needs and responses in the cities of Amsterdam, Athens, Berlin and Paris, using a Community-Based Participatory Research (CBPR). The CBPR approach included interviews with PMWUD and focus groups with professionals working with the target population.

We tried to identify current and future challenges and good practices in the field of migration and drug use in the EU, based on case studies in four selected capital cities: Amsterdam, Athens, Berlin and Paris. These cities were selected as they host a high diversity of vulnerable persons with a migration background who use drugs (Lemmens, Dupont, & Roosen, 2017). Paris and Amsterdam are for long known as multicultural melting pots, while Berlin and Athens have seen a huge influx of new migrants in the past decade. Hence, these EU capital cities are confronted with the growing presence of diverse groups of PMWUD that face various forms of ill health and encounter limited access to essential harm reduction and drug services. Following research questions will be addressed:

- What are the needs of vulnerable persons with a migration background who use drugs in the selected cities?
- What are core challenges and good practices in the field of migration and drug use in these cities?

Methods

The study applied a CBPR approach consisting of semi-structured interviews with vulnerable persons with a migration background who use drugs (n=98) in the cities of Athens, Paris, Amsterdam and Berlin (20-30 interviews per city) and focus groups in each city with a range of service providers.

Community-based participatory research is a participatory research method that involves all partners in the research process equitably and works with the unique strengths that each partner brings (Collins et al., 2018). From the start to the end of the research process, a team of trained academic, local (practitioners working in the area of harm reduction for PWUD in all 4 cities) and community (peer) researchers collaborated closely. During a three-day CBPR workshop in Ghent, Belgium, the local researchers were trained to perform CBPR research, coordinate and execute the research in their cities, conduct focus groups and train community researchers to conduct interviews. All local and community researchers received a compensation for their time invested in the research.

Participants were recruited by means of purposeful sampling, using a combination of community gatekeepers, venues-based sampling and snowball sampling. Across the four cities, a total of 98 participants were interviewed from 43 different countries of origin and 45 different nationalities. Most participants identified as cisgender men. Eight cisgender women (all Russian-speaking) and two transgender women also participated. Interviews lasted approximately 30-40 minutes and focused on migration background and status, living situation, substance use, physical and mental health, support needs, use of services and encounters with criminal justice and law enforcement. Interview data were transcribed verbatim from the original interview language, translated to English and analyzed thematically by the academic researchers.

In the second phase, focus groups were conducted in each city with a multidisciplinary group of professionals who have experience in working with PMWUD. The focus groups were conducted by the local researchers and focused on support needs, available services, barriers and areas of improvement in supporting PMWUD. Focus group data were translated and transcribed verbatim to English by the local researchers, after which the academic researchers conducted a thematic analysis on each focus group discussion to identify the main themes and topics discussed. The findings were shared with the local researchers, who provided feedback.

Main findings

To understand the specificity, depth and interrelatedness of the findings, we recommend the reader to browse the results of the interviews in each city in the full report and to approach the results with the heterogeneity of the population of PMWUD in mind, both within and between cities.

Many PMWUD who participated in this study were living in precarious situations of **homelessness**, which was mentioned as the main reason for continued substance use, constant cause of distress and a barrier towards legal documents. However, to get access to stable housing, a residence permit is often required. Some good practices of housing for undocumented PMWUD were mentioned in Berlin and Paris. This becomes apparent from the relatively low number of PMWUD living on the streets in Paris, since the social housing program Assore enables PMWUD to reside in a hotel. These differences may also be linked to the composition of the study samples. In Amsterdam, most participants from Maghreb countries were living in more stable housing situations, and it goes without saying that many people from the open drug scenes in Athens were homeless. Several participants occasionally stayed in night shelters, but these shelters were also described as temporal (only in winter or only for a limited number of nights) and insufficient (a place to spend the night, but not a home). Nevertheless, the living situations of study participants indicate that homelessness has a severe impact on PWMUD's future perspectives and may induce a vicious circle of homelessness, unemployment, substance use, health issues, ...

Having a **social network** to rely on came to the fore as an important resource of support, also for finding housing. Yet, study participants have very limited social networks, since their family is often abroad and they are socially excluded due to distrust of others and substance use, homelessness and related stigma within communities and society as a whole. Since it is difficult for PMWUD to rely on own social networks for help on multiple domains, they more often need to rely on services for help. As a consequence, the focus group in Paris mentioned the importance of including community workers in harm reduction services and offering service users a 'place to be' within their community.

A positive finding was the extent to which **basic needs** like hygiene and food were fulfilled among most PMWUD in the four capital cities. Services manage to cover basic needs by offering them places to shower, access to meals or food tickets (Paris). In wintertime, a substantial number of study participants could stay in winter shelters, but at the same time the challenges and stress related to the conditions and temporality of these shelters is a serious issue in all cities.

While equal access to health care is a fundamental right of all human beings, all focus groups mentioned barriers towards **health care** for many PMWUD, such as the lack of legal documents (residence permit, health insurance), stigma and misinformation among health care providers. Many PMWUD had many medical needs, often related to substance use and homelessness. The lack of insurance as a barrier towards health care was often mentioned, although many participants could rely on harm reduction services for urgent medical needs. Most participants had been screened and, if the test was positive, treated for infectious diseases such as HIV, hepatitis and tuberculosis. Regulations with the intention to ensure access to screening and care for infectious diseases clearly pay off.

PMWUD frequently make use of **OAT** in all four cities, but Athens. In Amsterdam and Paris, OAT was available to PMWUD, even to those without official residence or identity documents. In Amsterdam, however, waiting lists may keep PMWUD from accessing OAT. In Berlin, this is not the case and there is an organisation that is able to offer OAT to undocumented migrants. In Athens, OAT is not available for undocumented migrants. Several PMWUD described how OAT had helped them to reduce harmful substance use. Additionally, take-home OAT was mentioned as a prerequisite to be able to work, reducing financial needs and the risk of criminal activities. In Athens, OAT was mainly targeted at reducing substance use and working toward sobriety, whereas in the other cities it was more linked to harm reduction on a personal and societal level such as safe drug use and crime reduction. Also, a few PMWUD asked for specialised abstinence-oriented drug treatment, but this is generally not accessible for undocumented migrants. Culturally sensitive and linguistically accessible information on safe drug consumption was further mentioned as important for newcomers by interviewees and professionals.

While many participants struggled with mental health problems across all four cities, the extent to which **psychological support** was experienced as helpful differed. Moreover, the extent to which participants needed specialized support regarding mental health problems also depended on the root causes of these mental health issues (e.g. precarious living situations, trauma, migration process). Substance use was mentioned as a coping mechanism for dealing with psychological problems. Depending on the root causes of psychological problems, culturally and linguistically relevant specialised psychological support should be provided.

Many PMWUD indicated that they wanted to **work**, but that they could not do so due to homelessness, substance dependence (or lack of take-home OAT) or the lack of a work permit. The focus groups further revealed vicious circles of unemployment, homelessness and drug use. Hence, there is a clear need to decrease barriers towards employment for PMWUD.

Although the majority of participants faced several **legal barriers** toward health care and support services, having an asylum or refugee status, as well as having a permanent or temporary residence status significantly decreased these barriers. Yet, a temporary residence permit was often lost or expired, indicating the instability and temporality of the resources that persons with a temporary residence permit can access. Ukrainian participants who migrated due to the Russian invasion had either a temporal or permanent residence status. In Berlin, Ukrainian PMWUD had access to antiretroviral therapy and OAT, in contrast to some other intra-European migrants. Indeed, research has shown that Ukrainian migrants were generally better welcomed in EU countries than other intra- or extra-European migrants, with easier access to support related to housing, child care and financial support. This double standard has led to frustrations among other refugees who did not experience the same hospitality and opportunities. Yet, the way Ukrainian refugees have been received can also be an example of a good practice that should be further investigated.

In general, it became clear that PMWUD face many barriers towards exercising their basic rights and building a hopeful future. They generally do not want to go or cannot go back to their countries of origin for the reasons that they left their country (war, political prosecution or non-acceptance due to substance use, sexuality or other normative deviations and familial, vocational or financial hardship), in combination with new concerns regarding their living situation, stigma and lack of legal documents. By complicating the opportunities for PMWUD to build up a meaningful future in the countries they stay in, vicious circles of drug dependence, homelessness, unemployment, financial hardship and related crime are perpetuated. Experts and practitioners unanimously plead for more resources, not only to provide basic needs of housing and emergency health care that PMWUD are entitled to, but also to increase opportunities for work, mental health support and recovery. They underscored the importance of culturally and linguistically relevant, integrated and holistic support that adequately addresses the complex, interrelated and cumulative needs of PMWUD. Outreach activities were mentioned as an important part of tailored support for PMWUD. Participants further underscored the importance of systematically erasing (legal) barriers to care and providing other needed resources such as employment.

Discussion and conclusions

Homelessness and poverty amongst migrants has become a matter of growing concern in many European countries, particularly with respect to asylum seekers and refugees, irregular migrants and, increasingly, economic migrants from Central and Eastern European countries (Fitzpatrick et al., 2012). Research indicates that drug and alcohol dependence are strongly linked to both the onset and continuation of homelessness (Fazel et al., 2014). Contemporary perspectives view homelessness as the result of a complex interplay between individual characteristics and structural factors, which encompass the presence or absence of a support system (Fitzpatrick et al., 2012). A formal or informal support system may be particularly hard-to-reach for PMWUD (Pouille et al., 2021). Individual factors that are related to homelessness encompass poverty, early childhood adversity, mental health and substance use issues, a history of personal violence, and involvement with the criminal justice system (Fitzpatrick et al., 2012). Participants across the four cities referred to all of the above factors.

Studies on both migration and substance dependence have adopted the classical hierarchy of needs by Maslow as a useful tool to assess needs of migrants and persons who use drugs (Best et al., 2008; Carta et al., 2005). In Maslow's hierarchy, basic physiological needs must be met before addressing higher-level needs. The results of this CBPR study show that many PMWUD in the European Union are deprived from physiological, safety and belonging needs due to existing barriers on multiple levels. While these lower order needs are presented as the most important ones among the needs of PMWUD, this does not mean that no other needs are at stake. Rather, underlying issues are likely to remain concealed due to these lower order needs and these issues become apparent only when urgent challenges such as substance dependence and homelessness are effectively reduced. Hence, PMWUD will likely present lower order needs as the most pertinent to address and may be more sceptical toward the benefits of addressing higher order needs if they are not compatible with their more pressing needs (Best et al., 2008).

By addressing the challenges of substance dependence, homelessness and trauma that PMWUD face, as well as increasing feelings of hope and belonging (e.g., by offering PMWUD a community and a place to be), opportunities for change and increased wellbeing that enable them to focus on other life domains may arise. This study has shown that harm reduction and other services specific to the needs of PMWUD offer important contributions to the health and wellbeing of PMWUD. The study also showed that these services hold the potential to offer a myriad of material, social and affective resources (Duff, 2010). These services may offer a continuous presence amidst uncertain, unstable and ambivalent health, living and social conditions of PMWUD, addressing physical precariousness but also issues of belonging and connectedness (Brenman, 2021).

The various intersections of precarity that PMWUD face in urban realities imply they are marginalized in many ways, because they complicate and upset established norms, institutions and what is (not) seen as progress throughout their everyday struggles. This marginalization is the result of structural and institutional forces that shape and perpetuate marginalization in everyday life (Thieme et al., 2017). In that regard, Misje (2021) points out that the precarious inclusion of homeless migrants is often restricted to ensuring basic physical survival, albeit in an unpredictable and uncertain manner. This study confirms that legal access to care for PMWUD comes from a moral imperative to alleviate acute suffering, but insufficiently takes into account more comprehensive social rights. Furthermore, access to social rights often depends on multiple requirements, indicating that some persons are considered more 'deserving' of human rights than others (Misje, 2021; Ticktin, 2011). This implicit rationale, which tolerates distinctions in the values of individuals within the same context, seem to be accepted and reinforced by existing regulations within EU countries (Guentner et al., 2016). Ukrainian refugees, for example, have shown to receive much more support in having basic human rights met as compared to other refugees (Haase et al., 2023). Second, persons who formally reside and work in a country and have sufficient financial means, have more access to health care and social welfare services then those who don't. Many PMWUD are struggling financially, physically and emotionally. They face multiple barriers to so-called 'productiveness' (i.e., contributing financially to society through formal work), which has a major impact on ideas of deserving certain social rights (Keskinen et al., 2016). This notion of 'deservingness' may also emerge in the considerations of individual care providers when determining what qualifies as an emergency situation in cases involving PMWUD, possibly contributing to inequity in access to health care and other services for PMWUD (Misje, 2021). Without increasing access to care on a structural, social and personal level, PMWUD are inclined to stay trapped in a vicious cycle of precariousness.

Ensuring access to qualitative and humane healthcare for all PMWUD is a matter of human rights, but could in the long-term also positively affect societies as a whole. First, research indicates that granting access to preventive healthcare for migrants in an irregular situation does not only promote the realization of the right to the highest attainable standard of physical and mental health as established in the International Covenant on Economic, Social and Cultural Rights, but also makes sense economically as it leads to cost savings for governments (European Union Agency for Fundamental Rights, 2015). Second, the challenges that PMWUD face (i.e., barriers to mental and physical health (care), housing, employment, financial resources, belonging, language and knowledge barriers, ...) are also identified as barriers to integration. While some focus groups talked about integration as an important prerequisite for PMWUD to become accepted members of society, it is clear that basic needs to be able to integrate are often not fulfilled among PMWUD. By investing in the fundamental building blocks of integration, governments may increase access to 'productive' members of society (Keskinen et al., 2016; Kraler et al., 2022).

Finally, the harmful consequences of drug criminalization that have a tremendous impact on vicious circles of drug dependence, stigmatization and inequality and hamper opportunities for harm reduction and recovery, call for an open debate on decriminalization of drug use from various perspectives. This discussion should prompt researchers and policymakers to move away from the traditional reluctance to address this subject, which has its roots in long-standing prohibition traditions (Decorte, 2011; Rieder, 2021). A substantial body of research has highlighted the positive outcomes associated with regulated decriminalization of drug use, particularly in reducing the compounded marginalization experienced by persons with drug dependence, especially those already marginalized in society like PMWUD due to various forms of discrimination (Bratberg et al., 2023; Human Rights Council, 2023). Therefore, we probe policy makers and researchers to keep the debate regarding criminalization of irregular migration and homelessness alive, since it has a major impact on the access to rights for PMWUD and the vicious circles of precariousness that PMWUD may face (Commissioner for Human Rights, 2010; O'Sullivan, 2012).

1. Introduction

1.1. SEMID-EU

This report is part of the studies conducted for the SEMID-EU project. The SEMID-EU project is funded by the European Commission and aims to address knowledge and practice gaps regarding drug use among migrant populations in Europe.

While prevalence numbers regarding drug use among first-generation migrants are inconclusive, several risk factors make this population more vulnerable to substance dependence. These risk factors are related to pre-, peri- and post-migration mechanisms (van Selm, White, Doran, Pujol, Picchio & Lazarus 2022). They include traumatic experiences, social isolation, unemployment and poverty. This heightened vulnerability may be further compounded by limited awareness of and restricted access to treatment services, language barriers, absence of social safety nets like health insurance and other welfare benefits, and the apprehension of stigma and discrimination, including the risk of deportation when seeking information or support (UNAIDS, 2014).

The specific vulnerabilities of persons with a migration background who use drugs (PMWUD) poses challenges to services and municipalities across the European Union. Therefore, the SEMID-EU project aims to gain a thorough understanding of the needs of persons with a migration background who use drugs in vulnerable situations in various European countries as well as (barriers to) local responses that answer these needs.

The overarching aim of the SEMID-EU project is to enhance the well-being of PMWUD in vulnerable situations and to mitigate associated harms. The project is structured around four interconnected work packages:

1. **Assessing the current situation** through
   - a systematic review of the literature and database analysis to uncover drug use among PMWUD and access to health care (see https://tinyurl.com/5n6bxht6)
   - a three-stage Delphi study to develop statements and recommendations about drug use and access to healthcare services (see https://doi.org/10.1016/j.drugpo.2023.104087)
2. **Developing an inclusive understanding of local needs and responses** through case studies in the cities of Amsterdam, Athens, Berlin and Paris using a community-based participatory research approach, including interviews with PMWUD and focus groups with professionals working with PPMWUD
3. **Crafting policy recommendations, toolkits, and practical guidelines**
4. **Implementing these insights in daily practice** through local capacity building workshops

This report focuses on the results of the second work package: developing an inclusive understanding of local needs and responses.

1.2 Developing an inclusive understanding of local needs and responses

This work package aims to obtain an integrated understanding of local needs of persons with a migration background who use drugs (PMWUD) who live in vulnerable situations, as well as local responses to these needs by health care providers and social and community services. We aim to identify current and future challenges and good practices in the field of migration and drug use in the EU, based on case studies in four selected capital cities: Amsterdam, Athens, Berlin and Paris. These cities were selected as they host a high diversity of vulnerable persons with a migration background who use drugs (Lemmens, Dupont, & Roosen, 2017). Paris and Amsterdam are for long known as multicultural melting pots, while Berlin and Athens have seen a huge influx of new migrants in the past decade (of which some may have migrated for drug-related reasons (Tibi-Lévy et al., 2020). Hence, these EU capital cities are confronted with the growing presence of diverse groups of PMWUD that face various forms of ill health and encounter limited access to essential harm reduction and drug services.

In this work package we aim to answer the following research questions:

- What are the needs of vulnerable persons with a migration background who use drugs in the selected cities?
- What are core challenges and good practices in the field of migration and drug use in these cities?

The study applied a Community-Based Participatory Research (CBPR) approach consisting of semi-structured interviews with vulnerable persons with a migration background who use drugs (n=98) in the cities of Athens, Paris, Amsterdam and Berlin (20-30 interviews per city) and focus groups in each city with a range of service providers.

1.3 What's in a name?

In this study, we explore the needs of a diverse group of first-generation migrants with high-risk drug use who live in (very) vulnerable situations.

With **'first-generation migrants'** we refer to persons who are born in another country then their current country of residence. This category includes both short-term migrants ("a person who moves to a country other than that of their usual residence for a period of at least three months but less than a year") and long-term-migrants ("a person who moves to a country other than that of their usual residence for a period of at least a year (12 months), so that the country of destination effectively becomes their new country of usual residence") (UNdata, 2023). It also includes both documented (e.g., asylum seekers, refugees, labour migrants) and undocumented migrants: those who live in a country without official residence permits (Rechel et al., 2011).

First-generation migrants who use drugs (further abbreviated as PMWUD) may be in precarious and vulnerable situations due to structural mechanisms and experiences in their home country (e.g., war, poverty), their migration journey (e.g., traumatic migration experiences) and the country they reside in after migration (e.g., discrimination, lack of documents, social challenges) (UNAIDS, 2014). PMWUD are at risk of mental health issues due to pre- and post-migration trauma, loss and separation of social networks, as well as the long-term effects and accumulated strain of poor health care, chronic stress, and substance dependence (Carta et al., 2005; Lonn & Dantzler, 2017). Since homelessness, drug use and migration are criminalized, persons at the intersection of these situations are heavily impacted and have increased odds to be stigmatized and marginalized and to have encounters with criminal justice and law enforcement (Pouille et al., 2022; Provine, 2011; Rechel et al., 2011). Criminalization of drug use as well as encounters with the criminal justice system in general have shown to disproportionally affect PMWUD, increasing their vulnerable position in society (Brennan & Spohn, 2008; Provine, 2011; Seddon, 2016). Due to the criminalization of migration in Europe, 'undocumented' or 'irregular' migrants are openly denied access to social rights due to legal restrictions (Guia, Van der Woude & Van der Leun, 2013; Kubal, 2014). Also, those staying in a country with regular documents can become a victim of personal and structural discrimination, resulting in unequal access to rights and resources, including health care (Rechel et al., 2011).

While all EU member states have formally recognized the right of everyone to the highest attainable standard of physical and mental health, both documented and undocumented persons with a migration background face serious barriers to basic social and human rights (PICUM, 2022). In this research, we focus on persons who are particularly vulnerable, due to their migration background, substance use or other characteristics, resulting in structural, social and personal barriers to universal human rights, such as work (art. 23 of the Universal Declaration of Human Rights), housing, food, medical care and necessary social services (art. 25 of the Universal Declaration of Human Rights). These persons are often socio-economically disadvantaged and live in extremely vulnerable situations.

We focus on persons with a migration background in vulnerable situations who engage in high-risk drug use. This refers to the use of substances in a way that may cause health complications and psychosocial problems, either due to an intensive, recurrent and prolonged pattern of use or to the type of administration route (Thanki & Vicenti, 2013). Whether substance use is considered 'high-risk' or not does not only depend on the intensity of substance use, but also on the substances used and the context in which it occurs (Centre for Addictions Research of BC, 2006; Thanki & Vicente, 2013).

In this report we abbreviate this target groups as **PMWUD** (Persons with a Migration background Who Use Drugs), following recent recommendations regarding the use of non-stigmatizing language. However, in some cases widely used terms (e.g. 'undocumented migrants') will be used to clarify specific situations.

Other important concepts that are used throughout the report include:

- **Drug dependence:** this is recognized as a condition in which a person has a physical and/or psychological need to consume psychoactive substances regularly (Inpud, 2020).
- **Harm reduction:** Harm reduction is an approach that aims to reduce the negative consequences associated with drug use through evidence-based policies and practices that focus, first and foremost, on prioritising the health, lives, and wellbeing of people who use drugs. The goal of harm reduction is not necessarily to drive people away from using drugs, but instead providing tools to either be able to do that in a safe(r) way. Harm reduction focuses on engaging with persons who use drugs in a non-judgmental manner. The aim is to mitigate the risks linked to behaviours commonly associated with negative health consequences and, more broadly, to enhance overall health and well-being (EMCDDA, 2023).
- **Supervised Drug Consumption Rooms** (DCR) are an essential part of harm reduction, facilitating safe drug use in a safe environment and away from the streets.
- **Recovery:** While there are multiple definitions of recovery, in this study we view recovery as a personal and multidimensional process of change, characterized by increased wellbeing on various life domains including drug use (Pouille et al., 2021).
- **Stigma:** Stigma stems from an interrelated combination of stereotypes (negative public attitudes and opinions), prejudices (adverse emotional reactions) and discrimination (actions of social exclusion following prejudice and stereotypes) (Wogen & Restrepo, 2020). Stigma can occur at a personal (self-stigma and stigmatizing ideas among individuals), interpersonal, community, societal and structural level. PMWUD may be stigmatized due to their migration background, substance use or other stigmatized features. On a structural level, stigma leads to recurring inequities in access to resources such as housing, education, vocation and health care (De Kock, 2022a; Whitehead, 1992; WHO Commission on Social Determinants of Health, 2008).
- **Opioid Agonist Treatment (OAT):** Opioid agonist treatment is a widely established, evidence-based intervention for persons with opioid use disorders that is implemented in all European countries and is acknowledged as a protective factor against overdose deaths. Various opioid agonist medications are prescribed, but methadone is the most widely used type of drug: 56% of all clients in opioid agonist treatment programs in the EU receive methadone, while around 35% is treated with buprenorphine-based medications (EMCDDA, 2023).

1.4 Contextual background: Migration and the European Union

Migration to the EU from countries in the Middle East and Africa peaked in 2015 and 2016, driven by high levels of conflict in these regions. In 2019, 3 million persons were issued a first residence permit in the EU (Eurostat, 2023). Meanwhile, since the 1990s, many economic migrants have moved from Central, Eastern and Southeastern Europe (CESEE) to Western Europe. Between 1990 and 2015, almost 20 million people left the CESEE region; 80% of these emigrating persons left to Western Europe (Atoyan et al., 2016). Of the people living in Europe on the 1st of January 2022 (446.7 million), 23.8 million people were non-EU citizens. 2,3 million non-EU citizens entered Europe in 2021, an increase of almost 18% compared with the year before (Eurostat, 2023).

Precise statistics regarding the population of irregular residents in Europe are not available. However, research has shown that the majority of undocumented persons in the EU initially entered through regular channels, such as having valid permits for studying, working, family reunification, or seeking asylum, but subsequently lost their legal status (PICUM, 2017; Winters et al., 2018).

According to the World Health Organisation (WHO), several UN treaties and European legislation, every individual is entitled to the highest achievable level of physical and mental health, as a universal privilege that cannot be contingent on any particular status (Graetz et al., 2017; PICUM, 2022; Rechel et al., 2011). This right has been formally recognised by all EU member states (Rechel et al., 2011). The charter of fundamental rights of the European Union (2000/C 364/01, Article 35) states that “Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices”. While the Lisbon Treaty provided legally binding force to these fundamental rights, the last part of the declaration (“under the conditions established by national laws and practices”) still leaves substantial room for interpretation in national legislations of EU countries which makes its legal enforceability dubious (Rechel et al., 2011).

As stipulated in human rights regulations, housing and access to services are underlying conditions for good health. According to the International Covenant on Economic, Social and Cultural Rights of the UN, healthcare facilities, services, and goods should be available in adequate quantities, accessible (in terms of information and physical access), affordable for all, culturally sensitive (in accordance with medical ethics and gender and cultural considerations), and of high quality. Discrimination based on any status should be strictly prohibited (PICUM, 2022).

While access to health care for asylum applicants used to be restricted to emergency care only according to EU regulations, Article 19 of the Reception Conditions Directive of 2013 (Directive 2013/33/EU) states that asylum applicants should have access to necessary health care, including at least emergency care, essential treatment for illness and necessary medical and other assistance for persons with special needs (Lemmens et al., 2017). Healthcare entitlement for undocumented migrants, however, is regulated at a national level. Hence, access to emergency healthcare (including life-saving measures as well as medical treatment necessary to prevent serious damage to a person’s health), primary health care (essential treatment of minor illnesses provided on an outpatient or community basis) and secondary health care (medical treatment provided by specialists and inpatient care) for PMWUD differs from country to country (FRA, 2016).

Despite the right to the highest attainable level of health, in reality, numerous individuals are deprived of essential healthcare services solely as they do not have a documented migration status in the country of residence (PICUM, 2023; Winters et al., 2018). While documented migrants should have the same access to health care and social services as native citizens, access to these services may further be impeded by other barriers, such as personal, financial, legal (e.g., the need to have an insurance), cultural and practical (e.g., language, requiring a home address, transportation, ...) barriers (Graetz et al., 2017; Lemmens et al., 2017).

Drug treatment is not explicitly mentioned in EU regulations and is often not prioritized in delivering healthcare to PMWUD. Legal access to harm reduction and drug services for undocumented PMWUD is dependent on individual countries and whether these countries consider substance dependence as an essential health need (Lemmens et al., 2017). For documented migrants, access to drug services may be limited due to a multitude of personal, financial, social, legal, geographical or practical barriers (De Kock, 2022; Lemmens et al., 2017).

Related to the history of Western social welfare regimes, migrants generally have less access to social security systems such as pension, sickness fund, family benefits and guaranteed minimum resources. Their access to social security is often dependent on the existence of bilateral/multilateral social security agreements between home and host countries. EU regulations imply that intra-European migrants have more access to social benefits compared to third-country nationals, but in general, social welfare is still predominantly oriented to native individuals or those who have been formally residing in the country for a few years and have been contributing to the system. 'Undocumented migrants' often face challenges in accessing social welfare benefits in many European countries due to their lack of a documented status (Vintila & Lafleur, 2020). However, Vintila & Lafleur (2020) note that inequality in access to social security has more to do with exclusionary processes due to immigration policies and the labour market than with social policy regulations.

2. Methods

2.1 Community-based participatory research

Community-based participatory research (CBPR) is a participatory research method that involves all partners in the research process equitably and works with the unique strengths that each partner brings (Collins et al., 2018). The CBPR approach is a valid method for ethical and equitable research among specific communities and hard-to-reach populations. CBPR begins with a research topic that is of importance to the community to combine knowledge and action for social change to improve community health and eliminate health disparities. True dialogue in which everyone participates equally to identify common problems and solutions is central in CBPR. All parties work together toward a common goal through a participatory process (Collins et al., 2018; Israel et al., 2013). Figure 1 illustrates the core principles of CBPR that have been followed throughout the research process.

Figure 1. The core principles of CBPR (Adapted from Israel, B. A., Eng, E., Schulz, A. J., & Parker, E. A. (2013). Introduction to methods for CBPR for health. Jossey-Bass San Francisco, CA.)

This research was made possible thanks to a team of trained academic, local (practitioners working in the area of harm reduction for PMWUD in Amsterdam, Athens, Berlin and Paris) and community researchers that have a close connection to the communities of PMWUD in these cities. These three groups of researchers collaborated from the start to the end of the research project (from research protocol to data collection, analysis and dissemination). During a three-day CBPR workshop in Ghent, Belgium, the local researchers were trained to perform CBPR research, coordinate and execute the research in their cities, conduct focus groups and train community researchers to conduct interviews. All researchers received a compensation for their time invested in this research. The research team had two-monthly meetings throughout the course of the research to discuss the progress of the research in each city and to address questions on behalf of the local and community researchers or academic researchers.

In addition, the core group of SEMID-EU coordinators (from Mainline, IS Global, Correlation Network and de Regenboog Groep) and the Advisory Board (including members of the EMCDDA (European Monitoring Centre for Drugs and Durg Addiction), IDPC (International Drug Policy Consortium), PICUM (Platform for International Cooperation on Undocumented Migrants), Africa Advocacy and Harm Reduction Eurasia), were involved throughout the entire research process, providing valuable feedback and suggestions.

2.2 Ethical considerations

Since this research comprises the processing of personal data of a sensitive nature, several measures were taken to ensure the confidentiality of the data collected. The academic researchers developed a comprehensive research protocol including a specific ethical protocol, Data Management Plan, Data Protection Impact Assessment and General Data Protection Regulation record. This protocol was rigorously adhered to throughout the entire research process, safeguarding the privacy and rights of all persons involved in the research. This study was approved by the Ethical Commission of the Faculty of Psychology and Educational Sciences at Ghent University (ref. 2022-120).

2.3 Interviews

2.3.1. Sampling

For this study, we recruited first generation migrants in vulnerable situations (due to homelessness, social exclusion, unemployment, health problems) who use drugs regularly. Although very heterogeneous, the population of PMWUD is often concentrated in certain hard-to-reach neighbourhoods and communities, depending on the (historical) migrant flows. In each city, three communities of PMWUD were selected to target with the interviews (20-30 interviews per city). These communities were selected based on local needs and experiences in each city and the final decision on the communities to be included was taken by the team of academic, local and community researchers.

To select eligible participants, the local and community researchers made use of **purposive sampling**. This sampling technique aims to recruit participants who can provide in-depth and detailed information about the phenomenon under investigation and suited the purpose of the study (Etikan et al., 2016) The local and community researchers did additional efforts to recruit gender-minority participants, but since these persons are often even harder to reach, the number of gender-minority participants in this study is very limited.

To recruit participants, the local and community applied several recruitment techniques:

- **Recruitment through gatekeepers:** Gatekeepers are essential mediators for accessing study settings and participants in social research (Calsyn et al., 2004). These gatekeepers pitched the research project to people that they think are eligible for the interview and asked them to participate. Possible participants could contact the local or community researchers themselves, or they could give permission to the gatekeepers to pass on their contact details to the researchers so they could contact them.

- **Venue-based recruitment:** Participants were recruited by local and community researchers who went to venues where the community under investigation is present, advertising the research and talking to people and gatekeepers about the research to identify persons who are eligible and expressed interest to take part in the research (Muhib et al., 2001).
- **Snowball sampling:** This is a recruitment technique in which research participants are asked to assist researchers in identifying other potential subjects (Robinson, 2014). This means that, at the end of each interview, the interviewer asked participants whether they know someone who also complied to the inclusion criteria. The participants could give these potential participants the contact details of the researchers, so they could contact the researchers.

2.3.2. Data collection

A semi-structured interview protocol was set up based on existing literature, in close collaboration with the entire research team (core group with academic researchers, as well as the local and community researchers). The protocol was revised multiple times based on feedback of the research team and was tested in a pilot study among eleven participants in three cities (Amsterdam, Berlin and Paris). These pilot interviews were conducted in German, English, Georgian and Arabic. As these test interviews went smoothly and only minor changes were made to the interview protocol after the pilot interviews, these interviews were also included as research data.

The interview protocol (see attachment) was designed to get a comprehensive insight into the following topics:

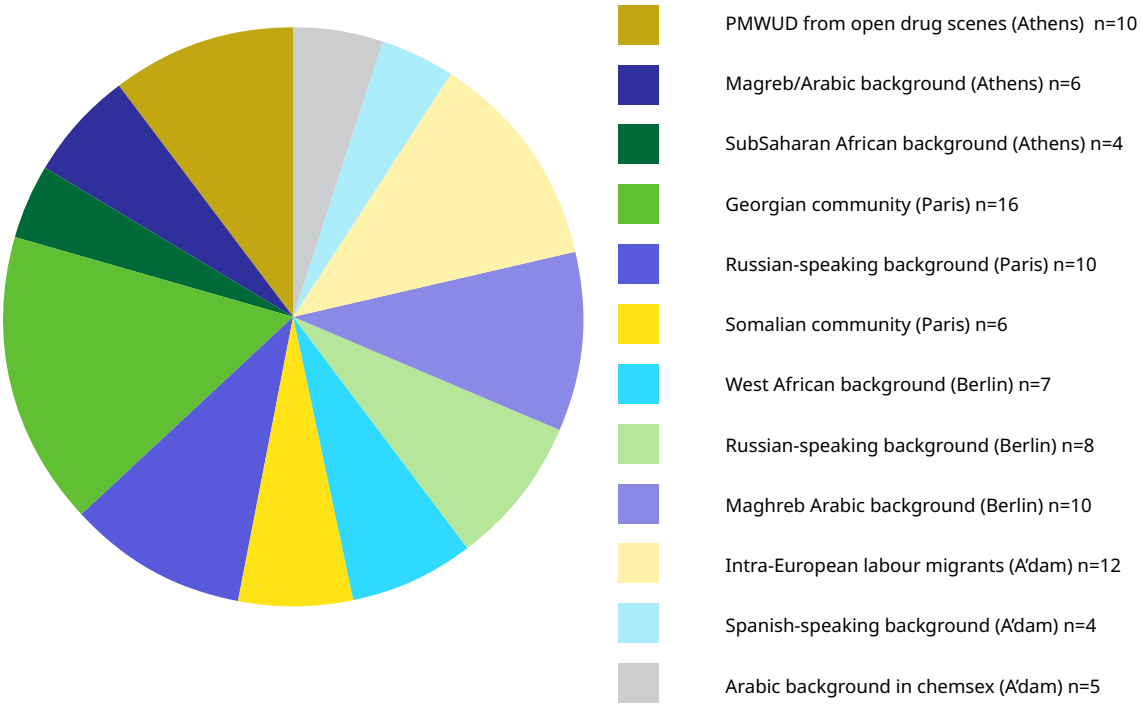
- Migration background and status
- Living situation: daily occupation, social network, basic needs
- Substance use
- Physical and mental health problems
- Support needs
- Services
- Encounters with criminal justice and law enforcement

Each question started with a comprehensive open question that could be asked to get a full insight into the situation of PMWUD. Under each of these open questions, several probing questions were mentioned asking for more details on particular matters. These questions were meant to motivate participants to clarify their answers and get a deeper insight into their experiences. The English interview protocol was translated into Arabic, French, Georgian, Polish, Russian, Somali and Spanish.

The interviews were mostly conducted by community researchers, who were trained by the local researchers to conduct the interviews. Most interviews took approximately 30 to 40 minutes. Each interview started with an explanation of the research purposes and the rights of the participants. Participants gave individual consent concerning the (re-)use of their data using an alias and after each interview, participants received a financial compensation for their time invested.

In total, across the four cities 98 participants from 43 different countries of origin and 45 different nationalities were interviewed in 14 different languages (see Figure 2). The vast majority of participants identified as cisgender men. Eight cisgender women (all Russian speaking) and two transgender women also participated in the interviews.

Figure 2. Communities of PMWUD involved in the study across the cities (Total sample n=98)



2.3.3. Data analysis

All interviews were recorded by the community researchers and transcribed verbatim by human transcriber of the transcription company GoTranscript (https://gotranscript.com/). Community researchers and the transcription company were both bound to protect the confidentiality of the data, which was facilitated by rigorous data management. For each city, the academic researchers became acquainted with the data by reading the transcribed interviews thoroughly. Questions regarding the interviews were discussed with the local and community researchers. Second, the academic researchers conducted a literal analysis of participants' answers on each question in a password-protected excel document. Third, they conducted a vertical thematic analysis of the answers to each question per community. When all interviews of the communities in one city were analysed in this way, the academic researchers either wrote a report per community if there were sufficient specificities to these communities, or across the communities if the answers did not differ substantially between these communities. Each report was discussed with the local and community researchers in the four cities, who provided feedback and added contextual information where needed. The reports were finetuned based on the feedback of the entire research team.

2.4. Focus groups

To answer the research questions from service providers' and practitioners' point of view, focus groups were conducted in each city with a multidisciplinary group of professionals who have experience in working with persons with a migration background in vulnerable situations who use drugs.

Purposive sampling was coordinated by the local researchers. After consulting the academic researcher, they identified local professionals who have experience or expertise in working with first generation migrants in vulnerable situations who use drugs. The researchers aimed to include a variety of profiles based on their domain of expertise, age and gender and aimed to include at least some persons who have experience with the communities under investigation.

The focus group protocol that was used by the local researchers who acted as moderators of the focus groups, was developed by the entire research team involved in the project (including the core group, local and community researchers). The focus group questions can be found in Box 1. During the CBPR training,

the local researchers were trained how to conduct the focus groups. The focus groups in each city lasted about two hours.

The focus groups were conducted in English (Amsterdam), German (Berlin), Greek (Athens) and French (Paris). They were translated and transcribed verbatim to English by the local researchers, after which the academic researchers conducted a thematic analysis on each focus group discussion to identify the main themes and topics discussed. For the thematic analysis, we followed the guidelines by Braun and Clarke (2006). The findings were shared with the local researchers, who provided feedback.

Box 1. Overview of focus group questions

Focus group question

Numbered questions = Main questions: should be asked
Bullet points = probing questions: should be given an answer to, but it might not be necessary to explicitly ask these questions. These questions can further help to facilitate discussion and deepen the conversation.

1. First, can you tell a bit more about who you are (you don't have to disclose your name), what your job is, and your link with migrant persons who use drugs?
2. According to you, **what are the greatest support needs** of first-generation migrants who use drugs in this city?
3. To what extent are there **services available that answer to these needs**?
    - What needs cannot be met by local services and why?
4. What **barriers** to these service do you identify?
    - What barriers do you identify among the service users, and how is this related to their migration background?
    - What barriers to substance use treatment are related to the services and how they are organized?
    - What barriers to substance use services does policy impose? (e.g. legal framework, funding)?
5. What is needed to **improve care** for first-generation migrants in vulnerable situations who use drugs?
    - What can facilitate access to support services for vulnerable migrants who use drugs?
    - What is needed practice-wise?
    - What is needed policy-wise (e.g. legal framework)?
6. Are there any **other aspects** of needs of and local responses for vulnerable migrants who use drugs in this city that you find important to address?

3. Results

3.1 Amsterdam

3.2.1. Context

About 873.338 persons live in Amsterdam, the capital of the Netherlands, which amounts to 1.5 million including suburbs. It is estimated that 14,5 percent of the Dutch population has a foreign country of origin. The most common countries of origin among documented migrants are Morocco (15,4%), Suriname (12,4%) and Turkey (8.9%).

The Netherlands are widely known for their liberal drug policy compared to other EU-countries, particularly in relation to cannabis. The most commonly used substances are alcohol, cannabis, ecstasy and cocaine (EMCDDA, 2023b). Among persons with drug use problems, the use of (crack) cocaine has been rising in the last years (Trimbos-instituut, 2019).

Access to health care

In the Netherlands, migrants and newcomers are entitled free emergency and primary care (essential treatment of relatively common minor diseases provided in outpatient or community-based centres). Specialist care by specialist doctors or provided in inpatient settings is also supposed to be provided for free (FRA, 2016). However, a report of Médecins du Monde (2017) showed that in 2017 undocumented migrants were expected to pay for treatment unless it was proven that they couldn't pay. In that case, general practitioners receive 80 percent reimbursement of the treatment costs from the healthcare authorities, but since persons without financial means can often not pay the additional 20 percent, they are often refused care. As a consequence, multiple barriers to health care for PMWUD remain.

For access to health care and regulated job opportunities, a BSN (citizen service number) is required. This number is required for employment, taxes, and for health insurance and can be obtained by means of registration of one's home address. Basic health insurance is necessary to access health care services, such as a visit to a general practitioner or psychiatrist, hospital visits and medicines (Government of the Netherlands, n.d.). Undocumented migrants don't have access to this health insurance, even with an authorization for temporary stay. As a consequence, they only have access to emergency care and care for situations that would jeopardize public health (Médecins Du Monde, 2017).

Intra-European migrants with a valid proof of identity have – after registration – access to a BSN number the first four months of their stay in the Netherlands (Government of the Netherlands, n.d.). After this period, however, they (similar to migrants from outside the EU) need to register at the local municipal personal records database to receive a BSN (Immigration and Naturalisation Service, 2023). To register at the municipality, a citizen must show a valid identity document (passport, EU identity card) and proof of occupancy (rental contract, contract of sale or written permission from the property's main occupant). A citizen needs to register at his/her home address. If they do not have anywhere to live or cannot use their home address, they can ask the municipality if they can temporarily register using a correspondence address (Government of the Netherlands, n.d.).

Testing and treatment of HIV and hepatitis are included in the coverage of the compulsory health insurance. Undocumented migrants are entitled care for infectious diseases as this is considered medically necessary care. EU citizens with no financial resources or health coverage, however, don't have access to testing or treatment. Yet, practitioners are allowed to offer screening for infectious diseases anonymously and free of charge to those considered 'groups-at-risk', such as undocumented migrants. Migrants suffering from tuberculosis will receive treatment until there is no contamination danger anymore (Médecins Du Monde, 2017).

Access to social security

EU citizens or third-country nationals who are officially employed in the Netherlands generally are subject to similar social security provisions as Dutch residents (i.e., access to social, national and employee insurance and benefits), though some exceptions may apply. Non-working regular migrants residing in the Netherlands have limited access to social assistance benefits, but after five years of living in the country, they are treated on par with Dutch citizens. Undocumented migrants generally do not have access to social security provisions (Pennings, 2020).

3.2.2. Interviews

Introduction

Most interviews in Amsterdam were organized by **De Regenboog Groep** that offers practical and emotional support to persons in vulnerable situations due to addiction, homelessness, poverty or psychiatric problems. De Regenboog Group aim to strengthen the social networks of these persons by linking them to buddies. They offer emotional and practical support via social workers, offer temporary shelter, have drop-in centres for persons living on the streets and offer training and work opportunities. Most interviews were conducted in the drop-in centre AMOC. This explains the large share of intra-European migrants among the Amsterdam sample, as AMOC is a drop-in centre for EU citizens from outside the Netherlands who are in vulnerable social conditions because of language barriers and structural barriers to housing, work and financial resources. In AMOC, there is also limited overnight shelter available, ensuring 24-hour accommodation in crisis situations.

The interviews with the LGBTQIA+ community were organized by **Mainline**, which is the coordinating organization of the SEMID-EU project. Mainline is an organization in Amsterdam that aims to promote health and improve the social position of people who use drugs, without primarily aiming to reduce drug use itself and with respect for the individual's freedom of choice and strengths. Mainline is committed to traditional harm reduction interventions such as needle exchange, opioid substitution treatment, HIV care (testing, treatment, support), combatting infectious diseases (such as hepatitis B and C, tuberculosis) and sexually transmitted infections by distributing information, education and communication materials, and overdose prevention and management. Their services are aimed at persons who are marginalized and who use a variety of drugs by injection, swallowing, smoking, inhaling, sniffing, anal or vaginal insertion. Mainline emphasizes the importance of a safe political and social climate ('enabling environment') and promotes rights-affirming approaches and interventions.

In Amsterdam (n=22), the following communities were targeted for the interviews:

- Intra-European labour migrants (n=12 of which 11 cisgender men and one transgender woman)
- Arabic-speaking LGBTQIA+ migrants engaged in the Chemsex community (n=5 of which four cisgender men and one transgender woman)
- Spanish-speaking migrants (n=5, cisgender men)

Due to the specific focus of AMOC on intra-European labour migrants, it appeared an evident choice for the local and community researchers to conduct interviews with this community and hence get more insight into how AMOC addresses their needs. According to the local and community researchers who have professional experience with working with this population, many EU residents look for better job opportunities in the Netherlands, particularly in Amsterdam, due to poor economic conditions and unemployment in their native country. Some of these Intra-European labour migrants come to the Netherlands with jobs aligned, especially in agriculture, industry or construction. Many of these jobs are seasonal and they also include shelter. When the work stops, so do the benefits. They also lose the living space and other arrangements, such as health insurance. Others find that their promised jobs do not exist and end up with no work, no accommodation and no rights. Based on the experiences of the local and community researchers,

intra-European migrants, usually find a harsh reality in Amsterdam with no work, no wages, nor shelter. The local and community researchers further observed that intra-European migrants usually have a poor understanding of the Dutch language and many only speak their mother tongue. Most are unfamiliar with laws and regulations or the healthcare system, and often have a poor social network. This combination often leads to a downward spiral, resulting in psychological and other problems. Returning to their country of origin is often not an option: they may have outstanding debts [there], a precarious employment situation or lack of job opportunities, they face poverty, have toxic relationships with their loved ones and/or they may be facing issues with the law. For many of them, living on Amsterdam's streets is better than living in their country of origin. More specifically, in case of persons who use drugs, many rather want to be a drug user in the streets of Amsterdam than facing the poor living conditions in their native countries, being inmates or facing drug use-related discrimination.

The second target population (Arabic-speaking LGBTQIA+ migrants involved in the Chemsex community), was chosen by professionals working in various organizations that focus on harm reduction and recovery support in Amsterdam. They identified this group as a growing group of concern about whom little is known. The local researchers described that Arabic-speaking LGBTQIA+ migrants in Amsterdam encounter a multitude of psychological challenges relating to their sexual orientation, social rejection and loneliness, as well as a commonly experienced culture shock and experiences of social dislocation. According to the local researchers, these Arabic speaking migrants come to Europe to escape war and/or search for social and sexual freedom. As they often lack comprehensive knowledge of drugs and its potential consequences, partly due to a dearth of accessible and appropriate information in Arabic, they may engage in drug use without fully understanding the associated risks. The local researchers further described that, during the process of establishing a new life characterized by loneliness and stress, they encounter drugs rather easily and primarily through gay hook-up applications.

The local researchers were told by service users that there is a substantial group of Spanish-speaking persons using drugs on the streets. However, they observed that not many Spanish-speaking people were using Drug Consumption Rooms (DCR) or Needle exchange programmes in Amsterdam, and wondered why they do not access these services. Therefore, this specific community was chosen to conduct interviews with, but according to the local researcher stigma surrounding drug use among Spanish-speaking migrants could impede study participation. This concern was confirmed during the recruitment process and eventually only five Spanish-speaking respondents participated in the interview. When local researchers contacted the main organisations that work with Spanish-speaking populations, they indicated not having many clients who use drugs and refused to let the local and community researchers hang up recruitment posters for the SEMID-EU study. Other gatekeeping organisations were hesitant to help as well, indicating huge barriers for Spanish-speaking persons who use drugs to open up about substance use problems.

Results

Profiles

a. Migration background and documentation status

Of all intra-European migrants that participated in the study (n=12), three were born in Poland, two in Slovakia, two in Hungary, one in Italy, one in Lithuania, one in Austria and one in Bulgaria. The transgender woman was originally born in Russia, but migrated to Belgium when she was one and a half years old. Because she lived in Belgium almost her entire life and because she migrated to Amsterdam for work-related reasons, we included her interview within those of the intra-European labour migrants.

None of the participants indicated to have the Dutch nationality. However, most of them had a valid proof of identity from their home country. One participant indicated that his ID was lost, while another indicated that it had expired, meaning that both didn't have access to the above-mentioned BSN number. These intra-European study participants were between 24 and 53 years old. Interviews were primarily conducted in English. Two interviews were partly conducted in Polish, one in Dutch.

Participants had been living in the Netherlands for 5 months to 10 years. Ten persons indicated they came to the Netherlands to find (better paid) work (sometimes alongside other reasons). They all indicated they wanted to build a better life for themselves and tried to stay in the Netherlands for at least a while. Three participants specifically stated they didn't want to go back to their home country because of bad social and political circumstances. One participant indicated he was excluded and discriminated in Slovakia, because his mother belonged to a Roma community and his father was from Ukrainian origin. "Getting rid of drugs" through finding "a better life" was mentioned as the reason to migrate by two participants.

Four of the five Arabic-speaking LGBTQIA+ migrants engaged in the Chemsex community were born in Syria. The fifth participant was born in Lebanon. All participants were recognized as refugees and had a valid Dutch ID. The participants were between 29 and 32 years old and arrived in the Netherlands six to eight years prior to the study interview. Two persons indicated they had to flee their home country for war, while three persons stated they had to leave their home country due to their homosexuality. Four of them indicated they would like to stay in the Netherlands because they felt that they were settled there to a certain extent. All but one participant, who had quit his studies due to substance use problems that made it difficult for him to focus on his education, were working and studying at the same time and resided in some kind of student housing. All interviews were conducted in Arabic.

Five Spanish-speaking persons took part in the interviews. They migrated to Amsterdam between two weeks and three years ago. Two persons were from Colombian origin, one was born in Peru and two in Spain. These participants had a European passport, as they had migrated to European countries (Spain and Italy) before. Four participants emigrated for family-related reasons, indicating that they had to get away from a distorted family situation characterized by substance use, criminality and an overreliance on them. Additionally, they all mentioned financial reasons, besides looking for new opportunities and a new future and fleeing from danger (unspecified). These participants were between 33 and 47 years old and were all conducted in Spanish.

b. Substance use

Among the persons with an intra-European migrant background, all participants used (crack) cocaine on a daily basis, the majority through injection. All but one participant indicated to also use heroin (intravenously) daily. Some also indicated they injected a cocktail of heroin and cocaine. Seven of these participants also used methadone daily, the majority through opioid agonist treatment programs (further referred to as OAT). Ten participants indicated to use cannabis regularly.

Eight participants were under the age of fourteen when they first used drugs, including cannabis, amphetamines, heroin and crystal meth. The remaining four participants were 16, 18, 24 and 51 when they first used drugs. Seven of them first used drugs in their home country. Nine of them indicated to use drugs at the DCR of AMOC, sometimes combined with using outside in summer time or outside the opening hours of AMOC.

The main reason for using drugs is physical dependence (not being able to function without drugs), which was specifically mentioned by four participants. Second, using drugs functioned as a surviving mechanism to deal with homelessness, helping to feel safer, feel more comfortable, feel "in peace", ...

> *I can tell you for sure that when I start being homeless and, uh, for example, to fall asleep in some place, like somewhere on the street or in the park when there are people around you and, uh, when I'm getting high of-of heroin or something else, whatever, it's make me more comfortable to being in this kind of place. Like I wear this blanket on me, and people cannot see me anymore. It's more easy being in this current situation as I will be sober. (D., male, 32 years old, Polish origin)*

Also, using drugs helped participants to 'forget their problems' and functioned as a self-prescribed "anti-depressant". One participant also used it as a painkiller for his leg, in which a tumour was surgically removed.

The Arabic-speaking LGBTQIA+ migrants used notably less drugs than the intra-European community. They were in less precarious situations regarding housing and were significantly less involved in criminal activities. All of them indicated they only used occasionally, mainly 3-MMC (n=4, snorting), cocaine (n=3, snorting) and MDMA (n=3, pills) at parties, during sex-related activities and at home. Other reasons for drug use included loneliness (n=4), boredom (n=1), trying to 'forget' or 'escape' trauma from the past (n=3) and a way to escape reality (n=1). Three of them started using drugs shortly after arriving in the Netherlands, stimulated by certain social networks within the LGBTQIA+ community and not knowing what they were getting in to.

> *I was still new in the Netherlands. There was an association that was organizing trips for LGBTQ refugees in Haarlem, I think. Through this association, I met people, and these people had my number, and one of the weekends, they told me that there was a party in Amsterdam that we wanted to go to, so I joined them, and someone offered me a pill, and I didn't know what the pill was at all, so I took it. They told me it was like an energy pill, so I took this pill. (...) The place was in the Netherlands through a guy I didn't know, a pill I didn't know, in a place I didn't know. But it was a good experience and I repeated it. (S.[1], male, 29 years old, Syrian background)*

The story of S[2]. embodies the intertwinement of migration-related trauma and loneliness in combination with ignorance facilitating addiction.

> *I am a person who-- when I came to the Netherlands, I did not know anything about drugs. What is the reason that made me use drugs? Loneliness, the trauma that I've been experiencing. I was born in a very religiously conservative environment, I come from an intolerant Muslim environment that rejects others or rejects diversity. I was the black sheep of the family, and this is the main reason that made me run away from them. Honestly, I first started using about three years after I arrived in the Netherlands. I've been living in the Netherlands for seven years. The reason it happened after three years is because I started to experience trauma after three years. I was lost, I was like, "Where am I at in life? What am I doing with my life? Why is my life like this?" The shock... I suffered from PTSD, three years after I arrived in the Netherlands. At first, I started using soft drugs, aka weed. Also, the gay community in Europe, most of them use drugs... And through certain people, I was able to try ecstasy, then I was hooked and became addicted to the 'high'. I wanted to forget all the stressful things in my life and get the negative thoughts out of my head. This is how I started. At first, it was just a small dose of ecstasy, then cocaine, and finally all kinds of... (S.[2], transgender, 29 years old, Syrian origin).*

This was also reflected in V.'s story, who indicated that social and material deprivation, trauma and loneliness led him to social networks where he, unaware and uneducated about drugs and its risks, used drugs to belong and 'escape' from his daily struggles in the refugee camp, both literally and figuratively.

The Spanish-speaking participants did not inject any drugs at the time of the interview. Three of them either smoked or snorted (crack) cocaine, at least multiple times a week. This was combined with heroin by two participants. One of them indicated to use less thanks to prescribed methadone use. The third combined snorting heroin and cocaine with crystal meth, which was described as a cheaper alternative. Two participants used marijuana daily, which helped them to survive on the streets. One person also indicated to have problems with alcohol and additionally used cocaine, ketamine and methamphetamine occasionally. The Spanish-speaking participants mentioned a social drive for drug use (using with peers on the streets), a way to kill the time on the streets, because it became a necessity due to addiction, and as a way to escape harsh life conditions and the lack of perspective.

> *Life's rough patches, really. Mental strain, money troubles, family issues, no job, no roof over the head. It's either drown the pain in booze or get high, one way or the other. (A., male, 36 years old, Spanish origin)*

> *When I'm frustrated because I can't find a house, can't find work, everything's going wrong, I feel isolated, and can't communicate with anyone, I punish myself when things go wrong. I punish myself with alcohol. I tell myself, "Let's drink because no one cares about me. Because I don't know a girl, let's drink. (R., male, 36 years old, Spanish origin)*

c. Social networks

Among the Intra-European migrant sample, participants often indicated they had one or two friends they could count on and that they "look out for each other", which was especially stressed as important when living on the streets. Only one participant talked about family as important network members, while one participant indicated he was looking for a "new family". Four persons indicated they were usually alone. Two persons talked about people in AMOC (both peers and professionals) as their social network. Two persons emphasized the importance of a friend to talk to and to laugh with:

> *Oh, we look after each other, like, uh, when you're sleeping outside, you could be attacked (...) We are good for each other. If we always ask, you know, you have bad moods or something, I say, "No, it's just like a bad weather or something". So that's good to be with someone, you know, like, uh, always asking each other or he make me laugh, fucking idiot, yeah. (B., male, 53 years old, Hungarian origin*

Most participants with an Arabic background indicated that they could not rely on family. Even though the majority indicated that they could count on some friends, four participants pointed to loneliness as the reason for their substance use. This loneliness was linked to the difficulties of fitting in in Dutch culture and social networks by two participants. S.[2] stated:

> *I have already told you that I am a person who lives alone here. It's been like that since I came to the Netherlands... and the idea of a social life here is very difficult. Most of my free time is on the weekend; Friday night, Saturday and Sunday. I feel very lonely on those days, because I don't have anything to do, so I always try to get acquainted with new people and hang out with them, but not once did I go out with someone and told him details about my problems or what I am going through, and felt that he really understands what I'm going through on an emotional level. (...) Exactly, the connection, the communication... they don't feel what I'm saying. (...) There is no emotional connection, because of the culture here in the Netherlands and the customs and traditions. Maybe this is just how the Dutch are, or maybe it's just a misconception I have, but not once have I been able to understand why they behave like this. I mean, most of the time they tell me that they understand me... But not once did I feel that there was a person who understood me 100%, and I am not looking for someone to pity, comfort or give me attention so that I can play the victim role. At the end of the day, we are all human, and we need to take care of each other as human beings. (...) I feel disappointed, I feel pessimistic about the future, I'm disappointed in people, in everything. I have sleep problems, I have stress problems, I have problems - fear from the future, and the feeling that took over me is disappointment. I'm disappointed in everything and everyone; in my family, the community here in the Netherlands, the LGBTQ community specifically. (S.[2], transgender, 29 years old, Syrian origin)*

> *When I'm frustrated because I can't find a house, can't find work, everything's going wrong, I feel isolated, and can't communicate with anyone, I punish myself when things go wrong. I punish myself with alcohol. I tell myself, "Let's drink because no one cares about me. Because I don't know a girl, let's drink. (R., male, 36 years old, Spanish origin)*

Similarly, one participant from the Spanish-speaking community indicated that he was 'going crazy' because of the loneliness related to not having a social circle he can trust. A distrust toward people in precarious situations was shared by two other respondents, because of their experiences of being robbed and misused, which resulted in a necessity for independence. Most participants simultaneously indicated to have a limited social network of friends or family that they could rely on, linked to having a disrupted family and substance use. Two participants, however, also described how shame about living on the streets kept them from being open to their friends and family. Additionally, not having a phone could stand in the way of staying in touch with friends and family.

> *When you're on the street, you become part of a group that shares the same daily spots. I mean, you take showers with them, you meet them collecting bottles or in the same places where you go to eat. They invite you. I'd be lying. I swear on what's most dear to me, in the past eight months, I've bought weed twice, but I've never run out. Perhaps, I don't know, these people offer you weed, but another day, if you have money, you give them €5. It's like an exchange, a trade-off. (J., male, 47 years old, Peruvian origin)*

d. Medical and mental health problems

Across all communities, participants mentioned rather few physical health problems. In the intra-European community, one person had problems with his leg due to a tumour and one person had been diagnosed with HIV. Three persons indicated they felt depressed, while three others talked about how they felt "stressed" due to their precarious situation, "unstable", "aggressive" and "sad", as well as "down".

Three participants from the Arabic LGBTQIA+ community stated explicitly that they had mental health problems at the time of the interview, and all five raised mental health support as an important support need for newcomers, especially due to trauma from the past.

> *A professional mental health therapist should be assigned the task of treating people who come to the country. I mean, when I arrived in this country with all the "traumas" - I mean, to this day I'm still seeing the social worker. I do not see a professional "psychologist", because I'm a refugee and I don't speak the language, so I have to be on a long waiting list to see a "psychologist" who speaks English, not Dutch. So, this is definitely something we need. (V., male, 31 years old, Lebanese origin)*

Dental problems were reported especially among the Spanish-speaking community, which may be related to snorting as a means of drug use. Two participants talked about psychotic episodes and paranoia, possibly related to drug use. Additionally, participants described their mental states as "not well", "restless", "a downward spiral" and "a roller coaster", linked to drug use and stressful life experiences.

> *More like restless, I guess. Sometimes, it's the usual drill. Barely getting two, maybe three hours of sleep. Bad food habits. Lots of folks. Day in, day out, on your own. Zero socializing. No connections, no social circle. This way, you end up badly. (A., male, 36 years old, Spanish origin)*

(Support) needs

Among the intra-European study participants, the majority was living on the streets (n=5) or spending their nights in temporary shelters (n=4), or a combination of both (n=1). It should be noted that the interviews were conducted in winter time and most temporary shelters are only open in the winter, implying that persons who stayed at temporary shelters at the time of the interview probably live on the streets in summer. Ten participants discussed the importance of long-term and stable housing conditions, in contrast to the everyday struggle and uncertainty of homelessness. While the shelters offer a short-term solution for not having to sleep on the streets during winter, participants indicated a strong need to have more stable and long-term housing conditions where they can feel safe. The shelters often concerned rooms that they had to share with up to sixteen people that they often cannot trust. Moreover, participants described having to leave the room early in the morning, but many of them considered themselves lucky they can often come to the shelter to stay warm and spend the day. The shelters offered participants a short-term place to sleep and a shower. S. talked about how this keeps her from having to rely on stealing for survival:

> *Actually, [...] I'm really happy about that, that it exists, let's put it that way. Otherwise, I would still be stuck and maybe have to get into the stealing environment, start stealing, selling stolen goods. That's not my intention at all. (S., transgender, 40 years old, Russian origin)*

Six participants discussed that they would like to work, to follow training or do something with their lives. Two participants talked about OAT as a prerequisite to be able to work.

Even though several participants talked about “depressive”, “sad”, “unstable” and “stressed” states of mind, few participants indicated that they wanted help with this. One participant talked about needing help to deal with psychological issues, while one participant indicated the importance of “a sympathetic ear” every now and then. One person who had been in residential treatment for substance dependence talked about how this had helped him a lot, giving him hope for the future:

> *Yes. So there are days when this depression, it’s knocking on the door, you know, because, uh, there is a time when you reflect about yourself and current situation. And when I see my past and I put everything together, I don’t see this light in the end of the tunnel, you know? I see only bad stuff. And there is sometimes nothing good. It’s happened for, um, one month, two month, three months, and then the depressions come in. But my last couple of months, uh, it brings me a lot of positive, you know, like I’ve been five months in this clinic. And even I didn’t finish, I don’t see this as a complete waste because I feel better. I put on some weight and, uh, and I reduce a lot with the using, and now I’m trying to find this work. (D., male, 32 years old, Polish background)*

Most participants indicated to have sufficient access to food thanks to social organizations such as AMOC (n=9) and a church (n=1), sympathetic citizens and restaurants (n=2) or by supporting themselves through begging (n=1) or financial support from family (n=1). Participants indicated few medical needs besides methadone.

Since all participants with an Arabic background belonging to the LGBTQIA+ community lived in (student) houses, they resided in less precarious situations with their basic (housing) needs fulfilled on a day-to-day basis. Most of them combined work and education to meet their financial needs. However, this combination was deemed challenging and hence four participants talked about the need for more financial resources. All of them discussed higher order needs of psychological wellbeing repressed by trauma and the need for connectedness and belonging. While one person indicated that his housing situation made him feel safe, two other participants discussed that they did not feel safe, nor at home, which was attributed to trauma from the past.

> *I think all refugees feel insecure, I think the feeling is ours, the feeling is always there. You know when you’re home, but you don’t really feel at home? I still haven’t gained that feeling in this country. From the moment I arrived, I was transferred from one place to another, I started first in refugee camps, then I lived in shared housing, and then I finally moved into my own studio. Recently, I’ve been living in my actual home, but I’m still testing whether this is really my home. Since I arrived in the Netherlands, I haven’t felt like I’m “home” yet. However, I know that I am living in a safe place. As Arab communities, we are still affected, maybe we want to connect with our families who may still be in Syria or another country. That weight stays with you on your back. Even if you feel safe, the feeling that your family is not safe can affect your own sense of security. (S.[1], male, 29 years old, Syrian background)*

When they looked back to when they first arrived, most of them talked about a lack of support services or not knowing where to find support, indicating that they needed to figure out everything on their own. This was related to procedures of migration (e.g., asylum request), legislation and customs, drugs (e.g., the legal framework on drugs and possible negative consequences) and drug services.

> *About two years or a year ago, I didn't know that these centres [support centres for migrants] existed or how to communicate with them. I had no idea about this, so if you know that this thing exists and what this centre provides, you can go back to it. But if you don't know that this centre exists, how can you refer to it? That's the idea. I think the lack of information is the reason. Luckily, I have people I met through my journey and my life here in the Netherlands who supported me a lot. I'm an immigrant, I don't know the laws, I don't know how things work, the way of life here. Without someone from this country, I cannot understand how things work, whether it is legal or just part of daily routine. These people helped me a lot from A to Z, even mentally. What I am going through in this country, I couldn't call someone from Syria to share it with, I need someone from this country to understand me and listen to what I am saying. Fortunately, these people appeared in my life by coincidence. (S.[1], male, 29 years old, Syrian background)*

All Spanish-speaking participants were living on the streets at the time of the interview. One participant talked about housing as a "top priority" to increase overall wellbeing on multiple life domains.

> *The absolute top priority is a roof above my head. Without it, you lose it, you get all paranoid thinking people are ... That's me right now. I find myself taking less crowded streets just to keep away. If you've got some money, you can afford a beer, light up a joint, stroll around, chill a bit., but when you're penniless, with no place to crash or food to eat, the last thing you want is company. (A., male, 36 years old, Colombian origin)*

Additionally, a participant indicated that finding housing is one of the most difficult needs to be addressed in Amsterdam.

> *Sleeping is a disaster, finding a home, being taken in or sheltered in Amsterdam, somewhere, is very difficult. You have to be Dutch or to have been here for a year. Most importantly, you need to be here for a year and have worked. There are many people on the streets due to that situation. The hardest part about Amsterdam and the Netherlands is having a home. (...) On top of that, not being able to be taken in somewhere, it's really tough. Now that it's warm, it's okay, but when it's cold, it's exasperating. You go crazy. (R., male, 36 years old, Spanish origin)*

The harsh conditions of living on the streets made J.[2] wish he would have been arrested so he had a roof above his head:

> *I have nowhere to go; I'm completely homeless. I live in a park. I'd sleep in the park and then go. I even slept in a car that wasn't mine because I wanted them to arrest me. It's madness. (J.[2], male, 39 years old, Colombian origin)*

Homelessness was also described as leading to unsafe environments of people using drugs, which may impede efforts to stop using drugs. Hence, a participant indicated that he wanted to be institutionalized in order to be able to quit using substances and reach out to his daughters.

While most participants indicated that basic needs of food and hygiene were fulfilled thanks to available services, A., who indicated not to know about or find the way to these services, stated:

> *Mostly it's for food, water, cleaning up, a quick shower, information about where to go, directions what to do, understanding the goal, the priority. You see, sometimes you just get overwhelmed. We've felt that way many times, even if it doesn't show. Sometimes you see it out on the streets. Many homeless folks have lost their mind. You can end up that way too, you know. I might eventually. And once you're there, you can't come back. That's the hard part. (A., male, 36 years old, Colombian origin)*

One participant indicated that he did not have to fall back on criminal activities such as stealing ever since he found support services that meet his basic needs. Two participants talked about the vicious cycle of drug use as making you lose everything, which simultaneously, keeps drug use going as a way to deal with these harsh conditions. Hence, supporting persons to get out of these conditions of material and social deprivation is pivotal to increase their wellbeing and opportunities for recovery.

Participants described a job as an important resource, both financially and in terms of daily occupation, to keep their minds away from substance use.

> *That [support with employment] is what we need. After all, I didn't come here to be a homeless person, I didn't come here to become a junkie, waste my life, or end up in jail. We came here to work, to change our lives, to have a better lifestyle. (R., male, 36 years old, Spanish origin)*

The importance of psychological support was mentioned by various participants.

> *Here, I've personally noticed a level of, well, a point where my mind starts to slip due to desperation, and especially due to loneliness. It's worse than work and everything else because extreme loneliness directly destroys your ability to communicate and do many things. That's where you start becoming a person who can be frightening, who can become extreme due to powerlessness. If you're psychologically unwell and you need medication but can't afford it, you're screwed. It's not the best place. You need to at least vent, not to mention the risk of suicide. (...)*

Harm reduction and other services

All intra-European and Spanish-speaking migrants were in contact with one or more support services related to the fulfilment of their basic needs and drug use. AHA, a day care that belongs to the Salvation Army and offers food, drinks and meaningful daytime activities and Blacka Watra, a drop-in centre, were mentioned as helpful. Multiple participants indicated that AMOC helped them with food, hygiene and shelter, as well as with medical needs, even if they did not have access to insurance (i.e., OAT, arranging dentist appointments and access to other health care services). A Colombian participant talked about the help of one social worker specifically, who called an ambulance when he had an eye infection and came with him to the hospital as support.

As opposed to the Spanish-speaking participants, of which only one participant indicated to have been tested for hepatitis, tuberculosis or HIV, all of the intra-European migrants had (recently) been tested on these diseases. Four persons tested positive on HepC, but this has been (or in one case, will be) treated or cured. One of these participants lives with HIV.

Among both communities, experiences with AMOC were mainly positive. The DCR, when used, offers participants a safe and warm place to use drugs with clean materials, which was described by one participant as very expensive in Amsterdam otherwise.

> *Fortunately, there is this place that, at least you feel kind of at home, safe. That's important, and warm. Yes, and also you don't feel so illegal. 'Cause when you are on the street, um, you feel that you do not something that everybody likes. So, I appreciate place like AMOC that is open here, and let us use, you know, in a healthy and quiet way. Because they give, uh, alcohol [pads], new syringes, uh, that's why appreciated. (F., male, 42 years old, Italian origin)*

Among the Spanish-speaking participants, however, only one person made use of the DCR, while others indicated they rather use alone, or they didn't want to be surrounded by injecting drug users as persons smoking or snorting drugs. In this sense, the importance of specialised services for persons smoking and snorting was mentioned as important by two participants. Additionally, one participant underscored the importance of more information on the safe consumption of drugs through snorting.

> *Passing a pipe from one person to another, same risk. Using a straw, too. The nose can bleed. I tend to use a magazine page, cut it, use it, then toss it. But a lot of folks just use a bill and keep it all night, blood and all. Most snorters? Their nasal septum is busted. They end up with a hole here, bleeding. Everyone's blood mixing together when they share. (...) With smoking, it's not as bad. Sure, teeth get ruined, but that's about it. But snort? That septum gets perforated. The acid in stuff like cocaine, heroin, it eats away the flesh, creating a hole. It's all raw inside. So, it bleeds. But you wouldn't know, never having used. If you ever did – and I hope you don't – or met someone heavy into it, you'd see the bleeding. It's just how it is. (A., male, 36 years old, Spanish origin)*

Two intra-European participants mentioned the presence of a social worker in the DCR as very helpful:

> *I think it's a good solution. I mean, I can go to the user room. (...) Like the clerk [one of the attendants] is making a good job. For example, he's also a little like a social worker, you know, he knows the people- (...) I mean, not just that-- something like a street worker, a social worker, something like this that you still ... that somebody from outside can have a look into the drug-using scene and you have contact and friendship and I think this is very important. (...) In the-the City of Amsterdam, the municipality itself accepts that there are users, and they offer us user rooms that they have contact with the drug users. I think that's important. Otherwise, it's something like day and night, you know, there's something going on, but nobody knows what happens. (R., male, 36 years old, Austrian origin)*

The social workers at AMOC were also considered helpful for arranging social affairs (e.g., short-term housing, help with paperwork, fines) and as someone to talk to. Nevertheless, three participants indicated that it depends on the (connection with) the social worker whether it feels like helpful or not. Some of them were described as "wonderful people doing it from the heart", while others were considered less friendly or helpful. In general, good social workers are described as open, friendly, whom you can have a "honest relationship" with.

> *You don't feel too much the difference. [...] Many people let you feel that you are, um, not sick person, but you different. But here, um, I never had this, uh, feeling, so I really appreciate, that's why I say very professional people, because, uh, I think not everybody can do this job. You must have it inside. The thing to help people, you know? And yes, until now, I find a lot of professionality from everybody. Very much. (F., male, 42 years old, Italian origin)*

The Arabic participants from the LGBTQIA+ community involved in this study were rarely in contact with services. They did receive benefits from the state through (student) housing and a student salary, but most participants indicated that this was insufficient. One participant indicated that he received support from a refugee organization the first three years after arriving in the Netherlands, but emphasized the importance of ongoing psychological support to deal with the loneliness and trauma related to being a refugee. One person referred to Mainline in that perspective:

> *I contacted Mainline and learned a lot from them. After that, I started to feel that there is hope. I'll be able to overcome or distance myself from the world of drug use. (V., male, 31 years old, Libanese origin)*

Yet, all participants indicated a severe shortage of support services for refugees.

Barriers to care and other sources of support

Among the sample of intra-European migrants, five persons talked about not having an insurance as a barrier to access medical care, including methadone treatment. One participant confirmed that this was related to not having a house and address. As there is a maximum of people without insurance that AMOC is allowed to provide methadone, one person indicated he was on a waiting list, while another person described that he only got access to methadone after he tried to hang himself under a bridge. Also, participants stated that not having a home address and related BSN number was a barrier to work. Other barriers to work discussed by the participants included not being able to work due to physical dependence and withdrawal symptoms and not having access to methadone. One participant talked about how the first month of not being paid by your employer is challenging for people in precarious situations, as trying to fulfil basic needs is a daily struggle that requires a lot of time on specific hours (e.g., to get distributed food).

> *I could go to work because I could go back to the shelter, you know at five o'clock, sleep and eat and the next day go to work. But without is not possible. So first, you would need housing, and then think about work. (B., male, 53 years old, Hungarian origin)*

Three people talked about waiting lists for shelter, especially in summer. For those eligible, waiting lists were described to make people wait up to ten years for social housing. Two persons indicated they did not want any help from drug services, either because they chose to use substances and had other issues to worry about, or because they wanted to face their substance use problems on their own.

Due to barriers to care, one participant indicated that he got himself detained in prison on purpose, so he would have a roof over his head and have an environment where he could refrain from heroin.

Two participants from Arabic origin indicated that support services were simply unavailable. They pointed to waiting lists for drug and psychological services. One person indicated he was refused therapy because of the language barrier, while another pointed to language barriers as a reason for the long waiting lists. On a personal level, one person did not like to ask for help because of bad experiences with services in the past, two persons talked about how they weren't aware of services and didn't know the way. Another person talked about self-stigma and shame about their drug problems as barrier to drug services.

> *I have no contact with any organization or with anyone. Not once have I contacted a hospital or organizations. (...) There is nothing preventing me from doing that, but the idea of me going to an organization and telling them that I am kind of addicted to a certain drug makes me feel shame. Or I feel that I won't be able to face them and say that to them... and just the idea of going there terrifies me. It's the same thing when it comes to psychological/mental health support. (...) I went to the family doctor here once and told him that I am a person who is addicted to drugs, and that I am using, and that without drugs, I am unable to communicate with people. He said to me, "I cannot help you. I can refer you to an organization that deals with addiction." And indeed, he transferred me and I didn't go to the appointment. I cancelled the appointment because I felt ashamed." (S^2., transgender, 29 years old, Syrian origin)*

To increase the accessibility of support services, participants mentioned the importance of Arabic or English-speaking therapists to reduce waiting lists and offer culturally and linguistically tailored trauma treatment.

> *The majority of organizations provide treatment in Dutch, so the ones (doctors) who speak English are very rare, and the waiting list is very long. In order to receive treatment in English, I had to apply through a third-party organization. (...) Unfortunately, today I was at X [organization] who informed me that there was something wrong with my application for "trauma treatment." Now she will send a new "letter" to the organization so that I'm put back on the list. This process can take between 6 months to a year. (V., male, 31 years old, Lebanese origin)*

Participants pointed to the need of increasing accessibility of information on drugs and drug services by distributing leaflets in different languages and in relevant contexts.

> *I feel that there should be organizations that raise awareness, frankly because I am one of the people who entered the drugs world because I didn't know better. I didn't know what drugs are, what they do to a person. And I had never bought drugs before. I mean, the drugs I used I got for free from other people who were present at a party or at a house, et cetera. I feel that awareness should be raised regarding this issue, so that no more people fall victims to it. (V., 31 years old, male, Lebanese origin)*

The main barrier toward (harm reduction) services among Spanish-speaking migrants is not knowing where to go or where to find the services. Participants talked about not wanting to be surrounded by persons using drugs, bad experiences with services in the past and personal barriers such as other priorities (a place to live) or a sense of willing to be self-sustainable regarding housing and psychological issues. The bad experiences in the past were related to not feeling heard and hence, one participant underscored the importance of acknowledging experiential knowledge in drug services.

> *I believe that all of these people wandering through the services have different needs, undoubtedly different needs. They also have a lot of life experience. Sometimes, in one or two sentences, they surprise you. (J., male, 47 years old, Peruvian origin)*

Several Spanish-speaking participants underscored the importance of work in order to increase their wellbeing, but mentioned various barriers to work related to addiction (i.e., needing to 'stop' or reduce substance use, as well as allowing the combination of medication or substitution treatment with work) or other issues (e.g. having lost their passport, language barriers and not having a place to live).

Encounters with the criminal justice system

The Spanish-speaking participants in this study had few experiences with the criminal justice system because they underscored the importance of finding 'legal' ways to survive, such as finding bottles to exchange for money. Three participants stated that they didn't have any issues with police officers because they were not involved in criminal activities such as stealing or dealing substances for financial survival (anymore). Nevertheless, J[1]., who was hold in arrest twice for sleeping rough without certified identity papers, pointed to the contradiction of being fined for "sleeping on the streets":

> *They wanted to give me a €150 ticket for sleeping on the street. I asked him, "Are you really going to give me a €150 ticket? How am I going to pay for it if I sleep on the street?" (J[1]., male, 33 years old, Colombian origin)*

Among the intra-European participants, all but one reported to have spent some time in prison, either in the Netherlands or abroad. Two participants had been deported from the US and came to the Netherlands, while one had been deported from the Netherlands to Bulgaria but managed to come back. The one person that had not been in prison before explained that this was thanks to the social (financial) support he received. The conditions in prison were described as generally comfortable and good, especially in comparison to life on the streets, except from the fact that methadone is not sufficiently provided in prison, which may cause health risks for persons who use drugs.

R. explained the vicious circle of homelessness and criminality as well as the irony of being detained for not paying fines related to public transport and homelessness:

> *Yeah, being homeless, sometimes they check you. I got a fine for sleeping outside, for being homeless. This is really crazy, huh? (...) It can be, uh, um, a self-fulfilling prophecy, the homelessness, to get criminal, you know? You get the fines, everything. But I was like three times in jail for the public transport ticket. For €1.90, I was 30 hours in the prison. [...] Then they need to give you four cigarettes a day, you get cheese, bread, you get coffee, you get sleeping place, they need to pay the people. So instead of the 1 euro 90, I didn't pay, they need to pay like €100 a day for you, you know? (R., male, 36 years old, Austrian origin)*

Encounters with law enforcement were generally described as positive. Depending on whom they encountered, participants described the police as mostly friendly, social and empathic, especially when compared to police in Austria and Poland. Four participants indicated that they had received help from the police to find shelter (n=3) and OAT (n=1). One participant felt that some arrests he had encountered as well as the way his case was handled in court was influenced by discriminatory attitudes towards migrants and people with a Russian background.

3.2.3. Focus groups

Respondents

In Amsterdam, one focus group was held with seven practitioners who work with migrants who use drugs. The focus group was held in English and lasted for about two hours.
The attendees were:

- A police officer, often the first contact of persons experiencing homelessness hanging around at the central station. The police often guides them to drop-in centres and services they can access.
- A social worker working at De Regenboog Groep and the DCR
- A social worker working at Schiphol Airport, where PMWUD regularly come to find shelter, come or gather drugs. They try to direct them to other services
- A person who is a migrant and who uses drugs
- A therapist for people with addiction problems at the Jellinek addiction centre. He works also in the client council for homeless people
- A staff member of the MDHG, an advocacy organization for persons using drugs
- A general practitioner working with refugees and homeless people and coordinating a medical centre that provides medical and psychosocial care to persons who cannot find help in regular healthcare services

One practitioner working at Mainline could eventually not attend the focus group, but provided the local researcher a document in which he answered the focus group questions from his professional experiences in the field of harm reduction, chemsex and sexualized drug use. His answers were also analysed and included in the results. Between brackets, we refer to which person mentioned which quote.

Results

a. A stable place to sleep

Needs

All respondents underscore the importance of a stable place to sleep for the general wellbeing of PMWUD, but also for creating opportunities for recovery.

> *I think one of the first needs that there are is, uh, a stable place to sleep. Doesn't have to be a house, doesn't have to be whatever, some beautiful thing, but a stable thing to sleep. Because if you cannot sleep, you cannot function. (V.)*

As a person with lived experiences, F. acknowledges the difficulties of living on the streets and the negative impact it had on his substance use. The stress that accompanies living on the streets as a PMWUD and the negative impact this may have on persons' wellbeing and opportunities for recovery is acknowledged by the other participants as well.

> *If you're in a survival mode all day by getting your drugs, um, finding a place to sleep, uh, running away from, uh, no from that, from, from M. [police officer], but just watching all your shoulder, that's like, that's like a whole day's work. That's what they say. You're, you're doing this whole day. You only moment in if you have some peace to yourself and a place to stay and to sit and, and rearrange your thoughts, that, that's usually the moment where you think, well, maybe I should think about quitting or kind of doing it like that. (D.)*

A stable place to sleep is mentioned as a prerequisite for being able to work, which is, in turn, mentioned as a prerequisite for access to other resources such as governmental support for housing and insurance, but also for being able to focus on personal goals, which may include (re)gaining control over substance use. Yet, the temporality of these shelters comes with a lot of uncertainty for the people making use of it as well. Respondents underscore the precariousness of temporary shelters with multiple people being crammed in one room and indicate that some PMWUD therefore rather sleep on the streets, in a train station, or at the airport, because it is more quiet. They advocate for Housing First-initiatives and private rooms in the shelters.

The respondents discussed about a project that carries out Housing First-principles. Though supporting this initiative, they also point at its limitations. There are only 30 places available and persons can stay in these places for a maximum of six months, which was considered insufficient to stabilize persons with severe needs such as PMWUD. This time limitation is not only a source of stress as such, but it is also insufficient to work toward a better future with someone, especially because of the complex problems PMWUD may face. V. mentions that many PMWUD suffer from PTSD due to traumatic experiences in their home countries and country of residence. To stabilize the many social, psychological and drug problems that PMWUD face, the participants agree that there is more time needed to promote change. V. critically remarked that merely offering housing for six months without other changes in the environment, does not offer any solution:

> *So basically what you do, you get sick fish out of a sick sea, you try to make them better, and then you throw out back in the sick sea again, hoping they are stronger. (V.)*

Respondents share their concerns about PMWUD often being surrounded by other people who use drugs in the shelter or other accommodations, which may have a negative impact on their substance use. This was also mentioned in regard to housing-related jobs, where, according to W., many EU labour migrants use amphetamines to be able work long hours. Hence, the respondents underscore the importance of long-term housing opportunities for PMWUD.

Barriers

Besides the discomfort of night shelters and the related preference of some PMWUD to sleep in other places, the respondents mainly point to meso- and macro-level barriers to housing. Respondents agree that there is too few shelter and housing opportunities for homeless people in Amsterdam, especially for PMWUD who may not be entitled to certain forms of housing because they are undocumented or have not worked for long enough. Hence, housing and shelter opportunities are often preserved for the most 'severe cases', excluding a lot of people whose situation may become worse because of the lack of housing. According to some respondents, a national, rather than local policy on this matter, may increase opportunities for shelter and housing. Several respondents indicate that they have been advocating for more and more humane shelter options for homeless people, but that the governments are not doing anything about it, because they are scared that it would attract people or that too many people would make use of it. Also, the 'not in my backyard' attitude was put forward as one of the main reasons why there are insufficient housing opportunities for homeless people.

b. Medical care and OAT

Support needs

While basic needs such as a shower and food are mostly addressed by available services, medical needs are considered at least as important but harder to be fulfilled. J. indicates that many of the diseases PMWUD suffer from, are related to homelessness. She underscores the importance of collaboration with centres like AMOC to combine social and health care services.

A central aspect of medical help that respondents talk about extensively is opioid substitution treatment. D. explains that history has shown that OAT can help persons who use drugs to (re) gain control over their substance use, it can decrease crime rates and increase the health of persons who use drugs. Other respondents agree and the same is said about harm reduction services. Hence, respondents underscore the importance of providing methadone and harm reduction services to PMWUD. Since many PMWUD live on the streets, W. refers to a good practice in Rotterdam, where a methadone bus provides health and social care as well as methadone to people living on the streets. She also indicates that this provides an opportunity to inform people about drugs, addiction and available services.

Barriers

While W. indicates that PMWUD do not need an insurance to receive methadone, other respondents still point to several barriers toward methadone provision. First, F. points to the fact that, because there is a black market of methadone in Amsterdam, health care providers are less likely to trust people who ask for methadone. Second, there seems to be a lot of misunderstanding on the right to health care for PMWUD. While PMWUD have the right to basic health care, it is not always clear to service providers what this basic health care comprises, which may lead to the unfair and unjust exclusion of PMWUD from certain services. Due to the free movement of persons within Europe, many EU migrants are not registered in the Dutch Immigration and Naturalisation Service (IND). These persons, who are granted BRP-code 30 by the IND, can access health care under certain circumstances. D. talks about how this 'code 30' functions as an exclusion criterion in certain services, becoming a barrier to services even though it shouldn't necessarily be one. Other confusions, such as needing a health insurance or being Dutch to access methadone, may also wrongly exclude PMWUD from essential health care. D. and W. share their concerns that it is almost impossible to fight these unjust exclusion processes in court, since they are not often written in paper.

This confusion was confirmed when the respondents started discussing access to healthcare through insurance. Some respondents stated that, while health insurance is obligatory in the Netherlands, undocumented migrants and EU migrants who have not worked for more than 6.5 uninterrupted months, may not have access to insurance. Since many PMWUD cannot work due to addiction, not having a work permit, homelessness or other personal or social problems, the respondents raise this prerequisite for insurance and other governmental financial and housing resources as problematic. Furthermore, the respondents discuss that PMWUD who don't have an insurance are often wrongly denied healthcare, while actually, they can still receive health care, but they must give an address for expensive bills that they are often not able to pay. J. points out that general practitioners can provide some basic health care to people without insurance and can declare maximum 80 percent of the costs made to the CAK[1]. However, D. points out that it is not always clear what elements of health care are included in this package of basic health care and whether harm reduction services, for example, are included.

Overall, the respondents emphasize the need to make health care, harm reduction and OAT services more accessible to PMWUD.

[1] CAK is a solidarity fund aiming to enable health care for undocumented persons (Velden, 2018).

> *We [in the Netherlands] have the most healthy drug, actively drug using people in the world. Why? 'Cause of this whole harm reduction program. And I think the majority of our members who are Dutch, they use every day, but they don't have a problem. Why? 'Cause they have a place to stay. They have. Uh, healthcare, access to healthcare, all these basic things they have access to that these people [PMWUD] have no access to. (...) Just give them what they're entitled to and give them more rights so they can, I don't know, get access to the same healthcare as I can do if I, if I hit rock bottom or before I hit rock bottom preferably, or, uh, and in the meantime, why you don't give them access to that? (...) Don't make it so hard for people to, to get access to things like methadone and these kind of things. (V.)*

c. Other (support) needs: information, jobs and financial resources

This importance of psycho-education about drugs and addiction is underscored by J., who has observed that many PMWUD are unaware of addiction as a brain disorder and what is needed to overcome addiction. Also L., who is working with persons with a migration background who use drugs in the context of chemsex, underscores that these people get into drugs unknowingly and unaware of its potential risks. They underscore the importance of providing information about drugs, drug policies and safe drug use in multiple languages.

F. talked about the importance to be busy and not having to think about drugs. However, when working, he often felt betrayed by his employees, who promised him things they did not honour. Other respondents describe the lack of work as a barrier towards health insurance, health care and money. Yet, they also mention creative ways in which PMWUD raise money, such as the collection of cans which can be exchanged for 15 cent each.

d. From harm reduction to recovery

J. conveys her struggle as a general practitioner with how to best help PMWUD when they come to see her. To what extent should a doctor address substance dependence when PMWUD come for other health issues? Depending on the needs of the person who uses drugs, the function of social workers and health care providers may range from acceptance of drug use and focus upon other life domains to helping persons move towards sobriety through residential admission or a gradual decrease of OAT. In that regard, V. indicated: "Some are very scared to stop", while F., a person who uses drugs, answered, "For me it's the opposite, I'm very scared to be addicted."

F. indicates that many PMWUD want to stop using drugs, but that they are not able to. The respondents point to a myriad of reasons why they find it difficult to stop using substances, even if they want to. Their substance use may be a survival strategy for other problems that need to be fixed first (e.g., psychiatric or housing problems). There may be a lack of motivation, no (supportive) social network, or insufficient hope for the future. As addiction is a brain disorder, respondents state that persons need at least a substantial period of residential admission, which may help them to physically detox and put things in order. They agree that there is no point in treating persons with drug dependence if they go back to the same environment with the same challenges.

e. From punishment to care

All participants agree that punishing PMWUD with fines and penalties does not work and may even add difficulties to their situation, increase financial problems, and eventually cause that their residence permit is revoked. One of the respondents stated that an accumulation of penalties and fines may reduce access to other resources such as a job.

> *You're just piling it up to the debt they have already. The bigger the debt, the further they will get away building something that they can have a normal life again. (D.)*

Respondents additionally talked about the fact that many PMWUD do not want to go back to their country of origin, because they are ashamed of their situation and don not want to contact family, or because their situation in Amsterdam is still better compared to the situation they would be in in their home country.

Several respondents state that many policemen take time to help PMWUD and refer them to help resources rather than punishing them. Still, some social and health care services find it difficult to collaborate with the police. Participants agreed that police officers need to be (better) trained in how to work with PMWUD.

3.2.4. Conclusion

Study participants from intra-European origin and Spanish-speaking migrants were mostly homeless at the time of the interview. They could occasionally make use of winter shelters, but due to the physical burden as well as the mental uncertainty and stress of homelessness, housing was by far the most prominent support need. The importance of shelters, housing and a stable places to sleep was confirmed during the focus groups with practitioners. They raised a shortage of shelter and housing opportunities for PMWUD as a major barrier towards increasing the wellbeing of PMWUD. Focus group respondents further stressed that long-term addiction support is not effective if basic needs are not met and PMWUD cannot stay in a safe environment.

The intra-European migrant sample predominantly started using drugs at a young age in their home country. Many of them were injecting heroin and cocaine, besides involvement in OAT, and they frequently visited a DCR. While many of them reported mental health problems, only few indicated they wanted support with this. Next to housing, the most common needs reported were the need for work or training and the importance of (take-home) OAT to be able do so. This was confirmed during the focus group, where - in turn - the importance of work was underscored to get access to health insurance.
Spanish-speaking study participants did not inject substances and used more frequently on the streets. Besides housing, they were mainly looking for education and work, and to a lesser extent, for psychological support.

Most intra-European participants had encounters with criminal justice system and had spent time in jail for (drug-related) offences either in their home country or in the Netherlands. Yet, the conditions in prison were often considered to be better than these on the streets.

While health issues among participants were limited and harm reduction services usually met these medical needs, the focus group discussion showed that many PMWUD are often excluded from medical care due to legal barriers. While most participants from a intra-European or Spanish-speaking background had European ID's, this does not necessarily mean that they have access to health insurance, which is necessary to access health care services such as visits to a general practitioner or psychiatrist, for hospital visits and medicines. The lack of health insurance (especially mentioned by intra-European migrants) is often related to homelessness, since the lack of a home address may be a barrier to accessing health insurance.

Persons from Arabic origin involved in the Chemsex scene displayed less frequent drug use and other patterns of use compared to the other participants. They often indicated a lack of support services and the lack social connection and search for belonging led them to use drugs after their migration. Relatedly, the importance of culturally/linguistically tailored information about drug use and safe consumption was underscored during the focus group.

Most of these Arabic speaking LGTBQIA+ participants were students who lived in student housing and who indicated they could barely make ends meet. Psychological issues due to trauma in their home country and the inaccessibility of support due to waiting lists and language barriers had a major impact on their wellbeing.

For all three ethnic/cultural communities in Amsterdam, waiting lists and language barriers were major barriers to receiving support. Also, the accumulation of fines and penalties had a counterproductive effect for PMWUD.

3.2. Athens

3.2.1. Context

About 3.15 million people are registered as residents in the metropolitan area of Athens, the capital of Greece and its surrounding urban and suburban areas. While the influx of migrants in Greece has decreased in the last few years, a substantial part of the Greek population is foreign-born (13,1%). The most common countries of birth among foreign-born citizens in Greece are Albania, Georgia and Pakistan (OECDiLibrairy, 2023). Since the start of the European migration crisis (2013), Greece is one of the countries where refugees first enter the EU.

The most commonly used substances by PWUD in Greece are alcohol, marihuana and cocaine (EMCDDA, 2023b). Additionally, sisa is a relatively new synthetic and low-cost drug that has been on the rise in Greece recently and is often used by persons with low socio-economic status (Nikolaou et al., 2013).

Access to health care

It is unclear whether emergency care for undocumented migrants and newcomers is for free in Greece. Primary care (essential treatment of relatively common minor diseases provided in an outpatient or community-based centre) and specialist care (by specialist doctors or provided in inpatient settings) are supposed to be available for undocumented persons, but only against payment (FRA, 2016).

A study conducted in 2017, indicated that the Greek Constitution recognizes health as a fundamental social right. In 2016, a new legislation (4368/2016) opened access to the public health system for persons without insurance and vulnerable social groups. Asylum seekers and refugees are considered vulnerable groups and thus, should have access to the public health care system for free. However, the law stipulates that a social security number needs to be presented to obtain care.

For undocumented migrants, offering support beyond emergency care is generally prohibited by law. EU citizens with no resources or health coverage are considered to be undocumented migrants for having access to health care. The Greek law also permits the detention of migrants and asylum seekers who are said to be a danger to public health, including persons who inject drugs, persons whose conditions don't permit basic hygiene and persons suffering from infectious diseases (e.g. tbc). HIV testing and treatment is supposed to be for free for all people living in Greece, regardless of their legal status and health coverage (Médecins du monde, 2017).

Access to social security

Greek citizens and foreign nationals with regular residency status in Greece can equally access social benefits, as eligibility criteria are not contingent upon nationality. However, social benefits are inaccessible for those without official residence papers (Marini, 2020).

3.2.2. Interviews

Introduction

The interviews in Athens were organized by Positive Voice, the Association of people living with HIV in Greece. The Association was founded in 2009 with the aim of defending the rights of HIV-positive persons, dealing with the spread of HIV, as well as limiting its social and economic effects in Greece. To achieve this purpose, the association strives to ensure better prevention and information practices, care and social support services for people living with HIV as well as HIV-vulnerable social groups. They offer peer-led harm reduction services to HIV-vulnerable groups, including persons who use drugs and those involved in Chemsex. At the same time, Positive Voice works for more social acceptance, solidarity and support of these groups to deal with violations of their dignity and human rights.

In Athens, the following three communities were targeted during the interviews:

- Persons from Maghreb/Arabic origin (n=6, all cisgender men)
- Persons from Sub-Saharan African origin (n=4, all cisgender men)
- Persons with a migration background residing in the open drug scenes of Athens (n=10, all cisgender men)

The interviews were conducted by Marios Atzemis. Marios, who works for Positive Voice, describes himself as a HIV+ former injecting drug user with the lived experience of problematic drug use (heroin and cocaine for more than 20 years). He is a board member of the Drug Policy Network of South-East Europe and participates in the steering committee of AIDS Action Europe, as well as the Civil Society forum on Drugs, which is the consulting body of the EU regarding drug policy.

All interviews were conducted in Greek (n=20), sometimes partly in English (n=4).

The local and community researcher identified the three above-mentioned communities for the following reasons:

Person from Maghreb and Arabic origin have changed the "human geography" of drug scenes in Athens drastically. They are generally older than other foreign populations in the drug scene. Most of them speak Greek, so they can reach the services more easily. They are also quite well integrated among Greek and Greek-speaking persons who use drugs. This particular population was chosen because they are accessible for interviews, but also because exploring their needs is interesting in light of the changes in the composition of the population of persons with a migration background who use drugs after 2015.

The Sub-Saharan African community is described as having specific peculiarities when it comes to problem drug use. Marios describes this as follows:

> *"It is common to see small groups of people, mainly from Nigerian descent, selling illegal substances, but it is unlikely to see people from Africa using in the streets. In that context, it is a hidden population that reveals itself when they reach out to services. I remember how surprised I felt when back at 2016 we went as Positive Voice to make an informative/educational seminar to Mosaic, a drug-free outpatient unit for foreigners, regarding HIV, HCV (hepatitis C) and HBV (hepatitis B) and the crowd there was mostly persons from Africa. A bit later, I realized for numerous reasons that persons using drugs from Africa are not going out to the open scenes for drugs, but rather tend to receive their supplies directly from their peers. Furthermore, after the Olympic Games in 2004, persons from Nigerian origin drastically changed the scenery of the open scenes. There was a change in availability, pricing, substance quality and in other things that affected the drug field and directly influenced the entire group of persons using drugs. It was a matter of time to affect other African populations as well."*

Immigrants residing in the open drug scenes of Athens were chosen to interview because they represent an increasing population. Though it was an accessible population for the interviews, they are described as particularly vulnerable because they don't reach out to services easily. Being present in an open drug scene makes them subject to numerous vulnerabilities other than problematic drug use itself. According to the local researcher, people that constitute the migrant and refugee population in the open scenes are mainly from Asian and (to a lesser extent) from Maghreb countries. The local researchers describes how their presence changed the scenery in the open drug scenes, especially related to the use of sisa. He further argues that, given the fact that there is not a specific therapeutic response for sisa, as well as due to the rising Islamophobia in the Greek society and the hate and smear campaigns and rhetoric regarding migrants and refugees, persons who use drugs from these populations are deemed extremely vulnerable.

Results

Profiles

a. Migration background and documentation status

The participants from Maghreb countries (n=6) were between 25 and 40 years old. Three participants were born in Morocco, two in Algeria, and one in Tunesia. They migrated to Greece between two and 16 years prior to the interview, which explains why most interviews were conducted in Greek. Reasons for migration included migrating together with the family (n=1), work (n=2) and 'looking for a better life' (n=2). Two participants indicated they had a valid residence permit in Greece. The others either lost their ID or had their residence permit expired before obtaining a new one. Most participants indicated that they wanted to stay in Greece if they are able to improve their living conditions (e.g., finding housing and a job).

Participants from Sub-Saharan African origin (n=4), were born in Ethiopia, Egypt, Sudan and Congo. They were between 33 and 56 years old and migrated to be reunited with their family (n=2) or for seeking political asylum (n=1). Two persons had a valid residence permit, one indicated he had lost it and one indicated that it expired.

In the open drug scenes of Athens, persons from various origins live on the streets and use drugs (n=10). Most of them identify as refugees due to war and prosecution in their home countries. Other reasons for migration included financial and job-related reasons and looking for a better future. Countries of birth included Iraq (n=2), Iran (n=2), Syria, Pakistan, Afghanistan and Bangladesh and Saoudi-Arabia. None of these participants had a Greek nationality, but six of them indicated to have official residence documents through an asylum status, either permanently (n=2), temporarily (n=2) or unspecified (n=2). The others indicated to have lost their identity documents (n=2), they expired (n=1) or only had documents from their home country (n=1). These participants were between 22 and 58 years old (mean= 40,9) and had been living in Greece for between five and 34 years.

> *"It's a long story... Politics. Okay, because it's my ancestry, my grandfather was born in Iran and stuff like that. And they... how do you... they cancelled our identities and they destroyed us, I mean they took my brother, they killed him." (K., male, 58 years old, Iraqi origin)*

b. Substance use

Among Maghreb interviewees, one participant did not want to provide any information on his substance use. Three participants indicated to use cocaine on a daily basis, of which two in combination with (injected) heroin. Two participants talked about smoking methamphetamine in the form of 'sisa'. Three participants used depressants, of which one participant indicated to use so-called green pills (better known as flunitrazepam, Rohypnol or Hypnosedon). None of the participants were involved in opioid substitution treatment at the time of the interviews. Participants mainly used on the streets and indicated that their drive for substance use could be traced back to physical dependence (n=3), next to giving courage (n=1) and helping to forget problems related to precarious living conditions and loneliness (n=1). The majority used illicit substances for the first time in Greece, indicating that 'dope' and other drugs like sisa were not around in their country of origin. This was also indicated by the persons living in the open drug scenes of Athens.

Persons living in the open drug scenes of Athens reported regular use of sisa (n=8), besides heroin (n=8) and so-called green pills (i.e., flunitrazepam) (n=4). The majority mentioned poly-substance use. However, one participant indicated that he only used sisa, while another one indicated that the use of sisa helped him stop drinking alcohol and use heroin. None of these persons was involved in OAT. They mainly used on the streets (n=8) and at the DCR (n=5). One person talked about how he got involved in the drug scene due to peer pressure, but all others linked it to passing time on the streets, which was considered a burden, and to coping with loneliness.

One participant from the Sub-Saharan African community was involved in OAT and used cannabis on a daily basis. The others used heroin (n=3) and (crack) cocaine (n=2), together with cannabis (n=1) and sisa (n=1). They all used on the streets, but one person additionally made use of the DCR.

Several participants described a negative vicious cycle starting with homelessness, living in the margins due to their illegal status and not having a job. One participant described how he eventually ended up in prison for dealing drugs. He lost his residence permit, leading him to live a life in the margins and not being able to travel to his home country. The related feelings of sadness and loneliness drove him to increase his drug use.

> *I was in a situation as I am now, unemployed, I had no job, I had nothing. I got busy using drugs. Using and using, then I said if I use, where am I going to get money? I was taking it and using and pushing also. That's how I got my stuff. Yeah. And we went together, somebody told me, good money, go to Giannena. I went there... It was 10 grams, not even 10 grams, it was three grams, they said 13 grams. 13 grams kept me in prison for 12 years. They had me on internal market and as a dealer. But for that to tear up my papers? So I wouldn't go home to see my mother [crying]. I haven't seen her since. (G., male, 44 years old, Bangladeshi origin)*

c. Social network

Most participants from the three communities in Athens were not in contact with their family, which was often a source of emotional struggle and pain that is numbed by substance use.

> *I only have the hope to go back to where I was born. To say home? Okay, it's not home. Until they [prosecutors in home country] say I can take it back. Home. To see my brothers and sisters, what can I say. (K., male, 58 years old, Iraqi origin)*

G. answered the following to the question about his drive for drug use:

> *I have nothing in my life, everything is zero. That's why. I left my brothers and sisters young, they're all grown up. My mother got old, I can't touch her for my father always complained that I wouldn't hold you in my arms. That's why. (G., male, 44 years old, Bangladeshi origin)*

Most participants simultaneously discussed not to have any friends to rely on, except for three participants who talked about a small network of people who are in similar situations like them (mainly persons with a similar migration background using drugs on the streets) and helped them. Two persons described the helpfulness of friends they could rely on. The others mainly referred to the harsh living conditions on the streets, including being betrayed by others in the open drug scenes leading to mistrust and social isolation.

d. Medical and mental health problems

Among the Maghreb participants, several persons described experiencing hallucinations, as well as feeling 'crap', 'very down' and 'awful' when asked about their emotional state. Three persons had been diagnosed with hepatitis C, two persons were living with HIV, and one participant talked about diabetes as a major physical health need. Both persons with HIV were not getting any medication or medical help for HIV at the time of the interview. Yet, they were referred to treatment during the interview.

Some persons residing in the open drug scenes reported HIV (n=2), Hepatitis C (n=2) and heart problems (n=2), as well as psychological problems referred to as 'problems in their head' (n=2), sadness, a mind that is 'not well', depression and suicide attempts. Among Sub-Saharan African participants, one had HIV, one was diagnosed with hepatitis, one described his mental state as being down and one talked about having schizophrenia.

(Support) needs

Related to the high homelessness rates as well as the lack of official residence permits among participants, the most pressing support needs mentioned were stable housing (including electricity and warm water) and legal residence permits.

Most participants from Maghreb countries and the open drug scenes were living on the streets. They found occasional shelter in a guesthouse or other emergency shelters. Fear and uncertainty of not having a stable home were linked to insomnia, while stable housing was mentioned as a prerequisite to be able to gain control over other life domains such as drug use and work.

> *Nowadays, I'm out on the streets because I do not have a home, nor somebody because there aren't many people here, nor people whom I know that could welcome me as a guest and sadly I am stuck in the streets which tires me out. (...) Basically, you live under constant fear that you will be robbed, or they will beat you up causing you to be unable to get any sleep, which in turn brought me insomnia. (...) I cannot take it anymore, I do not know how to cope with it, it's hard to live in the streets and not to have a house, a place to stay in if you understand me. (...) First things first, I would want to rest properly and have a place to stay, and afterwards I want to continue searching for a job, because I've been already searching for one but in my current condition, it hasn't been going well. I'm tired of not having my own shower, electricity, a roof above my head and my base utilities. (...) I would want a job in order to get myself organized. I constantly think about my future and I do everything in order to not have to repeat the same hardships. (...) If I had those I would stay away from drugs. (Y., male, 38 years old, Tunisian origin)*

Several participants underscored the harsh conditions of living on the streets where they don't feel safe. I. talked about how, due to his visible Maghreb migration background, he was enforced by other persons with a different migration background to do things he did not want to do out of fear for his own life.

> *And the guys don't accept, I need to steal, I need to... No, what should I do for the others... We found those we know, dead... It's hard to... We're having a hard time there and we feel now lately that it's worse and dangerous. I am afraid because I am a refugee and because I have black people... Nigerians look at me differently.... (I., male, 43 years old, Saoudi-Arabian origin)*

The Sub-Saharan African participants seemed to be in more stable situations, with three of them residing in a guesthouse. Nevertheless, one participant indicated that this wasn't a place that 'feels like home'.

Across the three communities, the majority of participants discussed that their basic needs of food and hygiene were met thanks to organizations such as emergency night shelters, KETHEA and OKANA. KETHEA is the largest rehabilitation and social reintegration network for persons who use drugs in Greece. Their services are aimed at abstinence and their programs are drug-free, but they have a specialised unit with cultural mediators, translators and staff experienced in supporting migrants and refugees. OKANA's work and programs can be situated in the fields of drug prevention, drug treatment and social reintegration of people facing problems related to substance use. They offer both drug-free treatment programs, low-threshold harm reduction services and OAT to persons with substance dependence. Hunger and access to food were mentioned as unfulfilled support needs by two participants. Additionally, two persons mentioned that they received food from people on the streets, unconnected to organisations.

> *Here in Greece, there is no problem with food, there is food...it is...from the municipality...from the church...from the people...do you understand? (F., male, 40 years old, Moroccan)*

Most participants indicated that they had worked in the past and wanted to work again, but that a stable home and residence papers are prerequisites to be able to work. Similarly, participants from the open drug scenes described their wish to work and earn a salary to provide for themselves, while five of them simultaneously indicated that they could not do so because they didn't have the required permits. Hence, legal support to acquire these permits was deemed important by the majority of participants across the three communities. Some already received help with their residence papers by so-called street lawyers, outreach lawyers from social welfare and harm reduction services.

> *I want to get my papers done quickly to get a job, to be well. (S., male, 25 years old, Iranian origin)*

Because they were not able to work due to legal or health issues, seven persons discussed the need of financial support. Furthermore, residence papers are needed for a social security number, which acted as a barrier towards opioid substitution treatment and HIV treatment. However, one participant without a residence permit indicated that he received free medical support for HIV. Residence papers were also described as needed to visit family (children, mother and other family members) and to overcome feelings of loneliness and guilt towards them. In addition, three participants mentioned the need for a friend or partner. A minority of participants across the communities mentioned the need for psychological support – someone to talk to –because they did not have a lot of persons to rely on within their own network.

Four participants expressed the wish to stop using substances and the need for a program where they can receive therapy (n=3). One participant already had positive experiences with treatment. He was able to quit using heroin after treatment in a 'mental hospital'. Still, he was living in the streets, had no official residence permit and no job. Hence, he described the need to get his papers legalized, find a job and build a stable life.

Harm reduction and social services

Participants were recruited and interviewed in a low-threshold drop-in day centre for persons who use drugs, a guesthouse by Athens' municipality for persons using drugs and a streetwork project offering harm reduction to persons in vulnerable situations. Ten participants pointed to OKANA (a harm reduction service) as a helpful service for having a shower, food, psychological and medical support. Some participants referred to an emergency shelter where food is provided, a specialised drug treatment centre for shower and food, an organisation with street lawyers, and a specialised drug service for persons with a migration background for psychological support. Street lawyers, an initiative by Humanrights360 in collaboration with Steps (a street work organisation), offers legal support to homeless people. They help around legal issues, especially with obtaining residence and other permits.

While few people described psychological help as a priority need, three persons from Sub-Saharan African descent and two from the open drug scenes described a psychologist to talk to as helpful in their trajectory. Thirteen participants across the three communities had been tested on HIV and hepatitis in the past, of which two indicated this happened in prison. In most cases, hepatitis had been treated, but two (Maghreb) participants out of five diagnosed with HIV did not receive any medication for HIV at the time of the interview.

Barriers to care and other resources

Next to housing and a residence permit as barriers toward various resources (cf. supra), participants mentioned accessibility issues towards (harm reduction) services. These barriers were mainly related to negative experiences with these organizations and their staff in the past. Six participants talked about 'not trusting' or 'not liking' staff because of 'bad experiences' in the past, without going into detail about why they felt this way. One participant indicated he didn't feel heard regarding his need to cut down on dosage in OAT. Additionally, the shame of not being able to quit using substances when services tried to help them do so was mentioned by a participant as a reason why he did not want to go back to this service for help. Three participants also talked about not knowing where to go for help.

One participant talked about not going to a service for shelter because he thought Greek persons in vulnerable living situations would get prioritized over his needs as a drug user with a migration background. Stigma regarding substance use was mentioned as a barrier towards a job, besides having no legal documents. A participant discussed the lack of opportunities for recovery after residential substance use treatment, which he called a 'closed community' and linked this to experiences of severe stigma.

Lack of a residence permit was also mentioned by numerous participants as a barrier towards receiving a social security number and OAT. The hopelessness related to barriers that participants experience towards housing and job opportunities, in combination with their current situation of homelessness, could lead them to substance use as a coping mechanism to deal with adversity.

> *That's why I used, because I was without a house, without a card, I can't work. I can't work without an AFM (Greek tax registration number) or AMKA (social security number). It's been a year since I got out of prison and they still haven't given me a social security number. They won't help me. Mrs Hara, the lawyer, helped to give me an asylum card. I wanna work in dish washing. Washing dishes, something else to pass the time, the day. (S., male, 25 years old, Iranian background)*

The same participant mentioned the feeling of not being helped because of his migration background, which drove him – in combination which his homelessness – to the use of sisa.

> *On the street. I had no home. On the street, nobody helps me from Iran and why be burdened with me? Sisa helps you pass the time. (S., male, 25 years old, Iranian background)*

Encounters with the criminal justice system and law enforcement

Half of the Maghreb participants indicated that they had spent time in prison in the past, mainly for drug-related offences, as did five participants from the open drug scenes and one Sub-Saharan African participant. They linked prison to drug use, but also talked about positive experiences of being tested for HIV and Hepatitis C, as well as related to receiving treatment for diagnosed illnesses. One participant who had been treated for HIV in prison, however, discussed that this treatment stopped once he got out, indicating a shortage of continuity of care in and outside prison. Also, two participants talked about not being able to pay the fines and bills for expenses in prison after being released. This led him to fear being arrested by the police, an experience that was shared by two other participants, who indicated that they are scared to be arrested because they have no papers.

One participant from the Sub-Saharan African community indicated that he was severely (physically) abused by the police, while another participant expressed fear of discrimination by police officers due to their substance use.

> *One time, there was a thing with the cops and they broke my ribs and this pierced my lung and I was bleeding internally. (N., male, 53 years old, Ethiopian origin)*

> *If you say any of this [interview content] out there to the police, they'll say something about you, that you stole, something, ... (S., male, 25 years old, Iranian origin)*

Yet, the majority of respondents indicated that they had no problems with the police. On the contrary, police officers were described as being 'good' and one participant talked about how police helped to get control over the violence on the street.

3.2.3. Focus group

Respondents

In Athens, the focus group with service providers was conducted in Greek. The discussion took about two hours and included seven respondents.

- The director of a national focal point involved in drug policy
- A sociologist, who is a person with lived experience of problem drug use who acts as chair in multiple organisations regarding drug dependence, drug prevention and homelessness
- The director of a specialised drug treatment unit for incarcerated or newly released persons who use drugs
- A psychologist and director of a specialized drug treatment unit for persons with a migration background who use drugs
- Infectiologist, specialized in HIV and treating the most vulnerable persons with HIV who use drugs including migrants/refugees
- Advocacy officer at an association for persons living with HIV who is also a gay activist for Human Rights
- President of an association for persons living with HIV

Results

A history of changing needs

The respondents first discussed how the population of users of drug and harm reduction services has changed throughout the years. D. describes how the clients of MOSAIC now have much more complex needs then they used to have, especially as compared to the period before the economic crisis in 2008.

> *I have a house, I have a job, I protect it, and I come to MOSAIC to take, have some sessions, and see what I can do, either get better or go to therapy. In '08 and '09, these populations begin to be very burdened. (...) (D.)*

Respondents further described changes in migration patterns (the increase in the number of refugees and decrease of intra-European labour migrants), as well drug trafficking and drug use patterns (e.g., the rise of sisa and 'Thai') as being one of the main reasons why the population in MOSAIC has changed. According to some respondents, this has led to an overrepresentation of refugees in drug treatment services such as KETHEA. They criticize that this situation may complicate integration efforts among PMWUD and raise the importance for treatment services to be a good mixture of Greek and non-Greek citizens (i.c. PMWUD).

According to some respondents, the changes in migration patterns have led to a growing share of refugees who are in Athens not because they want to stay, but because they are waiting to go to another country or to go back to their country of origin. D. explains that this feeling of temporality with all the uncertainty it brings, may further increase substance use problems and stand in the way of support.

> *"I'm going to leave at some point." Four years have passed. They are not gone. (...) To minimize the use, so that families accept it, even the families who came after living in Greece for four years, "at some point we will leave, at some point we will leave". The dependence became a livelihood, the use, because 70% do some kind of use. A lot of alcohol, so the waiting, the "I am leaving" condition, pragmatically brought an acceptance of the use, in the middle of the camp. From everyone, even the professionals. (D.)*

The respondents question the 'legal gap' in which some PMWUD who have committed crimes are caught, since they cannot leave the country because they are awaiting charges, but simultaneously they don't have any rights. They further discussed how to deal with these issues of temporality, both legally and regarding substance use treatment and care. Legally, some respondents argue that a temporal SSN number (offering access to insurance) for PMWUD with health needs may increase their access to health care, while others state that this may have unintended adverse consequences. In this regard, D. describes the adverse effects of a government measure that aimed to facilitate the provision of legal documents to PMWUD on the basis of humanitarian reasons in the past, but that urged illegal without substance use problems to come to drug services to facilitate access to these documents.

With regard to providing drug treatment and health care, some respondents argue that it is important to recognise this state of transition and the effects this may have on their life goals. The issue of temporality is also mentioned as one of the reasons why it is difficult to provide drug treatment and harm reduction in refugee camps. Nevertheless, experiences of the respondents show that many migrants who actually aim to be in Greece for a short term, eventually stay longer than they had in mind. Hence, V. argues that "we need to treat everyone as our tomorrow's neighbour" and explains:

> *You cannot immobilize a person who is coming as a temporary person [as someone] who will be here for a little while. That is why I describe and say that you are dealing with him potentially, as if he is a person who will be integrated into Greek society. From the beginning, from the first day he comes. And you are obliged to create such structures. Because if you don't create such structures, it goes without saying that he won't want to stay here. (V.)*

However, V. simultaneously pointed to a defence mechanism some migrants may have toward integration, due to a feeling of loyalty to their "Dear homeland" or a desire to go back or move on to another country eventually.

All respondents confirmed the growing complexity of support needs among PMWUD and discussed its implications for organizing care and support. They underscored the need for a hands-on, holistic and integrative approach that addresses the complex needs of PMWUD.

An integrated approach

Due to the rising complexity of the situations of PMWUD, the respondents pointed to a myriad of support needs among PMWUD, of which substance dependence is just one. They warn to look at substance dependence as one piece of the puzzle, one aspect of many roles a person can have and to avoid so-called "traumatic idealisation" and stereotyping.

D. explained that a safe space for PMWUD to reside in is needed for services to be able to provide, social, welfare, legal, psychological, medical and logistic support and "de-addiction". The respondents further discussed that awareness regarding specific support needs among PMWUD is needed. First, they talked about the importance to have interpreters to be able to connect and talk with these clients.

> *The safe space that we provide, and only that he hears his language from the interpreters, it is the first step in an intimacy. This is very basic. (D.)*

V. added to that that he thinks PMWUD learning the language is one of the first steps of effective treatment, so that counsellors can communicate with them and that they have increased opportunities to integrate. This focus on integration through hands-on support and education, vocation and rehabilitation was shared by other respondents.

Second, cultural and diverse sensitivity is mentioned by several respondents as important in supporting PMWUD: taking into account certain sensitivities within and between communities, respecting the diversity in morality and customs and a person-centred approach.

> *It is important that we preserve it [culture of person with migration background] or the songs or the holidays too. (D.)*

> *And the healers, the people who work in such structures, we always need to keep in mind that the one we have in front of us is different from all the others who have passed (V., psychotherapist)*

This was also mentioned in relation to other minority groups, such as sexual and gender minorities. Although respondents did not agree whether specialized services should be providing specific care and services to the needs of sexual and gender minorities, or whether existing services should aim to be inclusive, all participants agreed that a certain sensitivity to the needs of these minorities is needed in order to provide effective support.

The physical burden of substance use on one's body and the related medical needs are also indicated as vital support needs among PMWUD. Due to the interconnection between physical health and addiction problems, L. argued the importance of extending the interconnection of care. She criticized the difficulties of providing substitution substances in hospitals, because it is not generally accepted or because staff is not trained to provide OAT. Furthermore, she underscored the need for continuity between care in hospital and drug treatment services. The shortage of residential services that are open to providing OAT and gradually working towards sobriety is also mentioned as a limitation of the current treatment system.

Finally, some respondents indicated that PMWUD may experience severe pre-, peri- or post-migration trauma, related to the context of their home country (e.g., war, prosecution), traumatic experiences during their journey and after they migrated to Greece. V. explained that substance use is often a way of self-destruction due to trauma from the past. Other respondents agree that trauma-sensitive care and psychotherapeutic treatment to overcome these traumas are essential in supporting PMWUD. Additionally, the potential absence of family support due to migration or isolation is mentioned as a complicating factor related to the support needs of PMWUD.

Generally, all respondents agreed that PMWUD have multiple needs that cannot all be solved by one service. Therefore, they advocated for collaboration between different services that are able to – jointly – offer PMWUD integrated support. They underscore the importance of, among others:

- hands-on support: taking PMWUD by the hand and leading them to services if they don't find the way themselves;
- qualitative support: services that are monitored for quality and effectiveness
- continuity of care: smooth transitions and collaboration between services to facilitate holistic, continuous and step-by-step support and care

L. confirmed the need for a safe place as the basis for providing holistic support services.

> *Often addiction is not the first problem when you have issues. You may have health issues, you may have housing issues, you may have other types of issues. It doesn't tell you anything even if you go to OKANA possibly, which OKANA and what? Nor do you go anywhere for the issue of your addiction, you have other issues to solve. (...) There are other needs than just addiction treatment. And now with the dormitories, with the hostels, somehow, we can say that such a population can solve some issues of such type, in order to be able to address the addiction issues as well. (L.)*

Reducing barriers for PMWUD

A major barrier that PMWUD face according to the focus group participants is access to medical care in hospitals. L. and M. observed that the use of emergency services by persons who use drugs is limited and that they are a hidden population that is hardly reached by medical services.

Respondents identified legal access barriers (the issue of illegal migrants not having a SSN that gives access to health care) and language barriers (although the increase in organisations specifically targeting persons with a migration background has partly fixed that problem), but also exclusion processes and issues related to stigma by hospital staff members that stand in the way of good medical care provision. Hence, the respondents underscore the importance of stigma-decreasing initiatives that educate staff members and increase awareness to improve access to effective health care services for PMWUD.

> *There are very few hospitals that accept migrant addicts and keep them and help them. Most hospitals operate in the style of "may this cup be taken from me" (M.)*

These access barriers may also be true for services in other domains. Regarding legal barriers, the respondents further discussed access to a central HIV registry that increases access to healthcare for persons with HIV. While having a SSN was needed to access this registry before, a respondent argued that this issue has now been fixed and that PMWUD with HIV can now go to KEP (citizens' service centre) to receive a SSN that offers access to the registry. M., however, pointed out some barriers that may pop up during this bureaucratic process, including language issues.

Regarding substance use treatment, a lack of continuity was identified as barrier (e.g., no smooth transition between OAT and residential abstinence-based treatment), besides language barriers and waiting lists. Moreover, the strictness of some residential services which can lead to penalties and exclusion from the treatment program if clients do not comply to the rules in some way, was criticized by M. as exclusionary.

> *The penalty should therefore cease to exist. In other words, he is a man who was using concurrently, he didn't come to his appointment, I must somehow find what it is that will keep him back in care. (M.)*

Stigma based on multiple stigmatized features was also observed as decreasing opportunities for PMWUD to integrate in Greek society, especially when someone has been in prison.

> *The stigma in prisons as mentioned, is more intense. (...) There was a stigma of addiction. Working in prisons, there was also the stigma of being a prisoner. It is possible that this person has a third stigma, he had Hepatitis C, so it is a psychosomatic health issue, if he also has a mental health issue, there is also depression, for example a fourth stigma (...) If he is an immigrant, he has the stigma. If she is an immigrant woman, a mother,... so the stigma is now multiple. These people who have come, while we have worked and created services for social reintegration, mainly they want integration, it is different to reintegrate a person who goes to prison and must deal with these issues. (V.)*

Besides the stigma of having been imprisoned, respondents identified multiple other downsides of prisons that have a negative impact on the health and wellbeing of PMWUD. L. underscored that there is an overrepresentation of migrants and refugees in prisons according to a recent survey in Greece. Health care in prison is very limited, especially because many PMWUD don't have a social security number. According to L., there is no routine screening for health issues when PMWUD enter prison. Hence, diseases can remain undetected and treatment is not provided. Furthermore, anti-retroviral therapy is not always given in prison. L. demonstrates:

> *Balanced people, in chronic substitution, who are fine, they have found their families again, they take antiretroviral, they have everything. Suddenly they are stopped for old sins, they are stopped by the police, they are locked in, and Golgotha starts all over again. It is Sisyphean this struggle. That is, people who were on chronic substitution, great at antiretroviral, came back again. (L.)*

3.2.4. Conclusion

Although participants in Athens have been staying a lot longer in the country than study participants in the other cities, similar interrelated challenges of homelessness and lack of official identity papers and permits arose. These factors impede access to a social security number and, hence, health care services such as OAT. This may explain why only one participant in Athens stated to be involved in OAT. Legal barriers towards health care services were equally problematized by focus group participants. The focus group additionally identified language barriers, but since all interviewees spoke Greek, this was less frequently mentioned in the interviews.

The experiences of stigma and discrimination based on substance use that interview participants shared were confirmed by practitioners in the focus group, which touched upon the detrimental impact of multiple stigmatized features on access to care. While the focus groups and interviews revealed some severe medical needs among PMWUD, some good practices were identified that increased access to medical care for PMWUD. The focus group underscored the importance of psychological support addressing pre-, peri- and post-migration trauma. While various interviewees indicated to have mental health problems, the need for psychological support was mentioned to a lesser extent since other (basic) needs were often prioritized. Yet, those who had access to psychological support considered this helpful.

Participants mentioned mixed experiences with the police and criminal justice system. While the focus group discussed pointed out the shortage of healthcare in prison, some interviewees indicated they did receive health care in prison. However, prison also often had a detrimental impact on participants' drug use.

The focus group shed light on changing migration patterns that require constant adjustments to provide accessible and effective care for PMWUD in Athens. Interview participants conveyed a myriad of support needs that were insufficiently met by the current support system and discontinuity of care and support often led to increased health problems. The importance of an integrated approach to meet the complex needs of PMWUD, as well as the need for continuity of care were underscored by practitioners.

3.3 Berlin

3.3.1. Context

About 3.664.088 persons live in Berlin, the capital of Germany. 22 percent of the German population is foreign-born. The most common countries of birth among foreign-born Germans are Turkey, Ukraine and Poland (OECD iLibrary, 2023). According to the EMCDDA (2023b), the most commonly used substances among persons who use substances are alcohol, tobacco, cannabis and cocaine, followed by amphetamine, ecstasy and LSD.

Access to health care

In Germany, migrants and newcomers are entitled to free emergency care. Primary care (essential treatment of relatively common minor diseases provided in an outpatient or community-based centre) and specialist care (by specialist doctors or provided in inpatient settings) are available for undocumented persons, but only against payment.

According to a 2017 study of Médecins Du Monde, all German citizens are required to have a mandatory health insurance (GKV) that offers access to and coverage of healthcare services. This insurance requires monthly payments that are not linked to individuals' income. Unlike most European countries, asylum seekers and refugees are not entitled to the same health care services as German citizens during the first 15 months that they reside in Germany. In these months, they only have access to basic healthcare services, similar to those for undocumented migrants. After 15 months of residence, newcomers are entitled to the same healthcare services as German citizens, except if they have breached the law during their stay. A health insurance is needed to access all services but emergency care and covers basic health care. In some cities, asylum seekers and refugees who don't have access to health insurance can receive a health vouchers for specific health care needs. In Berlin, this system that very much relies on individual assessments, is replaced by a system in which mandatory health insurance cards can be provided to asylum seekers for free. In theory, undocumented migrants can receive a health voucher to be reimbursed for medical care. In practice, however, this rarely happens since social service departments are obliged to report undocumented migrants to the immigration authorities. Intra-European migrants who are not capable to work are not entitled to welfare benefits and public insurance. Those who cannot afford private insurance have similar access to health care as undocumented migrants.

Both basic and general health care encompasses HIV treatment for those who can't afford it. Everyone, irrespective of their documentation status, has the right to be tested and for counselling for communicable diseases (Medécins Du Monde, 2017).

Access to social security

The social security system in Germany offers non-discriminatory social security rights to both documented migrants and German citizens, promoting the social mobility of both groups. However, eligibility for minimum income benefits is limited to those who enter Germany without employment. Since the country's social security system has been designed to provide benefits to individuals who are legally residing and working in Germany, undocumented migrants typically have limited access to social security benefits (Schnabel, 2020).

3.3.2. Interviews

Introduction

The interviews in Berlin were organised by Fixpunkt. Fixpunkt aims to offer health promotion, crime prevention, daily structure, employment and training to persons who use illegal drugs in Berlin and does so in an accepting and non-judgemental manner. Fixpunkt provides health promotion and addiction support in Berlin, with a focus on infection prophylaxis by offering syringe vending machines, low-threshold mobile social work and medical support to reduce harm, medically supervised drug consumption and dental prophylaxis. Additionally, they promote self-organization among persons who use drugs by collaborating with and supporting communities as well as facilitating community involvement (https://www.fixpunkt.org/).

In Berlin, the following ethnic/cultural communities were targeted for the interviews:

- Russian-speaking community (n=8, of which 5 cisgender men and 3 cisgender women)
- Persons from Maghreb countries in North Africa (n=10, all cisgender men)
- West African community (n=6, of which 5 cisgender men and one cisgender woman)

The interviews were conducted by persons who had lived experiences as a migrant (who uses drugs). Two of them are employed in Fixpunkt as cultural mediators. MJ has been working with Fixpunkt as a cultural mediator since 2016. He is also a journalist and activist from Gambia, using his skills as a photographer to document artwork that portrays the daily struggles of persons with a migration background against societal barriers. Additionally, MJ is a radio activist on 'We are born free empowerment radio'. MJ mainly conducted interviews with West African study participants. Likewise, MK works at Fixpunkt as a cultural mediator, providing guidance to clients during the HIV/TBC/HEP testing process and promoting safer usage practices. He also assists clients in navigating the healthcare system and facilitates cultural mediation between clients and the healthcare system. MK is a member of BerLun NGO, a Russian-speaking users union in Berlin. MK conducted the interviews with Russian-speaking participants. SK is a community researcher from the Middle East. Her work focuses on various aspects of gender, harm reduction, mental health and sexual health. She conducted the interviews with the Maghreb Arabic participants.

The local and community researchers described the choice for the above-mentioned communities as follows:

The Russian-speaking community mostly already used opiates in their home countries. They often experienced stigmatization and imprisonment there, since repressive drug policies predominate in these countries. The main reasons for leaving their home countries were lack of prospects and no chance to access the labour market. The Russian-speaking group is divided in EU and non-EU citizens. Hence, they have different chances of realizing their human right to health. Persons from Ukraine, for example, can receive full support regarding HIV treatment, antiretroviral therapy and OAT. Persons from Moldova only have access to these resources through compensation systems described above, while persons from Belarus often have very limited access to health insurance and many of them live with HIV.

Among persons from Maghreb countries in North Africa, the local and community researchers have experienced that economic instability and entrenched levels of authoritarianism served as the main drivers for migration. Having fled horrible conditions, they face many challenges such as asylum status, housing, occupation, family, language, healthcare, integration and discrimination, which significantly affects their mental health. One specific factor is the process of obtaining a valid residence permit. Asylum processes and visa insecurity (as residence permits are limited in time) have an impact on individuals' psychological wellbeing. Many respondents do not have certified documents, which makes their employment undeclared and illegal, leaving them with no sustainable income. The harms of racism, in all its forms, are described as an essential part of their emotional baggage, which they carry around wherever they go, including treatment.

The local and community researchers stressed the importance of exploring needs and good practices for the West African community as follows: at the heart of Görlitzer Park, a diverse group of refugees hailing from various African nations find themselves in a challenging situation. These refugees are a hard-to-reach population, struggling against a multitude of obstacles. Stigmatization, discrimination, and a deep-seated lack of trust in the established systems further compound their difficulties. Navigating the care system proves to be an arduous task for these individuals. Several (systemic and practical) barriers hinder their ability to access the assistance they desperately need. The journey through the asylum process is often accompanied with disappointment, as many find their applications rejected, leaving them in a state of limbo. Stripped of financial stability, social support, and even basic health insurance, these individuals are pushed to the fringes of society, forced into the public space. Lacking the means to secure a livelihood, these refugees become trapped in a cycle of homelessness. Their vulnerability is heightened by their unfamiliarity with harm reduction strategies and safer drug use practices. Access to essential materials for safer substance use, such as paraphernalia, remains elusive, adding another layer of complexity to their already dire circumstances. In the face of these immense challenges, the African refugee communities in Görlitzer Park persevere. Their struggles underscore the urgent need for targeted support, effective policy changes, and a compassionate approach to uplift and empower these underserved populations.

Results

Profiles

a. Migration background and documentation status

Eight Russian-speaking persons from countries outside the EU, of which three self-identified women, participated in the SEMID interview. The interviews were conducted in Russian (n=7) and German (n=1). The participants migrated to Germany between one and 13 years ago (mean = 5,25) and were born in Latvia (n=3), Ukraine (n=2), Moldova (n=1), Lithuania (n=1) and Belarus (n=1). Participants were between 32 and 50 years old (mean = 41,1). Some of these Russian-speaking persons had European identification documents (those with Latvian or Lithuanian nationalities (n=3)), of which one indicated it was lost. Participants without EU identification documents either had no official identity document for Germany (n=2), had a permanent (n=1) (Ukrainian refugee), temporary residence permit (n=1) (other Ukrainian participant) or a registration certificate (n=1) (female from Belarus). Three male participants, of which two with an EU passport, stated that they had no medical insurance, impeding their access to medical resources and services.

One female participant migrated due to the Ukrainian war, while the other Ukrainian participant went to Berlin for work-related reasons, but was forced to stay due to the Covid-19 pandemic in 2020. The latter indicated to have stayed in Berlin because the conditions for persons who use drugs are better than in Ukraine in terms of therapy and medical help. Better access to medical and drug services (including OAT) was mentioned by two other participants as pulling factors for migration. One participant talked about problems with the police in Moldova that led him to migrate, while another participant (with the Russian nationality) discussed prosecution by the Russian government as pushing factor for migration. The female participant from Belarus mentioned how political and social reasons related to being part of the LGBT community led her to flee her country, besides medical needs that could not be fulfilled in her home country. Hence, reasons for migration were often related to a lack of resources in the home country, in combination with a hopeful image of better medical, financial and social resources in Germany.

> *I had a lot of reasons. In Latvia, I lost everything, basically. I lost my home, I lost my family. My wife died when she was pregnant and my house burnt down. All of that happened in a blink of an eye. After that, I went to jail for a few months for driving without a license. After being in jail for four months, I got out and all the things I had, my small business that I ran, a car wash, it all just fell apart. I lost everything. No family, no place to live, no job, I had nothing. So, I came to Germany, thinking that, maybe, I could start working somehow here. Get a new start. (E., male, 37 years old, Latvian origin)*

Among persons from Maghreb countries, the interviews were conducted in Arabic (n=7) and German (n=3). Participants (all male) originated from Algeria (n=3), Morocco (n=5) and Sudan (n=2). They migrated to Germany between 1 and 14 years prior to the interview. While multiple participants indicated they made a request for asylum in Germany (n= 5) and one in Italy, only two participants had official (temporary) residence papers at the time of the interview. Others indicated they had no official identification documents for Germany, because their residence permit expired, because they did never receive it or because they never applied for it.

Participants indicated they left their home country out of fear for their security in light of a political conflict (n=2, Sudan), domestic violence (n=2, Moroccan background), the "general situation" in Algeria (n=1), as well as due to dictatorship, racism and discrimination (n=1), general injustice and oppression by the 'rulers' (n=1) and to earn money (n=1). An important pulling factor for migration among most participants is the pursuit of a "better life" (n=3). Only one participant stated that he wanted to go back to his home country, while the others indicated they wished to stay in Germany.

> *I want to stay for a long time. This is my country now, because I grew up here, I don't know anyone elsewhere, I'm used to it here, not in my country, they made me hate it. (M., male, 22 years old, Moroccan origin)*

These participants were between 21 and 49 years old. While the participants with Sudanese background were in their late 40's, two participants with a Moroccan and Algerian background were in their early 20's. The others were between 28 and 49 years old.

Six persons from the West African community in Berlin were interviewed, of which one cisgender woman. The interviews were conducted in English and German. Participants were originally from the Republic of Guinea (n=2), Sierra Leone, Niger, Mauritania, Ivory Coast and Angola. Participants migrated between 5 and 15 years ago and were between 21 and 48 years old.

Three participants indicated that they came to Germany as a refugee related to war in their home country (i.e., Sierra Leone, Mauritania and Ivory Coast), of which two had temporary residence permits. The others who migrated due to family issues and 'troubles at home' or to study indicated that they had no official identity papers and/or that their temporary residence papers had to be renewed. Some participants indicated that they did not necessarily want to stay in the country, but that going back was difficult due to a lack of financial resources and official identity papers. All participants were homeless to some extent, sleeping 'here and there', with friends or in the 'school' (i.e., former school that is now an overnight shelter of Fixpunkt), but without a fixed residence.

b. Substance use

Among the Russian-speaking community, seven out of eight participants received OAT treatment in the form of methadone, polamidon or buprenorphine. Next to OAT, participants mainly indicated to use pregabalin (Lyrica) (n=5), alcohol (n=4), cocaine (injected) (n=3) or crack cocaine (smoked, n=1), and cannabis (n=3). One person injected heroin on top of his OAT treatment and one person indicated he injected polamidon, besides the prescribed polamidon he takes orally.

Besides the supervised consumption of medication, participants used in public spaces like the streets, parks, public toilets or subway stations. However, three of them indicated they used the DCR when possible, which was related to the distance and opening hours. The first use of illicit substances usually happened in the home country of participants, when they were between 14 and 29 years old.

None of the participants with a Maghreb or West African background (n= 16) was involved in OAT, since none of them indicated to use opioids. The main problem substance in both communities is (crack) cocaine (n=12 on a daily basis)., Participants from the Maghreb community snorted (n=3), sniffed (n=2) and smoked (n=3) substances. Two of them indicated they smoked before, but stopped smoking due to health reasons. Among West African participants, however, all but one smoked (crack) cocaine. Twelve participants also indicated to use cannabis, of which seven on a daily basis, but this was considered less problematic. Among the Maghreb community, alcohol was used by most participants (n=7). In the West-African community, three participants reported the use of alcohol. Of the twelve participants we have data on first substance use across both communities, only three situated first use in their home country. They mostly started using drugs in Germany and indicated that they used drugs on the streets and in the park, similar to their living situation.

In general, the use of substances was related to coping with psychological problems stemming from migration-related stress (e.g., the fear and uncertainty related to migration and risks of deportation), loneliness and isolation, trauma, grief and instable living conditions (e.g., not having a place to stay, keeping oneself warm at night). Boredom related to living on the streets and not having a job was also mentioned as a drive for substance use. Several persons described that the drive for substance use evolved from an urge to getting high due to a myriad of reasons described above to a necessity to function physically due to addiction.

> *When you can't find peace of mind and you're depressed, of course you're going to do drugs. When you sleep on the street, you only have to worry about yourself.. (...) The financial situation and the psychological condition. It's the snowball effect. I mean, after a long time of ... (...) I know that drug abuse is not good, but because of stress, the psychological factor, sleeping on the street, one finds himself in a situation where he has to do it. What am I supposed to do? There is no other solution. (B., male, 47 years old, Sudanese origin)*

c. Social networks

Most participants' social networks consisted of persons with a similar migration background who use substances. Persons living in the park or on the streets referred to people in this environment as their friends. However, friendships with these peers were often considered difficult because their peers are living in precarious situations and therefore have other priorities, or because their substance use is considered challenging when participants are trying to (re)gain control over their own substance use. One Russian speaking participant indicated having troubles connecting with persons from German origin, since "I do not quite understand these people and feel uncomfortable with them". As a consequence, two Russian speaking participants indicated that they felt alone. In the Maghreb community, eight out of ten participants described a feeling of loneliness and isolation, barely referring to family and related to a feeling of 'merely depending on themselves'. As described by two participants, these feelings contributed to their psychological issues and substance use. Two Russian speaking participants talked about the support they received in BerLUN, a low-threshold and activist mutual aid group of Russian-speaking person who (used to) use drugs. One Russian speaking participant had a close connection with his family, while the others indicated not to have any family or to have lost connection with them due to substance use and/or migration.

d. Medical and mental health problems

The Russian-speaking participants conveyed a myriad of medical needs, primarily dental problems. Participants from the other communities reported fewer medical needs. Mental health problems were reported across the three communities (though to a lesser extent among the West African community). Participants described ongoing stress due to their living situation and the uncertainty of migration. They further described their mental state as “depressed”, “sad”, “mentally and emotionally broken” and “living in darkness”. A few participants described traumatising experiences from the past that kept dominating their mental health.

(Support) needs

Among Maghreb community participants, only two persons indicated they had stable housing. The other participants, as well as all participants of West African descent were living on the streets, but because the interviews were conducted in wintertime, the majority indicated that they could sometimes spend the night in a overnight shelter, church or emergency shelter. Some persons from the West African community were also relying on friends for housing. Several participants talked about housing as an essential support need at the time of the interview.

Four persons from the Russian speaking community were mainly living on the streets at the time of the interview. Two of them indicated they sometimes found shelter in a place for homeless persons, but this shelter was described as unsafe and unhygienic, making them reluctant to use it often. These persons also indicated stable housing as an essential support need that should be met in order to be able to focus on other life domains, such as substance use, psychological wellbeing and employment.

> *The biggest need right now is to find some place to live. It’s the biggest problem for us all. Many drug addicts do drugs because they have no place to live. To be on the streets and stay sober at the same time is impossible, especially when the weather is bad. It’s just unreal. (S., male, 50 years old, Ukrainian origin)*

The other Russian-speaking participants were living in a form of community housing, where they had their own room (or shared a room with a roommate) with a shared bathroom. They had sufficient access to basic needs such as a shower and electricity, though one participant complained about the lack of privacy and not having his own space. Community housing is described as a good practice, because it offers people more than just a place to stay.

> *Right now, I have good living conditions. I live in a community housing where only women live. It’s very clean there, the conditions are good. You can get free meals every morning. You can go out with a food stamp and get a week’s worth of meat, bread, everything like that, all the food, and it’s for free. Social workers are also present in this community housing. I live with one roommate. Of course, I would like to live alone but, for the moment, there is quite a waiting line. I’m in it. So, that’s my living conditions. It’s not possible for me to have an apartment because I do not hold a permanent document so, nobody would want to deal with me in terms of housing. (V., female, 39 years old, Belarussian origin)*

Apart from housing, most participants indicated that other basic needs (access to a shower and food) were fulfilled to a certain extent, thanks to a range of services and help by friends. Two West African participants indicated access to basic needs as one of their most prominent support needs. Two participants from the Maghreb community with official residence papers, had access to financial support of 300 to 410 EUR/month. For others, financial support was often also a need, but some indicated that they wanted to be able to be self-sustaining by finding a job. One participant referred to jobs and housing as primary support needs:

> *I would like for the folks who use drugs to get involved in some community work so that they do not just use drugs. Many of them want to do something but don't know how and where to start. They can't make any money. They are forced to go around, steal and use drugs. If people will know that once they stop stealing and stop using drugs, and instead be given some sort of a place to live in, some sort of a job, I think, there will be those who will leave the streets and stop using drugs in order to have a chance to live a peaceful life in a place, even if it is a community house, and have a job, I think. (G., male, 42 years old, Latvian origin)*

Five participants from the Russian-speaking community talked about serious medical needs, including the need for OAT, dental care and problems with their stomach, liver or heart. Yet, most respondents indicated that they got help for these medical needs, because they had an insurance or received help from services. OAT was mentioned by most participants as very helpful to regain control over one's life. However, as a health insurance is inaccessible to those without a legal residence permit and is indispensable for accessing medical resources outside Fixpunkt and some solidarity networks, administrative support to access insurance and other permits was mentioned by several respondents. This appears to be particularly important, since two participants stated that it is very easy to get lost in the bureaucracy of official permits in Germany, especially when experiencing a language barrier.

> *In Berlin, or Germany in general, there is an extreme amount of bureaucracy. They acknowledge it themselves. When they need "this paper and that paper" then, to get them, you would have to go back and forth, from one place to another. If you don't know the German language well, then it's going to be your worst nightmare. It's so difficult for me because the head office is 80 kilometres away from where I live. It's not here. I go there every couple of months to extend [the temporary residence permit]. (S., male, 50 years old, Ukrainian origin)*

Persons from the Maghreb and West African community did not frequently mention medical needs, which is related to the fact that they did not report injecting opiates or other drugs.

The stress and uncertainty related to not having official identity papers, as well as the lack of resources like housing, financial support, insurance, and work were indicated as factors contributing to criminal involvement, psychological distress and substance use.

> *You find peace of mind when you have a place and ID documents like everyone else. When you do not have ID documents, a place, and have a drug addiction, how could you find peace of mind? As I'm sitting with you right now, I can't find peace of mind because I don't have a place, I don't have a wife, I don't have children, I don't have ID documents, I don't have-- I don't even have an income source, frankly... How could I find peace of mind? Psychologically, I feel distressed. (S., male, 49 years old, Moroccan origin)*

> *I had a few things going on in my life, but then-- when your passport expires in Germany, that's a one-way ticket to the streets. (B., male, 47 years old, Sudanese origin)*

> *If I don't have papers, I studied with them and everything but I don't have papers, I don't have the right to work, what can I do? I have to sell drugs or steal, because they don't support you, they don't give you support. (M., male, 22 years old, Moroccan origin)*

Persons whose basic needs were fulfilled talked about higher order support needs, like the need for employment or other ways to spend their day purposefully (e.g., learning or doing sports). Mental health support was also mentioned by several participants, while other needs concerned 'love' and affection, seeing their family again, and needs related to decreasing drug use.

Harm reduction and social services

Among the Russian-speaking participants, Fixpunkt (n=8), Berliner-Aids Hilfe (n=2) and general practitioners (n=2) were mentioned as important support services, besides community housing. They provide OAT as well as social support and practical help with housing, paperwork and access to medical support. Some locations of Fixpunkt were mentioned to be particularly accessible because of the Russian-speaking counsellors and long opening hours. Support from social workers depended on the social worker and experienced power relation with the social worker, as well as the continuity of care and support: one social worker over a longer period was deemed much more helpful than various social workers over time.

OAT was considered helpful by participants to function physically, to (re)gain control over their substance use and to be able to focus on other things in life.

> *If you use drugs then use those that they give you at Praxis [OAT service]. I would like to do it myself, to use what they give me at Praxis and lower the dosage. You can decrease your dosage to the point where it becomes zero and you become clean and normal person. I wish it to everybody and, first of all, to myself. (S., male, 50 years old, Ukrainian background)*

Three participants underscored the importance of a drug consumption room and mobile van to use substances in a safe, non-public space. They talked about the dangers of syringes lying around in the park and the syringe distribution service that aims to avoid that.

> *People must go to F. [harm reduction centre] and do it there, instead of going to parks. You make it better for yourself and don't make it worse for the people. That is first of all, that you don't put people at risk. If you find yourself doing it out on the street or at a park, then just take the syringe with you, put it in your pocket and clean up after yourself. There are special cans for such things, not the regular trash cans but special ones, with an image of a syringe printed on it. Take it there and throw it in that can. That's how they must do it (S., male, 50 years old, Ukrainian origin)*

Yet, harm reduction centres do more than fulfilling basic health and substance-related needs. A participant described how the harm reduction service became a place where he can go to talk and meet with counsellors that are role models for him, while another person discussed doing voluntary work at the centre. Two participants expressed the need for more recovery-oriented support that would enable them to find a job and be surrounded by people who don't use drugs.

V. compared the approach towards persons who use drugs in Berlin to that in her country of origin, illustrating the added value of harm reduction in securing human rights.

> *I want to say that, in comparison to my homeland, I witnessed and experience a lot of support here. It's like two different worlds that we talk about. Back in my homeland, they don't want to help drug addicts. The government does not help us. Everybody criticizes NGOs, their help and actions, because it's the policy of our government that we don't have drug addicts. Everything is fine in our republic. Here, I saw a different picture. They don't deny that such a problem exists here and they try to get it solved and do a very good job at it, in my opinion. I saw how they clean up after addicts. People walking around, picking up syringes with special sticks [...] I don't know, it just works here somehow and I really like it. Even if you live on the streets, if you're the worst addict out there, you still can count on some basic support. Not even basic, a good support. You will have something to eat, you will have a place where you can take a shower and get clean, you will be able to ask for clothing for yourself. Do you agree with me? They do a lot in this country for drug addicts. (V., female, 39 years old, Belarussian origin)*

Six participants indicated that they had been tested for HIV, tuberculosis and hepatitis. Of these, all but one indicated that they had tested positive on Hepatitis C. Three of them were treated for Hepatitis C, either in their home country (n=1) or in Berlin (n=2). Four participants live with HIV, of which three indicated they were treated for this in a good manner by Berliner-Aids Hilfe. One participant tested positive on tuberculosis, for which he got extensive treatment during his time in jail.

Contact with harm reduction services was much more limited among participants from the Maghreb and West African community, of which only seven participants were in contact with harm reduction services for the provision of safe drug consumption materials, emotional and practical support and clothes and food.

> *The services that I benefit from are the Fixpunkt services. Fixpunkt services help me with personal hygiene, washing my clothes, and everything. Fixpunkt is what helps me with everything now. (...) I would like to thank Fixpunkt. (S., male, 49 years old, Moroccan origin)*

None of these participants were involved in OAT, as they experience fewer problems with opioids. Yet, these communities are less in contact with harm reduction services. They all use in public spaces such as the streets or a park. Six participants stated that there was no support for them, saying that they have to "deal" with their problems "on their own", referring to problems with paperwork, psychological problems, food, drugs and financial challenges. Only four participants indicated they had recently been tested for hepatitis, tuberculosis and HIV, of which one in prison.

Barriers to care and other types of support

Across all three communities, the most important barrier to care was not knowing where to find services, enhanced by language barriers and the lack of legal documents that offer access to services. Language barriers (especially discussed by Russian-speaking participants) were also mentioned as hindering qualitative mental health and medical care as people often feel not understood. Multilingual services and referral to more appropriate support services may help to overcome these barriers.

> *There is so little information. If a person comes here and doesn't understand the German language, just like I didn't when I came here... But at least I learned some German from the streets so, I can communicate more or less, I can get some information. I didn't take any German lessons. So, if a person doesn't know the language, he doesn't have access to the so-much-needed information. I met many people who don't even know that there is such a thing as Berliner Stadtmission, a place where one can stay for the night. (...) Then, questions like where to get clothing, there is no information about it too. Actually, there is a bit of information about it but only a tiny bit. Then questions like where to get medical help, medical treatment, people don't know it at all, especially, if they don't have insurance or personal identity documents. (A., male, 37 years old, Latvian origin)*

The lack of official identity papers and related health insurance was mentioned as a major barrier towards housing, employment and financial and medical support. In Berlin, no identification documents are needed to utilize harm reduction services. Yet, authorized insurance and/or being officially recognized as a refugee is necessary to access OAT and residential services, especially if a client cannot pay for it independently. As discussed by some Russian-speaking participants, one organization offers financial support for using drug services to persons without official insurance or residence papers. Not having officially recognized residence and identity documents and the related risk of being deported also induced fear to contact services. Practical barriers toward support services were the distance, opening hours and waiting lists mentioned in the context of residential medical treatment, shelter and food distribution. Police controls in public spaces where harm reduction services operate may scare off visitors.

A few participants (n=6) indicated that they did not need or want support and that they didn't want to rely on others for help or that they don't trust certain institutions because of experiences in the past. One person with strong Islamic religious beliefs shared a distrust toward institutions that do not share his beliefs. For him, a harm reduction service by and for Muslims specifically may be a better fit.

Among Russian-speaking participants, Fixpunkt was discussed as a helpful service to overcome some of these barriers, especially because there are Russian-speaking counsellors. G. discussed the importance of an all-encompassing harm reduction service that helped him in multiple ways:

> *The city meets all my needs extremely well but the thing is that, oftentimes, people just don't know about various services or help they can get. For example, for a long time I didn't know that... I was using drugs and, for the most part, I didn't have any documents really, and I didn't know how to sign up for a program. Again, the workers from Fixpunkt helped me get into a program and, for more than two years now, I only use what the doctor prescribed me and nothing else. (...) Where and what kind of help they can get, oftentimes, they just don't know it. (...) When M. [social worker] came into my life, she resolved all the issues that I couldn't figure out on my own. I just didn't know where to go and what to do, or what agency do I go to for a specific need. (G., male, 42 years old, Latvian origin)*

Some participants discussed stigma regarding the use of (illicit) substances, in combination with intoxication and criminal involvement. Stigma may impede access to qualitative care for persons with a migration background who use drugs. A.'s story illustrates the persistence of stereotypical ideas in society that do often not reflect reality:

> *We are sub-humans to them. They only show it off for the cameras, for the journalists when they say things like, "They are just sick people who need our help" but in reality... I'm going to tell you a story. It used to happen a lot to me. For normal people, at least they consider themselves to be normal, so, in their minds, there are people whom they consider scum of the Earth, and we, drug addicts, are scum of the Earth for them. I was going up the stairs once and saw there was an old Arab woman, who also wanted to go up. She had such a huge and heavy bag; she couldn't even carry it up those stairs. Many men of different nationalities just pass her by, ignoring her. But that's not it. Young and strong men, those who consider themselves to be normal, they are not drug addicts. So, they see her and suddenly start talking on the phone, turn their heads the other way. Somebody goes a different way so just they avoid going by that woman and helping her. For them, I'm a drug addict, a social scum, not a human. I was raised that I have to do it, have to help that old woman. It's not even a good deed or anything for me, it's just a natural thing that humans do, just like giving your seat in public transport. I took her bag and carried it up the stairs. I helped that old woman; she thanked me and I went on with my way. But later I had this thought, "Only if that woman knew, who helped her and who did not." (A., male, 37 years old, Latvian origin)*

Encounters with the criminal justice system and law enforcement

Five Russian-speaking, four Maghrebine and three West African participants had been detained in Germany before, while two Russian-speaking participants had also been detained in their country of origin. Reasons for detention were theft (which was linked to rough living conditions and substance use), lack of residence papers and amounting fines. Their experiences in (German) jail were surprisingly positive, probably because of the contrast with the rough living conditions outside prison. Participants indicated they had access to medical (OAT, tuberculosis and Hepatitis C treatment), legal (with identification documents and residence permits) and social support in prison. One Russian-speaking participant discussed how she learned German in prison and talked about the help she received from some individual guards. However, three participants also talked about prison as another stepping stone towards substance use and criminal activities.

> *When I went to prison, they told me you have a court date. I went to court and they explained to me everything. You have a fine from 2012 a €300 ticket. And it kept increasing until it became a little over 6,000 ... since 2012. It kept increasing, not decreasing. When suddenly they brought me to jail and put me in prison with people who do drugs, and people who do other things. I mean, even if you don't know anything about drugs, you will leave prison as an expert in drugs. (...) Do you have money? If you do, you can have access to everything. They taught me a few things. Some inmates actually run the entire prison. They told me, "Do this and we'll give you some money. And If you have money, you can get this, that and the other... You can have whatever you want." I didn't participate, nor did I listen to them. (B., male, 47 years old, Sudanese origin)*

There were also some accounts of discrimination toward persons with a migration background in prison and psychological distress related to the rough conditions of solitary confinement and lack of freedom to move.

> *It was tough in the beginning, but later, you get used to it. Honestly, I had these kinds of thoughts recently: "Maybe, I go to prison for the remainder of this winter, just to have a break from it all, at least." Because I have nowhere to live now. It's just an option. But the truth is, it's really tough psychologically to be in a prison here. First of all, you're alone in the cell, but in the last few years, they've limited the amount of free time. Limited it in a big way and shortened the amount of time you have for walking outside. They started to crack down on daily schedule in prison. They said that it was because of constant confrontations and conflicts, and fights in there. Well, sorry for them, but it's prison after all. Even if you're going to let people to walk outside for just an hour, it won't eliminate the conflicts. It will stay exactly the same as before, but they don't understand it. (A., male, 37 years old, Latvian origin)*

One participant mentioned how he was helped in many ways in prison, but also how a lack of continuity of care after detention led him to become homeless, give up HIV and OAT treatment and relapse into heroin use after a period of controlled substitution.

Many participants had similar, mixed experiences with law enforcement in Berlin, depending on the person they got in contact with. Participants discussed some positive encounters with police officers helping them out when they were in trouble (e.g., finding an OAT service, helping during a fight, referring to services for asylum requests). A Maghreb country participant who had been living in France prior to the interview stated that German police is very respectful compared to French policemen.

> *In France, my sister, if you don't have ID documents, they despise you. I entered a police station in France, they beat me, threw my phone on the ground and broke it because they know I can't do anything about it because I don't have ID documents. But over here the police is good, there are laws, respect... No matter what you do, they don't bother you. Here I think it is a country of justice and a country of law. And if you are a person who doesn't cause trouble, no one would bother you. (...) If you are not a trouble maker, you don't get into trouble. (R., male, 35 years old, Moroccan origin)*

When checked for drug possession, the drugs were mostly taken without any fine or arrest. However, two participants pointed to the contradiction of this approach, since taking away drugs may be an incentive for committing crimes as persons with substance use problems may need substances to survive anyway.

> *There were also cases when the police saw me do drugs and were just taking them away from me. I tried to explain it to them that, by doing it, they push me to do crime again because I have no money anymore to buy drugs. If they take it away from me, I will go and commit some crime, so, essentially, they were forcing me to do crime (...) Go after the dealers. Why do you pursue sick people, I mean. (A., male, 37 years old, Latvian background)*

One person talked about how police controls related to drug possession happened nearby a harm reduction service, which may compromise access and functioning of this centre for persons using substances.

> *They told me, "You are not allowed to carry it with you." I didn't understand how am I supposed to reach this [DCR] then. Do I get there by helicopter or drive a subway train into there? I mean, how? They go. "No questions. You have broken the law." (S., male, 50 years old, Ukrainian background).*

3.3.3. Focus groups

Respondents

In Berlin, two focus groups were conducted with a total of 15 participants. Both focus groups lasted for about two hours. Attendees of focus group one were:

- Lawyer in criminal and migration law
- Social Worker from a street work organization
- Coordinator of a Homeless Care centre
- Social Worker and coordinator the Drug Consumption Mobile
- Social Worker from the Drug Consumption Mobile
- Social Worker and Addiction Therapist
- Social Worker from the Health Department, Centre for Sexual Health
- Deutsche AIDS Hilfe, International department

Attendees of the second focus group were:

- Social Worker from a drug counselling service
- Coordinator of an intercultural centre for inpatient drug treatment
- Social Worker from a health and social centre with a drug consumption room
- Social Worker and coordinator of the European Aid Fund for the Most Deprived
- Social Worker from a harm reduction centre
- Social Worker from a social security service
- Sociologist from an organization for street social work specialised in refugees and migrants

Results

a. Prevention, education and vocation

The second focus group mentioned the importance of certain measures that prevent that migrants engage in substance use and lose themselves in drug dependence. First, they emphasized educating migrant groups about the risks of drugs as well as about safe consumption and the role of OAT in a linguistically and culturally sensitive manner. Second, they encouraged policy makers to look critically at the numerous barriers toward work permits, since the lack of a work permit holds people from working and may lead migrants to become and remain homeless and end up using psychoactive substances on the streets as a coping mechanism.

> *People are quite clear here because they want to work, the labour market leads to people having no access [to it], and they end up on the street. They start consuming on the street. This is a chain that absolutely does not break. (P.)*

Work is mentioned as a way to increase financial resources among PMWUD, as well as giving them a form of stability, recognition and meaning in life. Yet, some respondents recognized that working may not be possible for persons who are still heavily involved in substance use and that other needs may need to be fulfilled before a person can engage in work. Related to drug prevention among PMWUD, some respondents mentioned the potential power of integration courses:

> *I would like to see integration courses too, as is the case in Scandinavia, for example. Namely, integration courses are offered like German courses right at the beginning, when the people arrive here, to catch them, right away. They get free accommodation, they either get access to the language, a connection to the people who live in the country, and accordingly, I think at least, a lot of possibilities are created so that people don't just slip into these situations. That's exactly the same as I would just wish for people to have a right to work directly. We have a lot of people here at Kotti who tell me they studied something else. One of us studied history, he was actually in Syria, I think that was it, was the teacher, but is not recognized here, and de facto, not allowed to work. Then slips into the drug scene, he's homeless, and stands around at the Kottbusser Tor, committing petty crimes, getting arrested, and all that while he actually holds a high-quality degree. On the other hand, we have a skills shortage in Germany. It would simply be very clever, also from the point of view of the state, to provide this probationary residence permit with a work permit per se. (J.[2])*

b. Housing and basic needs

Both focus groups underscored the importance of addressing basic needs such as food and hygiene, but especially accommodation as a first and essential step toward other resources.

Most PMWUD that the respondents are in contact with have a temporary residence permit or no residence papers at all. Hence, they can only access emergency shelters. While in wintertime, there are emergency shelters available for most PMWUD, in summer, almost all these shelters are closed. The respondents underscored the importance of more housing options, preferably where integrated care on multiple life domains can be provided. Some respondents in focus group two talked about housing opportunities for drug users specifically, inspired by Housing First initiatives abroad, where drug use is accepted and a DCR is included.

Respondents from focus group two mentioned that some PMWUD prefer to live on the streets. Given the shortage of shelter and housing opportunities, this increases the need for communicating with residents of the neighbourhoods where PMWUD live on the streets. Some initiatives were mentioned in which neighbourhood residents can share their concerns with authorities responsible for the maintenance of the neighbourhood, making the residents feel heard and being able to answers to some of their complaints.

c. (Mental) health needs

Both focus groups discussed the main (mental) health issues that PMWUD are confronted with. Respondents discussed the difficulties in accessing health care such as HIV and hepatitis treatment. They criticized that only 'emergency help' is available for PMWUD without residence papers, leading to an aggravation of health problems over time. After receiving emergency care in a hospital, according to one of the participants, these persons then go back to their own environment, often in the streets, where it is more difficult to heal.

Both focus groups addressed the intertwinement of substance dependence and mental health problems since substance use is often a way of coping with mental health issues. The respondents talked about the importance of on-site specialized mental health support by expanding existing interdisciplinary low-threshold services, because general mental health services are often inaccessible to PMWUD due to waiting lists, individuals' precarious situations (not being able to meet appointments) and the complexity of the intersection of migration (and related language barriers) and substance use issues (stigma) that causes psychologists to reject PMWUD.

Respondents criticized the fragmentation of (mental) health care and pointed to the importance of collaboration between services to provide multi-disciplinary and integrated care. For example, J. explained that treatment for undocumented migrants with HIV and hepatitis C happens through different authorities and services, generating unnecessary complexity.

d. Needs related to the use of substances

OAT was mentioned in both focus groups as an essential, though not always accessible need for many PMWUD without residence papers. To decrease geographical and other barriers, respondents discussed the possibility of on-site OAT, bringing OAT to PMWUD instead of waiting for them to come to their services.

Additionally, a respondent pointed out the need for a better legal framework for DCR's in Germany. It is often the first point of contact with PMWUD, which may enable further follow-up and monitoring. As the current legal framework on DCR's still excludes many possibilities, it hinders long-term solutions for PMWUD.

Addiction counselling for regaining control over substance use was also mentioned as something that could support PMWUD. As this type of support is not part of emergency health, this is hardly accessible for PMWUD. One of the participants mentioned the possibility of offering some kind of counselling regarding drug dependence in a homeless care centre by collaborating with harm reduction services.

e. Legal issues and requirements

Both focus group mentioned a myriad of legal barriers toward care and resources for increasing the wellbeing of PMWUD. Legal documents are mentioned to be necessary for having access to housing, health insurance, work and education (e.g., language classes). However, several respondents pointed out that PMWUD often don't have legal documents. First, the application processes are very complex and time-consuming. Second, PMWUD are often fearful to register themselves, because they are afraid that they will be deported due to aspects considered criminal such as drug use and residing in the country without legal documents. Third, for obtaining legal documents an empty criminal record is required, which poses problems for some PMWUD. The respondents discussed how the criminalization of migration and drug use, as well as the precarious situation of PMWUD, increased their chances of being detained.

> *It's assumed that in the future, many drug-using migrants will end up in jail. (...) The mere fact that we don't give out syringes in prisons here is awful, in my opinion. Multilingual offers in prisons don't exist at all. They get out and remain on the exact same side as before. (L.)*

Another participant indicated how they are caught in this situation:

> *Actually, with all these 'perks' and regulations from the Residence Act, you get 50 daily rates from the stupid judge for stealing a Labello lipstick, and that's just the way it is. That means that a relatively large number of drug users engage in drug-related crime, but at the lowest level, like stealing perfumes, which is the absolute classic. People are immediately excluded from such regulations or from permits for studying, employment, humanitarian residence permits, and the like. (A.[1])*

Additionally, A.[1] discussed how the lack of a home address may result in the fact that persons are not allowed to leave prison during pre-trial detention. Consequently, they may spent months in prison for very small crimes, without anything changed in their situations, on the contrary:

> *I think it's the stories of people being released from prison who come back to me in Görli the very same day. Preferably on a Friday afternoon, so you can't do anything. So, they spent several months in custody but did not take care of personal documents in the meantime, for example, getting an ID, registration papers, or finding accommodation again. Only then can you take steps to initiate the process, because they're completely outside the system. The problem arises when they say, "I'd like to get out of the Park, I'd like to be housed somewhere again". Yet, we can't do anything without their ID document, which is also only available with registration. (A.[1])*

Respondents of focus group one discussed that, while Berlin – in theory – offers free legal advice to residents, the reality is that free legal representation is only for the happy few that are considered likely to win in court. They pointed out that – in practice – there is insufficient legal support for PMWUD, because they can't afford legal representation. Unpaid penalties may add up to grave debts, and without legal aid, PMWUD are likely not to be allowed to (further) stay in the country.

However, some respondents stated that police officers do not prioritize fining persons who only use drugs. Furthermore, J. said that Kotti [harm reduction service] has a good collaboration with the police, keeping them from checking directly in front of their doors and even engaging in prevention meetings. Nevertheless, other respondents argued that the collaboration with the police is still too limited, leading police officers to spread wrong information about certain rights for PMWUD. Moreover, some respondents pointed out the discrepancy between the rights of PMWUD (e.g., German Social Code 12) and how it turns out in reality due to a myriad of barriers to these rights, such as a lack of resources among service providers, complex and long bureaucratic processes, legal or language barriers, etc.. This is a discouraging situation for both PMWUD and service providers.

> *Someone with no [access to] rights, however, and a migration background, isn't entitled to the same help. My hands are tied there, and it's always difficult to tell them, "Hey there's nothing I can do for you." This is truly upsetting. (S.)*

f. A multitude of needs and barriers

According to the respondents from both focus groups, the complex and interacting needs of PMWUD in combination with language, legal, social and geographical barriers, urge for collaboration between services to meet these needs.

> *There simply has to be an awareness of how severely stressed certain groups of people are. There are simply no offers for these groups at the moment, but they are urgently needed. Namely, we no longer have "just a homeless person," or "just a person who consumes alcohol." No, we have a person who has migrated without health insurance and has psychiatric issues due to trauma while also being homeless. (A.[2])*

Also, the respondents unanimously mentioned the shortage of structural resources for services that support PMWUD in precarious situations. In combination with multiple legal barriers, this causes persons to feel like basic rights of PMWUD are not respected:

> *The paths are too long and the structures are too complicated. All is well and good, but the existing system only works with budgeting. Also, budgeting has to be flexible and allow for some breathing room, so to speak. It has to be able to be replenished, and not allow anyone in charge to make excuses such as: "if the money is no longer there, then we'll ignore the basic right to health, period." O:, "We don't care about HIV. Let's just wait until the immunity cells fall below 300,000 and then see what happens." We see that behaviour every day. Despite having a clearing house, we can't get people to receive treatment, and that's a pretty big problem. There is best practice available all over the world, yet Berlin is not interested in it. (S.)*

A shortage of staff and resources was described as limiting opportunities for harm reduction and social services to offer PMWUD shelter, help them with basic needs and put in the effort that is needed to overcome barriers to care and resources. For example, S. discussed how their services were obliged to stop their street work for a while due to a shortage of staff, while street work is identified as one of the main ways to decrease barriers to care for PMWUD.

Focus group one also mentioned collaboration on an international level: being able to learn from good practices abroad, being able to collaborate with services in the countries of origin of PMWUD to ensure continuity of care between the countries, and even collaboration with organisations abroad to inform migrants about realistic expectations PMWUD can have when coming to Germany.

To overcome language and cultural barriers, the respondents pointed to community engagement as a valuable strategy. However, language mediators are underpaid and community organisations often run fully on volunteers. The latter may stand in the way of long-term and effective engagement, limiting opportunities to educate these communities on matters such as harm reduction.

g. Good practices

Despite the multitude of barriers toward effective treatment for PMWUD, respondents mentioned some good practices that helped to overcome these barriers. Yet, they expressed concerns that some of these good practices are project-based and funding may be limited in time. Simultaneously, they expressed their hope that these good practices can keep on existing and expanding to meet the needs of more people. Some examples of good practices mentioned by respondents are listed below.

- Johanniter as an emergency night shelter has succeeded to overcome language barriers through a myriad of volunteers with different migration backgrounds. They are able to cover all basic needs of PMWUD. They don't ask for any identification, lowering barriers for PMWUD to come to the shelter. Nevertheless, they express the need for more resources to continue their work in summer and be able to collaborate with other organisations to offer more specialised addiction and mental health care.
- The Clearing Stelle, an organisation by Berliner Stadtmission for people without health insurance, is mentioned as an organisation covering the costs of OAT for migrants without health insurance.
- The SuN Project by Berliner Stadmission is mentioned in two focus groups as a good example of immediate social housing that integrates assistance on multiple life domains.
- According to some respondents, language mediators, the use of translation software and pictograms to communicate has shown to be valuable for multilingual communication.
- Safe consumption workshops that go beyond merely explaining and that really show clients how to safely inject are agreed upon as a good way to prevent physical harm due to unsafe drug consumption.
- How Europe handled the situation of Ukraine is mentioned by some respondents as a good practice of how to make care for PMWUD more accessible.
- A 'ad hoc' practitioner group including police officers, a harm reduction representative, representatives of parks and public space management, as well as representatives from other relevant authorities was described in focus group two as very effective to help people get out of homelessness.

Finally, a social worker from the drug consumption mobile described a good practice of how they got the Russian-speaking community engaged in care:

> *I know there is a large Russian-speaking community at Stuttgarter Platz and they have been very well received. There is also a drug consumption mobile and a counselling mobile. We even have a Russian-speaking colleague in the drug consumption mobile, as well as a Russian-speaking language mediator on site. They have gained quite a bit of trust and have arrived and were also mediated in some cases via the clearing house. Then, for example, there is always a project to collect syringes in that district. This is also something where people who are not German and also had certain language barriers, were well experienced. They regularly collect syringes, are paid for them, and have gradually become more stable, among other things. (A.[2])*

3.3.4. Conclusion

In Berlin, the study participants conveyed a multitude of support needs that were fulfilled by harm reduction services, especially when these services were able to overcome language barriers. The West African community had less contacts with these (harm reduction) services.

Housing needs were described as a priority for increasing the wellbeing of PMWUD in both the focus groups and interviews. So was the importance of legal access to housing, which was now often limited because many participants did not have official residence permits. While emergency shelters offer a short-term solution for PMWUD who are homeless in wintertime, this does not imply long-term solutions and remains a source of stress. Both the focus group and the interview participants pointed to the importance of jobs and meaningful activities for the wellbeing of persons who use drugs, as well for drug prevention and recovery.

The focus groups discussed the unavailability and difficult access to (mental) health care. While Russian-speaking participants mentioned a multitude of medical needs, they also described that these were (partly) fulfilled by harm reduction services. A shortage of mental health support was mainly discussed by participants from Maghreb countries. Participants from West African origin indicated to have limited contacts with (harm reduction) services, but also indicated less medical needs. Legal barriers toward mental health and substance use treatment as well as other resources such as housing, work and education were mentioned in both interviews and focus groups. The multiple remaining support needs among PMWUD confirm that there is a substantial discrepancy between the rights of PMWUD and their access to these rights. Although harm reduction services showed to offer PMWUD support on multiple life domains, their possibilities were also limited by legal barriers.

During the focus groups the importance of collaboration between services and continuity of care was emphasized. They underscored the importance of providing (more) resources to (harm reduction) services to keep up the good work and further investing in supporting PMWUD around harm reduction and recovery.

3.4 Paris

3.4.1. Context

About 2.145.906 persons live in Paris, the capital of France. If suburbs and the suburban region of Paris are included, the population of Paris amounts to 10 million. A substantial part of the French population is foreign-born (13,3%). The most common countries of birth of foreign-born French people are Algeria, Morocco and Portugal (OECDiLibrary, 2023).

The most commonly used psychoactive substances in France are alcohol, tobacco and cannabis, followed by cocaine, ecstasy, LSD and amphetamine.

In France, undocumented migrants and newcomers are supposed to be entitled to free emergency and primary care. Specialist care by specialist doctors or provided in inpatient settings is also supposed to be provided for free (FRA, 2016).

Access to health care

While emergency medical care is provided regardless of one's documentation status, a health insurance is needed to cover the costs and grant access to other medical care. Health insurance is mandatory in France. EU citizens possess a European Health Insurance Cards, granting immediate access to vital healthcare. EU citizens that stay and reside in France for more than three months in an authorized manner, as well as documented migrants that work or live in France in a stable manner, are eligible for PUMA (Protection Universelle Maladie) if they can prove that they do not have health insurance in their home country. PUMA is the French system that offers free access to basic health insurance benefits and requires an (administrative) address in France (Médecins Du Monde, 2017).

According to the Social Security Code, asylum seekers and refugees have the same access to healthcare as authorized residents. Persons without official documents that allow them to stay in France (including EU residents without a residence permit) can access AME (Aide Médicale d'État) after residing in France for three months. AME offers access to certain forms of essential health care for free. It requires an authorized proof of identity, an (administrative) address and yearly renewal. Persons without AME can only get access to emergency care (Médecins Du Monde, 2017).

Testing and information about HIV and hepatitis can be provided for free to both documented and undocumented migrants with or without health insurance. Treatment for tuberculosis also falls under the urgent care scheme (Médecins Du Monde, 2017).

Access to social security

Over the past few decades, various conditions have emerged as barriers to social protection for non-national residents in France. While earlier legislations mainly referred to residents' nationality, more recent regulations focus on the requirement of 'regularity' for most social benefits. Furthermore, an additional condition of continuous and official prior residence was introduced and extended, particularly for non-EU foreigners. This continuous residence requirement has posed challenges for many non-EU foreigners in France as immigration authorities sometimes renew residence permits with delays, making it difficult for them to meet the specified timeframes. Undocumented migrants, by definition, do not have a regular status in the country, which can significantly restrict their access to social benefits (Isidro & Math, 2020).

3.4.2. Interviews

Introduction

The interviews in Paris were organised by Gaïa Paris. Derived from the projects of Médecins du Monde in the field of harm reduction and drug use, Gaïa Paris is an association that has been managing two medical-social services since 2006. These services include a centre for care, reception and prevention in addiction medicine (CSAPA) and a centre for reception, support and harm reduction for persons who use drugs (CAARUD), both funded by the Regional Health Agency. The goal of Gaïa-Paris is to reduce harm for persons who use drugs in Paris. Gaïa prioritizes addressing the needs and goals of individuals to enable them to enhance the social, medical, and psychological context of drug use. Ultimately, the aim is to better address the overall health and well-being of individuals (https://gaïa-paris.fr/lassociation/). Gaïa Paris offers needle distribution, opioid substitution treatment, has a drug consumption room (DCR), a mobile awareness and screening program for HIV/AIDS, viral hepatitis B and C, and liver fibrosis, and a social integration program that offers workshops for persons using drugs in which they create objects made from recycled materials that is aimed at regaining a rhythm, rebuilding self-confidence, restoring one's image, and envisioning a life project (LaboFabrik).

In Paris, the following communities were targeted during the interviews:

- Georgian community (n = 16, of which 15 cisgender men and cisgender woman)
- Non-Georgian Russian-speaking community (n = 10, of which 6 cisgender men and 4 cisgender women)
- Somali community (n= 6, all cisgender men)

Both the Georgian and non-Georgian Russian-speaking community were interviewed by Datuna. Datuna is from Georgian origin and arrived in France in October 2019. His first contact with Gaïa was from the side of a person using drugs. Later on, he became a volunteer and peer worker. Datuna speaks Georgian, Russian, English and is learning French. Partly thanks to their shared experiences, Datuna has a good and trusting relationship with the community of Georgian and Russian-speaking persons in Paris who use drugs. The interviews were conducted in Georgian (n=13), Russian (n=10) and English (n=3).

According to the local and community researchers, Georgian migrants who use drugs became visible in harm reduction services around the year 2005. In some organizations, Georgian people (and more generally Russian-speaking people) account for up to a third of the new outpatient admissions, especially in Médecins du Monde's methadone and needle exchange program (which became Gaïa in 2006). The local and community researchers note that gradually, this community became an important group in all Gaïa services (methadone program, needle exchange program, drug consumption room, housing program, ...). They observed how political and geopolitical instability, poverty and high unemployment rates offer few prospects for the future of young people, which are the main motives for Georgian people to migrate to Western Europe, including France. Many of them are described to suffer from HIV and/or HCV, coming to France in search of the possibility of treatment. The local and community researchers further describe that the living conditions of Georgian drug users in Paris are often marked by precarious situations: most of them live in hotels, in their car, in squats, etc. Since the Covid-19 pandemic, some of them got rooms in social hotels. Since Georgia is not a EU member state, it is more difficult for Georgian migrants to access the labour market and they have less access to legal resources compared to European citizens (e.g., Russian-speaking migrants from Baltic countries). According to the observations by the harm reduction teams working with them in Paris, Georgian drug users seem to inject drugs more often than other communities, particularly opiates (morphinesulphate, Subutex, heroin and even methadone). This (way of) substance use has often been initiated in Georgia. Gaïa's work with persons from Georgia who use drugs is now well established, although social workers still face several barriers in supporting Georgian migrants. They can be experienced as a source of fear as they often live in groups. Furthermore, most of them don't speak French nor English, which challenges effective harm reduction counselling. These barriers complicate communication and contribute to negative representations and stigmatization. Yet, the local researchers state that harm reduction, medical and social services aimed at Georgian migrants who use drugs are quite successful.

The local and community researchers in Paris reported that, among non-Georgian Russian-speaking migrants, the migration background and main drivers for migration are more or less the same as among Georgian migrants, even though political reasons are more often reported (e.g., fear of death, of being hurt, problematic situation of their families…). Similar to Georgian drug users, other Russian-speaking migrants are mostly using opiates by injection. Their living conditions are also mostly precarious. According to the community and local researchers, the main difference concerns their access to work, depending on their country of origin and whether it is a EU member state.

Six male participants from Somali origin were interviewed by Ismaël, a community researcher with Somali background. He has lived experiences as a person with a migration background using drugs and was able to connect with the participants through their shared language and experiences. Yet, these interviews were generally shorter than the other interviews and not all questions were asked during the interviews, leading to some missing data in the results about Somali persons. The interviews were mainly conducted in Somali. The local and community researchers reported that the Somali community was totally absent among service users welcomed in Gaïa services until 2019. The opening of the "Espace de repos" (a drop-in for persons who use crack cocaine) at Porte de la Chapelle at the end of 2019 made it possible to identify this new target community. The SEMID-EU project was a good opportunity to obtain more information on these hard-to-reach drug users. They don't consider themselves as drug users and don't attend harm reduction services. There's a big taboo around drug use and sexuality in this community. At the "Espace de repos", Somali clients are exclusively cisgender men, mostly between 18 and 35 years old. Their living conditions are particularly precarious and most of them are undocumented migrants, which complicates their access to health care and social rights. They use a variety of drugs, depending on their resources, mainly medication (e.g. benzodiazepines, tramadol), crack cocaine, MDMA, and alcohol, which is sometimes consumed in massive quantities. Their migration history is often traumatic.

Results

Profiles

a. Migration background and documentation status

All Georgian participants had the Georgian nationality (even though one participant was born in Germany), meaning that none of them had adopted the French or Georgian-French nationality. They are between 25 and 62 years old. Ten participants indicated they had no official identification papers in France. Three persons indicated that they had an expired récepissé (a temporary residence document). It serves as proof that a particular document or application has been submitted or received by the relevant authority or organization (République Française, 2021). Two participants have an acknowledged asylum status in France. Thanks to the AME legislation in France, multiple participants indicated that, even though they did not have a documented identity status in France, they do have access to health insurance and health services. A minority of participants did not (yet) apply for health insurance and experienced difficulties in accessing health services. Participants had been residing in France between four months and 13 years. Reasons for migration included financial reasons (n=7), political reasons (n=6) (e.g., being chased by police due to substance use) and medical reasons (n=2).

The main pushing factors for migration among the Georgian participants are financial hardship (n=5), non-specified political reasons (n=4) leading to being pursued by the police and factors related to family issues (loss of a family member by death or family conflict) (n=2). Relatedly, the main pulling factors for migration were the search for financial stability and better life conditions, medical assistance and a feeling of liberty and safety regarding substance use.

> *The main reason was, uh, the liberty, you know? But, uh, one of the liberties what I searched was to [...] because I'm addict, you know, addicted to drugs so it's very difficult for me to live in Georgia, because I risk to go to prison every day, you know? (A., male, 37 years old, Georgian origin)*

The non-Georgian Russian speaking community encompasses a diverse group of people stemming from different countries. Participants originated from Latvia (n=2, of which one female), Chechenia (n=2), Belarus (n=1, female), Ukraine (n=1), Moldova (n=1, female) and Lithuania (n=5, of which one female). Almost half of the non-Georgian Russian speaking participants self-identified as cisgender females. Some nationalities are unknown, but the six nationalities we know of are the same as the participants' country of origin. The respondents immigrated to France between 0.5 and 9 years before the time of the interview, with one exception of a participant who migrated 16 years before.

An important distinction within this group is whether participants originated from an EU or non-EU country. The European citizenship of the Latvian and Lithuanian participants permits them to reside in France in a manner that is recognised as legal. Of the other participants, five had no official identification papers in France, impeding access to resources such as health insurance. The woman from Belarus applied for a protected status following a request for political asylum and was in possession of a récépissé. This does, however, not include a work permit. Both Chechen participants indicated that their reason for migration was related to fleeing their home country out of fear for their lives, respectively related to war and Russian prosecution. The Ukrainian participant immigrated due to what he calls 'governmental injustice', before the Russian-Ukrainian war broke out. Other reasons for migration included medical needs (treatment for HIV), prosecution by the police due to criminal offences, financial and social reasons, and work-related reasons. These participants were between 25 and 47 years old.

The Somali participants migrated to France between 0.5 and 7 years ago. Most of them had the Somali nationality. Four of them had a récépissé, while the other two indicated they had no official identity documents. Reasons for migration included fleeing from war (n=2), being 'displaced by their country' (n=1) and wating to create a better life for themselves (n=4). Some participants had been living in other European countries before coming to France, and one participant indicated he had been refused asylum in Germany before coming to France. These participants were all relatively young, aged between 25 and 35 years old.

b. Substance use

Among the Georgian participants, all male participants reported the use of opioid substitution substances (i.e., Subutex® or buprenorphine, methadone), mostly provided by an official service. Two of them indicated to inject methadone besides the OAT programs. Six participants indicated concurrent use of heroin with methadone or Subutex, while nine participants indicated to use cocaine (and derivates) next to other substances. Most Georgian participants started using substances in their home country, when they were 12 to 29 years old. Six participants discussed the sensation of relief from stress, suppression of bad thoughts and forgetting their problems (related to homelessness, psychological issues and past trauma) as the main drivers for substance use.

> *I would say that I am depressive and I have post-traumatic stress. There were a lot of confrontations in my life, including beatings [by police in Georgia], eye damage, shootings, and so on. I don't have parents, they died tragically and I buried three people in nine months, two cousins and my mom. I think you can guess how is my emotional well-being. (...) That's why I consume antidepressants, sleeping pills, and beer. I sleep badly at night. The doctors prescribed me medications that help me sleep (T., male, 48 years old, Georgian origin).*

The female participant, M., had a different substance use pattern, which was limited to the use of cocaine, MDMA, ecstasy, ketamine and LSD a few times a month. She did not experience her substance use as problematic and hence did not indicate to need any help with this.

Participants described how substance use boosted their mood and gave them more energy, as well as how they could not live without substance use due to their physical and mental dependence on substances.

Among the non-Georgian Russian-speaking participants, most participants reported methadone use in the context of OAT. Only two participants indicated additional use of heroin, one participant indicated additional use of 'street' methadone and one injected Skenan on top of methadone OAT. Five participants started using substances in their home country, while the other three respectively started using drugs in England, France and Germany. Their first use of substances occurred between the age of 16 and 33 years. Substance use was related to coping with psychological difficulties and physical craving.

Among the Somali participants, the majority smoked crack cocaine and cannabis. Two participants reported drinking alcohol (daily), one participant used methadone next to (crack) cocaine, and two participants talked about using 'tablets'. They all reported using substances on the streets. Participants indicated their substance use was related to coping with the uncertainty, stress and boredom of being homeless. Three of them started using illicit substances in Italy, while two of them indicated that their first use could be traced back to France.

> *I have been in Europe for the past nine years. I haven't been able to secure a job, an ID nor a home and this made me fall into endless thinking. Then some friends suggested that I take drugs to help cope with the stress. (H., 28 years old, male, Somali origin)*

c. Social networks

The majority of the Georgian participants indicated they had a supportive social network. This mainly consisted of (Georgian) friends that are caring for them. However, two of them also indicated that they did not have what they considered "real friends", because they prioritized substance use over friendship. Family was less prominent because participants lost contact due to substance use and/or migration or, in one case, because they were deceased. A supportive social network may decrease support needs among persons with a migration background who use drugs, as it offers certain resources that persons without a social network can ot access (e.g., help with basic needs and someone to talk to). Those who felt that they could not count on a supportive social network (n=3) indicated that they felt alone and depressed because of that. Two of them expressed the need for social and emotional support.

In contrast, four non-Georgian Russian-speaking participants indicated that they felt mostly alone, as did four Somali participants. Family was often absent because of death and migration or they lost connection due to substance use. Most of these participants indicated they had few 'real' friends or people to count on for support. However, two participants from the Somali community indicated they had friends they could rely on. Furthermore, what soon became apparent in these interviews was the fact that these participants often talked about 'we' and 'the community' when answering questions, indicating that they belonged to a certain collective or community of people they felt part of.

d. Medical and mental health problems

The majority of Georgian participants (n=11) indicated they had psychological problems such as depression, neuroses and psychoses, PTSD, feeling stressed or anxious due to harmful life conditions and sleeping problems. Among the non-Georgian Russian-speaking participants, five participants talked about severe psychological health issues such as depression and suicidal thoughts, often related to traumatic experiences (war trauma, rape, death of loved ones).

The other participants indicated that they were sometimes anxious, stressed and sad because of their unstable living conditions related to homelessness and substance use problems or the loneliness related to being a migrant who uses drugs. One female participant talked about receiving psychological support from a psychologist.

In both communities, several medical health problems were reported: dental issues, problems with their stomach, infections (often related to drug injection) and infected or badly healed wounds as well as other complex medical problems such as hepatitis, HIV and heart, liver or lung diseases.

The Somali participants, who were relatively younger, indicated not to have any medical needs and only one person talked about unstable mental health and depression as a root cause for substance use.

(Support) needs

Among the Georgian participants, eight persons indicated they had been homeless in France. Yet, only three of them were homeless at the time of the interview. The Espace de Repos was mentioned as an important organisation offering participants a place to stay. Six participants stayed in a hotel paid by the local health agency and social services. Having an asylum status offered participants access to social housing, while persons without official documents mainly resided in the hotel or on the streets. Because most participants had a roof above their heads, they indicated that their basic needs for a safe place to stay and access to resources for personal hygiene were fulfilled. All but one persons who were homeless indicated they had access to a communal shower once a week or during winter. Furthermore, most participants indicated that they had access to food thanks to professional services, for example through food distribution on the streets. Several participants talked about food tickets that Gaïa provides. However, some participants described that the food tickets were not enough, leaving them with hunger at times. One person was confused regarding how to get the tickets and how much tickets they were entitled to.

> *Yes, they used to give us tickets once in a while, but they don't give me anymore [chuckle]. I don't know. I can't figure out when they gave it, when they bring it, where they bring it, what they do. I can't figure it out. I use that. (...) Even if you do everything you can, how long can 20 euros last? One week? And you must make it last for two weeks. That's it. They give you four tickets [of 5 EUR] every two weeks. (G[2]., male, 58 years old, Georgian origin)*

Participants whose basic needs were not fulfilled indicated that this had a major and detrimental impact on their wellbeing and substance use.

> *I don't have a house. I can't afford to lower the dosage and stop using the drug, due to the fact that I don't have a home and I'm on the street and nothing changes. I am in the same situation as it was 2-3 years ago. (...) If I had a house, many things would change. I would give up medicine and drugs, I would take a more serious look at life. (...) I don't have anything. They don't even give me shelter. They don't give me anything, not even a house, the procedure that goes on and that I get into this drug. I'm tired already. The end of such a life is death. (B., male, 48 years old, Georgian background)*

One participant talked about how the lack of an official address kept him from being able to authenticate his papers. Having an official residence permit was mentioned as a bridge toward housing, medical care and employment. Furthermore, some participants indicated that they didn't want to stay in France, but needed official identity documents to be able to travel to the country they were meant to go to. Legal and administrative support with requests for official identity documents was therefore considered essential to decrease drug-related harm and increase opportunities for recovery.

Even though most participants indicated that their basic needs were met to some extent, the need for additional financial support and help with finding a job to be financially independent was mentioned by most Georgian participants.

Six participants indicated they needed help with regaining control over their lives by assisting with safer drug use (n=2) or the reduction of harmful drug use (n=5), as their substance dependence stood in the way of resources that may increase their wellbeing, such as employment and good health. However, this was often related to the need for other conditions to be fulfilled, such as housing.

While almost all non-Georgian Russian-speaking participants had been living on the streets before, only one participant lived on the streets at the time of the interview. Four participants lived in housing programs provided in hotels (i.e., project Assore). The other participants lived in what they called the 'foyer', a room on a boat provided by CSAPA EGO, with family or in social housing. Except for the person living on the streets, all participants indicated that their basic needs of personal hygiene and a safe place to sleep were fulfilled, although uncertain for some in terms of how long they could make use of these resources. Participants had access to food through food tickets, food distribution on the streets and the dining room of the Espace de Repos, where they can get breakfast or some food during the day. Most participants indicated they had access to basic medical care, often provided by a harm reduction service.

> *"One feels more at ease in France, but I was here a broken man. Look, brother, these clothes are still from Germany. I've been poor like this for three years. Every month, my income is only these tickets that they... These four tickets are my only source of income here for 3 years now. I swear. I was able to contact my family for the first six months or so, and they were helping me in one way or another. Now, I do not have that opportunity and the only source of income for me is these tickets. (M., male, 47 years old, Chechen background)"*

One female participant with a European passport (A.) talked about the financial support she received from the RSA (Revenu de Solidarité Active, a solidarity income) (+- 500 EUR/month), as did the Chechen participant who had been living in the country for 16 years. He used to have documents (a medical card) allowing him access to a source of income by the RSA and housing, but since his documents expired, he indicated not to have access to these resources anymore. The financial support from the RSA in combination with housing support and job training helps A. to (re)build her life, but at the same time she indicated that this is insufficient to care for herself and her child. Also, the hotel is not a long-term solution and she looks forward to having a job and getting 'back on her feet', in order to be able to take care of her daughter who is now in foster care. The job training provided her a sense of hope for the future. According to A., employment may help her to overcome some of the psychological difficulties that are partly the reason why she started using drugs.

> *Tomorrow I have a very important meeting regarding training at the Charles de Gaulle Airport. That's very important for me. I'm worried because I can't write or read very well, and I understand French, but I speak English very well. That's why they gave me a chance for a very good profession, to go through training. I'm like a child, like a ninth-grader before an exam, I am so nervous. Really. I will be learning for a week and then, I think, everything will be great. After that, when you travel somewhere, I am going to be the one who will be checking your passports. (...) I have some sort of depression. Somehow, I am lacking something. There is some emptiness inside that needs to be filled with something (...) To fill the void I had with that, the depression that I've been talking about, that is, to stuff my head with useful things for that depression, all the pain, all of that to move to the background and then completely fade away little by little. (A., female, 40 years old, Latvian background).*

This need for help with employment was also uttered by four other participants. However, it was clear that participants could only imagine finding a job when they: (1) had a work permit and (2) a stable living situation. This would require a) help with paperwork, b) help with housing and c) overcoming language barriers.

> *I need assistance in finding a place where I can sleep, wash myself, and only after that I can find a job for me. I cannot work without having a home, it's impossible. (...) Without having a home, how can you go to work? How can you sit there all dirty, without having slept well and without resting your body? You need to recharge after work in order to get back to work again. (...) Damn, here people say: "Go find yourself a job". Fuck you all, fucking smart guys. (E., male, 33 years old, Lithuanian background)*

All participants indicated they needed help with getting official residence and other documents, such as insurance, disability benefits, work permit and a SIAO file[2], in order to get access to resources that may offer them a more stable life situation and open up spaces for increased physical and psychological wellbeing and integration in society.

Two persons referred to the need for psychological support to overcome psychological distress, while one woman was already in touch with a psychologist. Yet, most participants indicated that the reason for their psychological issues (such as unstable life conditions, addiction and loneliness) should be tackled to increase their quality of life, rather than talking to a psychologist. One person indicated he needed treatment to overcome his addiction, but most participants only wanted to reduce (harmful) substance use. Two participants talked about how they were helped before by a residential treatment service focusing on substance use and psychological problems. M. talked about how he was able to refrain from drinking and injecting heroin following psychiatric treatment that referred him to an OAT program. A. had been attending a residential treatment program to refrain from problematic methadone use. She talked about the helpfulness of physical and emotional support by professionals and female peers, as well as the importance of the recognition that substance dependence is an illness, not a crime.

[2] The SIAO file serves as a central repository of data to facilitate the referral process, ensure coordination among different organizations involved in providing assistance and track the progress of individuals seeking help. It is a nationwide system implemented to manage and coordinate the provision of housing and support services for individuals experiencing homelessness or facing housing difficulties (République Française, 2014).

> *I came with 20 mg of methadone. On the first day, they already cut it down to 10 mg for three days. It was Monday when I came. On Thursday they got me off completely. It all started on Thursday: medications for easing withdrawal symptoms, for all of that, and strong sleeping pills so that I could sleep, so that I wouldn't be nauseous, so that I wouldn't be in pain, because methadone is a tough thing. You can't do it alone, I don't know. Well, of course, you can, but somebody needs to be there with you, someone who would prepare some food for you, etc. In a hospital, the doctors and the nurses are constantly looking after you, plus, the groups have started. The psychologist was individual and everyone was together as a group. (...) (A., female, 40 years old, Latvian background)*

Among the Somali participants, who all lived on the streets at the time of the interview, housing was mentioned as a top priority and, by one participant, as a prerequisite to stop using drugs. Basic needs such as food and a bath, however, were often met thanks to services such as Aurore Boréal. Next to housing, four participants underscored the importance of a residence and work permit to find a job, which was talked about by two participants and should, according to one participant, also be accompanied by the cessation of drug use. Three persons talked about their financial needs, which they either wanted to be met through financial support or through finding a job. One person with mental health issues indicated this as priority need and another person indicated not to have enough access to food. Several Somali participants pointed to God as a supporting figure in meeting their needs and laying out their paths.

> *Thanks to God, I'm healthy but my problem is homelessness and lack of ID. If God makes it happen, I want to live longer in this country and receive the necessary assistance from the French government. (A[3]., 27 years old, male, Somali origin)*

Harm reduction and other types of support

Most Georgian participants were involved in OAT. Four participants talked about a methadone programme (or bus) as a helpful service. While regular side use of other substances was reported, the positive impact of the OAT program was acknowledged. One participant indicated that he used to inject methadone, but the OAT program enabled him to stop injecting. Others acknowledged that OAT and DCR kept them from using substances on the streets and being judged or convicted for it.

> *People don't go searching for the drugs in the streets. They come to the centre, take methadone and drink it at home. They don't walk on the street and do drugs there. (D., male, 55 years old, Georgian origin)*

While most participants from the Georgian and non-Georgian Russian-speaking communities indicated several unfulfilled needs, the added value of harm reduction services in their lives was clearly visible. It helped to be tested for HIV, hepatitis and tuberculosis and, if necessary, to start up treatment. Eight Georgian participants tested positive on Hepatitis C, of which five stated that they got treatment for HCV. One participant tested positive on tuberculosis and HIV, but was not in treatment at the time of the interview. Participants who were not treated for communicable diseases were offered support by the interviewer (a volunteer at the harm reduction service) during the interview.

Overall, participants were positive about the support they received from harm reduction services.

> *In everything, whatever I need, even if I need elementary food, if I need something elementary, I know that they will not leave me, they will provide something for me, that's what I want to say. Sorry for the rest, that they can't buy me a house, and what should I do now, they help me with everything that is elementary. There will be food, such things, that will be personal in everything. (...) whatever I want and whatever I ask, they help me as much as possible. (...) Gaïa helps me, she gives me tickets or whatever they are called, they give me once a week, if I need anything, they tell me about everything, come and contact us, I don't even know, I didn't need to ask, I don't know anymore, but I know that from what I've seen personally, if they help me with tickets, they tell me that If you want something to eat and wear, come to us. (...). (G[1]., male, 42 years old, Georgian origin)*

All non-Georgian Russian-speaking participants had been in contact with services such as Gaïa, Aurore and CSAPA EGO and Horizon. These services were deemed helpful in providing support around basic and medical needs, keeping people from using substances on the streets and providing social support. More specifically, participants mentioned the housing program Assore for shelter ('the hotel'), as well as the food tickets and the DCR. The latter was mentioned by seven participants as a safe place to use substances. Four participants indicated they felt comfortable to ask for help when needed and that these services help in every way they can. The extent to which the services were deemed helpful varied from merely fulfilling basic needs and reducing harm to truly supporting recovery in various ways.

> *We talk about many things. Plus, the team here in the hall [DCR] is treating me well, they are giving me some courage, since they are satisfied. They support me in some initiatives if I talk with them. Also, the whole Horizons team is supporting me. That's very important. (...) When you are left alone and you don't know where to go, you go to the right, to the left, straight. When you are being supported not only in one aspect, but everyone is also yours, that's awesome, that's a huge stimulation, a huge motivation. (A., female, 40 years old, Latvian origin)*

Through providing basic support, it seems that these services are able to link with persons in vulnerable situations such as PMWUD. By offering them a place to go for help, they increase access to resources that reduce harm and enhance recovery.

The Somali participants reported few contacts with drug services, but did indicate the helpfulness of services like Gaïa, Aurore and Boréal in providing basic needs such as occasional shelter, a shower and food. One participant pointed to the social workers of the Espace de Repos for help with the application processes for housing. At least three participants from Somalia had not been tested for HIV, Hepatitis or tuberculosis.

Barriers to care and other resources

The study participants from Georgia experienced a language barrier towards social and health services. Since a Georgian volunteer is working at Gaïa, this facilitates access to care for Georgian persons who use drugs. Other barriers toward social and health services were not knowing where to go or what to do, lack of insurance, the lengthy enrolment process for drug treatment programs and "not getting there" due to substance use and physical and geographical barriers.

> *I live on the street, my documents were stolen, absolutely everything was stolen from me. Then I should have gone at that time, but I couldn't. I missed the train. Then, I couldn't buy a ticket (...) I think it was my fault. It was because of my carelessness, but also, I was robbed, and I lost everything, so I couldn't get there because of that. (N., male, 25 years old, Georgian origin)*

B. described the accumulated and intersectional impact of drug use, homelessness and barriers to care:

> *My sleeping hours are messed up and so I use more drugs to cope with it all. (...) It takes time because there are so many people. There are many homeless people. These organizations are not able to help you suddenly. It takes time to give you a home, to walk, to bother and to meet. It is very difficult to sleep at the airport and in the car. Again and again, this drug to endure all this. I'm struggling with treatment... (...) A shower and something free helps. You can wash, but it still needs an appointment, it still needs time, it needs to come again, I have an appointment there, I have an appointment here. And I'm sleeping at the airport because I haven't slept at night. Then they tell me why you didn't come. I have to find the medicine in so many problems. I have a very difficult condition and, therefore, I use additional drugs. (B., male, 48 years old, Georgian origin)*

Among the non-Georgian Russian-speaking participants, persons without any official identity papers pointed to their undocumented status as the most important barrier toward medical care, an income and housing. One participant mentioned how native French people were prioritized at the shelter if there was a line at the shelter. Two persons discussed not having a health insurance as a barrier to care. Four persons pointed to substance use as an important barrier toward care (e.g., being able to meet appointments) and other resources such as finding a job or learning the language. The language barrier hampers access to care and employment and may result in "not knowing where to go". The availability of interpreters was mentioned as helpful to overcome language barriers. A service that links persons to care was suggested as a solution for helping them with appointments and – literally, by providing a map – showing them the way to helping resources.

One woman talked about the importance of providing care before someone hits rock bottom to prevent that individuals' situations deteriorate.

> *In the beginning, I received everything very badly, more precisely, I didn't receive anything. When we lived here for three and a half years, whenever we went to different agencies, they said that "you don't look bad, you didn't lose anything yet (...) We fear that you'll only become worse by living with them, by looking at them." We needed accommodation. Like, "you're not completely lost, you'll still make it on your own" You'll make it on your own? They were wrong, radically incorrect, otherwise, if they had helped me back then, I would have had a much calmer psyche and all that. They built up that kind of system. I am not saying that everyone, but most organizations have created a system where they help only those people who are already struggling, while those who are still good at something themselves, "You can do it, do it on your own". I believe it is necessary, and vice versa, to motivate more those who are still able to do without assistance. So, I haven't gotten enough professional help. (A., female, 32 years old, Belarusian origin)*

Another participant also indicated he only got in touch with medical and social services once he had severe medical issues.

When they were in contact with some kind of support service, the lack of continuity in social workers was indicated as a barrier by two participants, as this impeded building a helping relationship.

Among the Somali community, one participant pointed to the lack of a valid residence and work permit as a barrier toward a job and financial resources. Additionally, drug dependence stood in the way of finding a job and being able to work, but simultaneously one participant pointed to his harsh life conditions as a reason why he was not able to focus on drug treatment, as well as not knowing about these services nor looking for them. When asking to A[1]. if there was anyone who he could rely on for support, he pointed at the consequences of stigma related to the outer features of homelessness:

> *Because I am not living with the society. (...) Because when the people see me with these old dirty clothes of vagrants during the day, they usually run away from me, because they think that I am a mad man. (A[1]., 30 years old, male, Somali origin)*

Encounters with criminal justice and law enforcement

Four Georgian participants shared their experiences of resorting to theft as an alternative means of self-sufficiency due to their limited financial resources. Also, three participants mentioned that they were fined by the police for using public transport without paying. The local researcher clarified that these fines can accumulate when not paid for. Other contacts with the police in Paris were related to substance use and being undocumented.

Most Georgian participants described their encounters with the police as stressful and fear-inducing. This may be related to the traumatic experiences some participants have had with police in Georgia. One participant talked about how he lost an eye due to violence by Georgian police (which he called "dogs"). Police was rarely considered helpful, with the exception of one participant who talked about being "grateful" for being treated "humane" by the police. Language barriers may lead to the experience of not being understood and not understanding what is happening.

Furthermore, as one participant described, when an arrest leads to a trial, the lack of a home address may keep them from being informed about their trial. Two participants mentioned that they had received a deportation order by the court, while another respondent discussed his fear for deportation. Several participants reported stigma and discrimination by the police because of their Georgian migration background or the (accumulated) impact of a migration background, drug use and criminal offending due to financial hardship (e.g., not paying for public transport).

> *You are Georgian and you are not protected from anyone. Even if I want to complain, they tell me to leave. (...) The police may stop you for something, either you entered the subway without a ticket or something else and they insult you, looking at you as a commodity. (D., male, 55 years old, Georgian origin)*

Two participants indicated that they had been imprisoned in their home country, while one had been in prison in France. One participant reported how he was arrested for drug possession and needed to undergo mandatory drug treatment.

Among the non-Georgian Russian-speaking participants, four of them had been in contact with the criminal justice system in their home country. Six participants had been detained in France, of which two had been deported to Latvia multiple times and one faces deportation in case of future arrest. Similar to the Georgian community, five participants indicated that their imprisonment was related to theft to provide for basic needs and substance use. Two participants mentioned that being arrested for drug possession is almost inevitable if you have an addiction problem.

> *Yes, it [the arrest] was related to drug use, unfortunately. Because of that, I ended up in jail for a day, and the police saw everything. Today, by God's grace, I have no issues with it. I can choose to inject drugs or not. Before I had to do it constantly, every day I needed to get high. (R., male, 43 years old, Chechen background)*

While there is an agreement with the police that PWUD can carry their dose for own use to the DCR, the accounts of study participants indicate that this is not always the case. One participant talked about being checked for documents in a rude way. One participant indicated that the police took his identity papers away, but did not know why this happened. Three participants discussed stigma and discrimination by the police based on substance use.

> *Before that they looked at me like I looked like a normal girl, all the cops treated me great. As soon as they found out, "Oh, so you're using methadone." I said, "I'm getting treatment, so I don't use other things". The attitude changed immediately. This was not just felt morally, it was seen physically. They began transferring me from cell to cell and putting me in jail with some strange drug addicts who I didn't understand and didn't even want. They weren't all the same after all. I felt that they were treating me differently after they had found out that I was on the programme. (A., female, 32 years old, Belarusian origin)*

Participants who had been in prison in France reported mainly positive aspects about detention: having access to a free lawyer, hepatitis treatment, being able to decrease substance use and reduce dependence, as well as having a job in prison that gave a certain sense of meaning. Positive encounters with the law enforcement system were limited and included not being arrested for drug possession even though carrying crack and support by the police after encountering rape.

Most Somali participants did not report any major problems with the police or judicial system and one participant even stated "respecting" the police. Two participants indicated that they had been checked by the police for their documents, which resulted in one night of detention for one participant, but neither talked negatively about these encounters.

3.4.3. Focus group

RESPONDENTS

Ten respondents took part in the focus group in Paris that was conducted in French and took around two hours.

- Coordinator of a regional drug monitoring centre
- Public-health pharmacist in a harm reduction centre
- Community researcher from the Georgian and Russian-speaking community
- Psychiatrist in a hospital service for young migrants using drugs
- Social worker at a support service for persons in precarious situation who migrated from Georgia
- HR team manager at a support organization for persons in precarious situations
- Pharmacist and assistant manager in a harm reduction service
- Social worker at an organization for migrants who use crack targeted toward asylum seekers' rights
- Project manager from Doctors of the World
- Assistant project manager from Doctors of the world

Results

Needs of PMWUD

a. Basic needs

The respondents described a variety of needs among the PMWUD they are in contact with. The primary things mentioned in the focus group are the basic needs of food and a place to sleep. While the targeted communities seem to be able to gather food through a variety of social services/initiatives, work and creative ways of finding money and food themselves, the issue of a safe place to sleep may remain unaddressed since there are several barriers towards housing and shelter for PMWUD. Representatives of harm reduction services mentioned that offering basic products such as coffee and water may encourage individuals to come to the services.

b. (Mental) health needs

Respondents stated that PMWUD have a variety of health needs, such as somatic health problems, hepatitis treatment and opioid substitution treatment. OAT may be the first support, but by getting to know service users better additional needs may slowly come to the surface.

> *Often, when these users go to a CSAPA, they say: "I need OAT because I've run out of money, I'm in withdrawal," and that's what they need and ask for first. Later, you'll be able to unravel the thread, pull on the wool, and evaluate specific needs and all that, but that's the need they initially express in 95% of the cases. (L.)*

OAT was also discussed as a way to get persons out of criminal networks, because this responds to individuals' need for substances and may keep them from turning to criminal activities to support their drug use. The participants regard OAT as a type of emergency care that answers essential health care needs of persons in precarious conditions who are in withdrawal and have no resources. Some participants reported several overdoses among PMWUD, especially among those who have only been in the country for a short while.

> *Many people arrive in the country from the nearby airport. Somebody from their community picks them up and they stop four blocks down the road and buy heroin and cocaine, which I'm sure isn't in the same dosages as back home, and then they turn blue 3 hours later. (Y.)*

One respondent mentioned that CAARUD started with overdose prevention among PMWUD. They offer free Prexonad to PMWUD and educate them on how to use it. They have received positive feedback from PMWUD, who tell them that they have saved lives. Educating PMWUD is important to reduce misunderstandings within communities about overdose prevention. Among the Russian-speaking community, for example, the injection of a mixture of salt and water is often used as a means of overdose prevention. However, this is ineffective and Russian-speaking migrants would hence benefit from education about overdose prevention and Prexonad. Related to this, L. indicated that PMWUD may benefit from more information and assistance around drug consumption (e.g., dosage, consumption times and areas, drug dispensers).

A survey at CAARUD showed that persons who overdose are in need of psychological support afterwards. However, one respondent stated that their service has limited access to psychologists who speak the language of PMWUD. According to the respondents, many PMWUD suffer from psychological problems (especially since drugs may be a coping mechanism to deal with psychological problems and trauma), but they are often not trained to treat that in harm reduction services. They underscored the importance of linguistically accessible and culturally sensitive specialised psychological support for PMWUD.

c. A place to be

Multiple respondents described that the reposing area of Gaïa is often overcrowded, as it has a lot to offer to users.

> *Our facility also serves as a place where they can reconnect with their communities and not just to be assisted or to see a social worker. It's a spot, especially for newcomers who are still undocumented. It's also a place for people to stay together in their community, where they can benefit from the community's assistance and have access to financial support. This time that they spend together is also a time without police control [...]. It's also a place where they can relax and be safe with the members of their community. (L.)*

The respondents indicated that the precarious living circumstances of PMWUD drive them to the reposing area as the next best thing.

> *[About a service user] He'd say things like: "Here I eat, I drink coffee, I shower, sometimes I sleep. It's home." He said it a bit like, "I don't want it to be my home, but considering what you're offering me and my situation, it is my home." (T.)*

The connection with service providers, their openness and non-judgmental attitude are described as additional reasons why PMWUD like to stay in the reposing area as a 'place to be'.

> *When you were talking about those who stay all day at the rest area, it's because they feel the need to be somewhere. This is particularly true of Porte de la Chapelle. These people live in an ultra-hostile environment so the rest area is a kind of sanctuary where you can be with others without necessarily expressing any need. You just sit there, and you have a bit of companionship, a bit of a connection within the community, with the employees. I don't know if it's still the case, but they can spend days doing nothing and just being there, without necessarily expressing any need other than just being there. (L.)*

d. Day activities and work

Besides a 'place to be', D. explained that PMWUD need a 'place to do', referring to activities and job opportunities. By offering social, educational and vocational activities to PMWUD, their integration in society and naturalization may be facilitated. Training certificates could increase their chances for naturalization, though these trainings are very hard to access for undocumented migrants. Several respondents confirmed that many barriers toward education and paid work remain, urging PMWUD to turn to alternative forms of financial provision, such as off-the-books work, dealing drugs, and other activities that are seen as illegal.

e. Legal and administrative needs

A major need that respondents emphasized among PMWUD is the elimination of administrative barriers for a better future. PMWUD come to services for legal advice regarding residence and work permits, as well as other needs that require administrative support (e.g., finding housing). The respondents talked about 'the waiting game' that often follows such a request.

f. Specific needs of ethnic communities

The respondents described how support needs may differ from community to community and from person to person. While the Georgian community is described as mainly attending harm reduction services for OAT, to talk (in their own language) and to fix administrative problems, the Punjabi in Paris seem to be mainly looking for take-home OAT so they can go to work. Communities also differ in the way they can fulfil certain needs on their own or within their community, and there are also differences within communities. For example, some of the focus group respondents had very different experiences with the Punjabi community. Some described this community as a hard-working community in need for take-home OAT, who are mostly well-dressed and don't embody a lot of problems, while another respondent experienced the Punjabi community as a community where a lot of problems cumulate. She described how these communities may have a negative impact on newly arrived persons from Punjab, who feel misused and are often misinformed about aspects such as residence papers. Some additional challenges were discussed regarding unaccompanied minors, who often experience psychological problems due to identity issues and trauma. Although representing themselves as minors helps them to access care, it may also lead to additional barriers such as difficulties to receive OAT and find help from harm reduction services. Getting to know the needs and resources of each community and understanding certain behaviour in the light of their culture and context is therefore deemed important.

g. The holy grail of harm reduction

Due to support barriers in other services or within their own community, the respondents stated that many PMWUD come to harm reduction services to address their complex needs. Respondents from these services indicated that they feel it as their duty to help them with these needs, but simultaneously expressed concerns as this is not feasible with the current resources.

Access barriers and how to overcome them

The focus groups respondents mentioned several barriers to care for PMWUD, which were related to barriers within migrant communities, within services and on a structural/systemic level. The findings are divided according to the levels on which the respondents situate these barriers and how to overcome these.

1. Community-related barriers and how to overcome these

Respondents described that they were unable to reach certain persons in need due to a lack of knowledge about existing services in certain communities. Additionally, stigma on migrant community level may impede access to services. Some respondents indicated that, for example, persons who use drugs may not turn to their community for help on some domains, since they feel stigmatized based due to their drug use. Stigma may form a barrier to OAT and by some communities OAT and harm reduction services may be associated with "the State", which refrain some PMWUD with Georgian background to go to OAT and harm reduction services. Respondents further indicated that some migrant communities have certain cultural perceptions about psychological problems and psychiatric care that may stand in the way of mental health support.

2. Service-related barriers and how to overcome these

a. Linguistic barriers and accessibility

The respondents primarily situated language barriers at the service level. Their organizations were able to overcome many language barriers thanks to interpreters and community inclusion, but since language barriers remain in other services, such as administrative services for migrants, they are often forced in a position of 'middleman'. Access to specialized mental health care is also limited for PMWUD due to language barriers. Respondents further underscored the importance of providing information about safe drug consumption and available services in multiple languages to reach communities that experience language barriers towards care and support services. Some respondents criticized the fact that some services hide behind the language issue and do not help persons in need. They point to translation software as a creative solution for overcoming certain language barriers, but also to more systemic solutions to bridge language barriers in services.

b. Cultural barriers and accessibility

The respondents discussed that a lack of cultural awareness and sensitivity toward PMWUD may lead to misunderstandings that impede access to treatment. They underscored the importance of truly getting to know persons and communities to increase understanding of their needs and how to address these. Cultural awareness and sensitivity are detrimental in this regard.

> *Back in the day, with Russian-speaking users generally speaking, and with Punjabis later on, we managed to overcome the language barrier and talked to each other, but that didn't mean we understood each other. So, the involvement of anthropologists in the teams, or of specialists with some knowledge of the communities and the issues at stake, helped the teams to understand why people say yes all the time and then leave and nothing happens. Why do they use false IDs and it takes years before they give their real names? Then you understand a little better. For the Punjabis, for example, it really helped the team to soften certain conditions of admission and ways of working with users and to facilitate the connection. For example, for the Punjabis, we had an anthropologist from Inalco coming for two half-days, who knew nothing about drug addiction and all that, but who had spent years in Punjab and explained to us things like, "Migration routes are like these. Community is this. This is what family means. This is what it means to work, the value of work, et cetera." It really helps to unravel things. (T.)*

The respondents further underscore the importance of cultural sensitivity and awareness in mental health care as well as recognising alternative ways of support within communities.

> *It depends on what they think of their symptoms and hallucinations. A lot of them say jinns and demons talk to them. To say, "No. You're obviously mentally ill because Jinns aren't real," is not very respectful of other people's cultural backgrounds. So how can we integrate intercultural considerations into the health care process? (N.)*

A solution to be able to overcome cultural and other barriers may lie in the inclusion of people from the community within the staff of services.

> *Yes, we can also set up mechanisms for political participation. It's complicated to work with users who are oppressed, who don't have any administrative voice, who don't have a voice because of the language barrier, but at least in a place where they're used to come, they have the opportunity to speak. (...) I think it's also vital to start asking them what they really want, to set up mechanisms to find out, in their opinion, how we can help them, and how we can find solutions for access to care? What do they find? We speak as professionals, but on the users' side, they may have other difficulties that we don't see. (N.)*

c. Stigma

The respondents pointed to multiple forms of stigma that exist and are acted upon on a service level. Stigmas is related to migration background, substance use and (other) criminalized features.

> *Double stigmatization. Not only are they crack users at Porte de la Chapelle, but they get woken up. You're not allowed to sleep anywhere. Plus, you're undocumented. It's a double problem. The cops can do whatever they want. They're the ultimate victims of mistreatment. (M.)*

Nevertheless, there is a difference in opinion among respondents about the role of police toward service users. While some indicated their service users had been confronted with unfair treatment of police during custody and arrests, others stated that police did not bother their service users. One participant described, however, that PMWUD are sometimes contained in a cell for more than 24 hours without getting access to OAT. This means that they may already be in withdrawal when they get out, which can be dangerous for their physical health and potential overdose.

The respondents talked about how multiple stigma led to the denial of certain rights for PMWUD.

> *You feel that it weighs heavily on these users who know that they're already seen as delinquents because of their drug use, or the fact that they also sell drugs to support themselves, whether it's for food or drink. It's very specific, this deportation, this double delinquency. They don't have accommodation at the moment, at Porte de la Chapelle, they're homeless. That weighs on them and makes it even harder for them to claim their space because we're already denying them so many rights and we can do things. (M.)*

Stigma regarding drug use was mentioned by multiple respondents as keeping PMWUD from finding shelter. According to the respondents, misperceptions about PMWUD and related fear led housing services to exclude PMWUD from support. Some respondents took specific actions to avoid that PMWUD become a victim of substance-related stigma.

> *So, we wrote a letter and put the Aurore logo on it. I stamped it right on the name CAARUD Aurore 93, so they won't see the name CAARUD and think, "Another drug addict," and create even more problems. It's tiring. (Y.)*

> *When you show the French authorities that you live in a house and not on the street, that's also a solid way of moving forward. When you're on the street, you're mistreated by civil servants. "A bum who hasn't achieved anything, who'd rather stay on the street, et cetera." (D.)*

Training of staff to overcome stigma-related fear that leads to violation of the rights of PMWUD is therefore deemed essential by the respondents.

Because the rights of PMWUD are unrightfully violated, some respondents raised the need to also educate PMWUD about their rights and empower them to claim these. However, others raised the concern that in their organisation, some system barriers sometimes stand in the way of being able to meet these rights.

> *The rights that are written down somewhere for these users are impossible to be put into practice on a day-to-day basis, for reasons of size, complexity, or endless waiting. We all agree and it's important to point this out. (V.)*

Stigma creates power dynamics between carers and patients that may increase cycles of negative experiences and mistrust. Hence, the respondents underscored an open and non-judgmental attitude toward PMWUD as essential in harm reduction services. Additionally, they talked about bringing services to PMWUD instead of waiting for them to come to the services (e.g., through mobile services), decreasing linguistic, cultural, personal, social and practical barriers toward care.

3. Structural/system barriers and how to overcome these

A recurrent theme throughout the focus group was the need for systemic solutions. Respondents unanimously agreed that there is a shortage of resources for services working with PMWUD (and migrants in general), as well as a myriad of complex system barriers to care and future perspectives for PMWUD. These systemic problems are described to be rooted in a security-focused political discourse concerning PMWUD. Furthermore, the respondents discussed that regulations that make PMWUD 'criminals' impose fear among PMWUD to be deported, which, in turn, increases distrust toward institutional services and support.

The respondents described that harm reduction services are supposed to be low-threshold services that are accessible and offer solutions to acute needs. However, with their current resources, they are often not able to do so, which creates frustration among both PMWUD and service providers.

> *There's also a kind of tension, like "I have no choice but to be here. You're an institution and now you're not helping me," because we don't have a lot of solutions.(..) . There's nothing more you can do because we're totally diminished in our ability to offer anything else to these people. (T.)*

PMWUD are described to get lost in translation and in bureaucracy and therefore come to harm reduction services for a myriad of needs regarding multiple domains. D. described that this also applies to migrants who don't use drugs:

> *Sometimes, some people come to us, who are not drug users, but they prefer to come to us because they've heard from other drug users that we receive people easily, and we listen to them, and so on. So they come and say, "Yes, I'm taking this", and then when you ask questions, you realize that they're not drug users. They just wanted to be admitted into the organization because they have trouble making appointments at services. (D.)*

The respondents criticized that they are overcharged and that the organizations are overcrowded, with waiting lists of up to 5 months to provide essential health care such as OAT. They pointed to the fact that PMWUD are often in precarious situations and have acute needs. However, they are not able to provide acute help due to lack of time, resources and a myriad of barriers that keep PMWUD from getting access to support.

> *I think that when it comes to access to health care, there's a structural problem that's not going to be solved for another 15 years, and we're not going to wait 15 years for the shortage of doctors, nurses, and especially doctors, because it's a machine that creates insecurity, desocialization, and health problems. (T.)*

They further discussed whether or not certain tasks could be delegated better to decrease the pressure on certain services. Doctors, for example, are told to be overcharged for OAT, while the distribution of opioid substitution substances may also be a task that nurses or social workers can do. While some believe this could help to decrease waiting lists and increase access to care, others disagree saying that specialised services are needed to offer tailored care to migrants. Nevertheless, all respondents agreed that, in order to offer tailored care, more collaboration is needed between various services that have resources to offer linguistically and culturally sensitive support.

Furthermore, respondents described that legal barriers on a structural level hindered access to care and resources among migrants. A respondent told a distressing story of a migrant in need that emergency services did not want to help because he did not have a social security number. Additionally, the various requirements for receiving an AME (State Medical Aid) complicate PMWUD's access to health.

Legal barriers also hindered harm reduction services to work toward concrete goals with their service users. For example, the respondents talked about wanting to include people from specific communities in their services to increase access to their services. Yet, they are often not able to hire them because these persons don't have required papers. Finally, the complex processes of applying for documents such as residence and work permits lead to what a respondent called 'a permanent waiting cycle' that may discourage PMWUD and hinders hands-on support to acute needs.

3.4.4. Conclusion

The focus group identified housing as a top priority for increasing the wellbeing of PMWUD. Yet, the interviews demonstrated that, especially among the Georgian community, many of them had found a stable place to live thanks to Assore, which provides PMWUD the opportunity to stay in hotels. This initiative decreases homelessness including several related (health)h risks. In Paris many PMWUD are engaged in OAT. The focus group emphasized this as an important stepping stone towards help on other domains. A shortage of psychological support was mentioned in the focus group, while many participants conveyed severe mental health problems, which are linked to homelessness and drug use.

While the Georgian community indicated to have social networks within their community, this wasn't as much the case for non-Georgian Russian-speaking participants and respondents from the Somali community. The focus group discussed that harm reduction services (unintentionally) became an area where PMWUD could connect with each other, increasing feelings of belonging and opportunities for finding resources within their own communities. Having something to do was mentioned as an important support need among all three communities, but there are a multitude of legal and other barriers toward necessary resources such as housing and employment. Hence, focus group and interview participants indicated the need for legal and administrative support.

The Russian-speaking participants (Georgian and non-Georgian) seemed to find their way to harm reduction services, as opposed to Somali interviewees who indicated to have limited contact with harm reduction services. This may be a result of initiatives that were mentioned during the focus group to make harm reduction services more accessible to Russian-speaking migrants by adapting these to be more linguistically and culturally sensitive. Even though services are clearly able to reach some migrant groups, a substantial number of PMWUD are not familiar with (harm reduction) services. This confirms the need for lowering linguistic, cultural and stigma-related barriers to care, both within communities and within services, as well as reducing structural and systemic barriers.

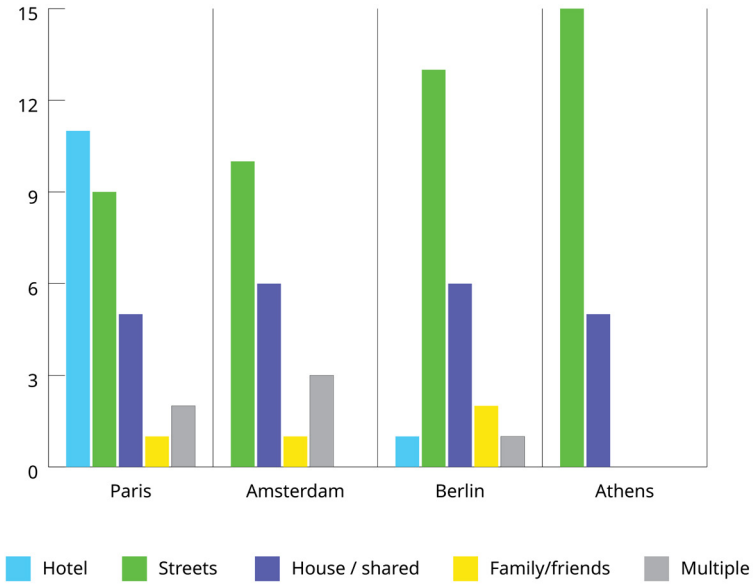
The focus group and interviews shed light on the various support requests that harm reduction services receive from and see among PMWUD. However, the focus group respondents underscored that the complexity and multitude of needs requires structural resources to appropriately answer these needs.

4. Overarching findings

In total, 98 participants from 43 different countries of origin and with 45 different nationalities were interviewed as part of the SEMID-EU project across four metropolitan cities using 14 different languages. Table 1 provides a brief overview of the most important themes that were discussed in the interviews with PMWUD. However, to understand the specificity, depth and interrelatedness of the different aspects that were discussed, we recommend the reader to browse the results of the interviews in each city. Furthermore, we probe the reader to approach the results with the heterogeneity of the population of PMWUD in mind, both between and within cities. This translates into complex support needs that may be person-specific rather than specific to the population of PMWUD or an ethnic community.

Many PMWUD who participated in this study were living in precarious situations of **homelessness** (see Graph 1). Homelessness was described as one of the first things to be solved among during the interviews and the focus groups. However, to get access to stable housing, a residence permit is often required. Some good practices of housing for undocumented PMWUD were mentioned in Berlin and Paris. This becomes apparent in the relatively low number of PMWUD living on the streets in Paris, since the social housing program Assore enables PMWUD to reside in a hotel (Graph 1). These numbers may also be linked to the composition of the study samples. In Amsterdam, for example, most participants from Maghreb countries were living in more stable housing situations, and it goes without saying that many people from the open drug scenes in Athens were homeless. Several participants occasionally stay in night shelters, but these shelters were also described as temporal (only in winter or only for a limited number of nights) and insufficient (a place to spend the night, but not a home). Nevertheless, the living situations of study participants indicate that many PMWUD are homeless, which has a severe impact on their future perspectives and may install a kind of vicious circle. Homelessness and the related stress were mentioned as the main reason for (continued substance use, a cause of psychological distress and a barrier toward legal documents such as health insurance or a work permit.

Graph 1 also suggests that having a **social network** to rely on can be an important resource of support, also for housing. However, the interviews simultaneously confirmed that study participants have very limited social networks, since their family is often abroad and they are socially excluded due to distrust of others and substance use, homelessness and related stigma within communities and society. Since it is difficult for PMWUD to rely on own social networks for help on multiple domains, they more often need to rely on services for help. As a consequence, the focus group in Paris mentioned the importance of including community workers in harm reduction services and offering service users a 'place to be' within their community.



A positive finding was the extent to which **basic needs** like hygiene and food were fulfilled among most PMWUD in the four capital cities. Services manage to cover basic needs by offering them places to shower, access to meals or food tickets (Paris). In wintertime, a substantial number of study participants could stay in shelters, but at the same time the challenges and stress related to the conditions and temporality of these shelters is a serious issue in all cities.

While equal access to health care is a fundamental right of all human beings, all focus groups mentioned the inaccessibility of **health care** for many PMWUD. They described several barriers toward health care, including exclusion of health services based on the lack of legal documents (residence permit, health insurance), but also unfair refusal due to stigma and misinformation among health care providers.

Many PMWUD had many medical needs, often related to substance use and homelessness. The lack of insurance as a barrier towards health care was mentioned by several participants, though many of them could rely on harm reduction services for urgent medical needs.

While research has shown that migrants are disproportionally affected by chronic hepatitis B and C (European Centre for Disease Prevention and Control, 2016), also persons who use drugs are at increased risk of **infectious diseases** such as HIV and hepatitis (United Nations office on drugs and crime, n.d.). The majority of the study participants indicated that they had been screened and, if the test was positive, treated for infectious diseases such as HIV, hepatitis and tuberculosis. This was especially the case in Amsterdam and Paris, where only a few PMWUD indicated that they had not been tested for HIV or hepatitis. Regulations that aim to ensure access to screening and care for infectious diseases clearly pay off.

PMWUD frequently make use of **OAT** across all cities, but Athens. In Amsterdam and Paris, OAT was available to PMWUD, even to those without official residence or identity documents. The focus group in Amsterdam, however, revealed that waiting lists may keep PMWUD from accessing OAT. In Berlin, this is not the case and there is an organisation that is able to offer OAT to undocumented migrants. In Athens, OAT is not available for undocumented migrants. Several PMWUD described how OAT had helped them to reduce harmful substance use. Additionally, take-home OAT was mentioned by both focus group and interview participants as a prerequisite to be able to work (physically). It decreases financial needs and may prevent them from having to turn to criminal activities as a way to be self-supportive. While it turned out that OAT in Athens was mainly targeted at reducing substance use and working toward sobriety, OAT in the other countries was more linked to harm reduction on a personal and societal level such as safe drug use and crime reduction. Also, a few PMWUD asked for specialised abstinence-oriented drug treatment, but this is generally not accessible for undocumented migrants or people without insurance. The importance of culturally sensitive and linguistically accessible information on safe drug consumption was further mentioned as important for newcomers by interviewees and professionals.

While many participants struggled with **mental health problems** across all four cities, the extent to which psychological support was experienced as helpful differed, which could be linked to the fact that some had more pressing needs at that moment. Moreover, the extent to which participants needed specialized support regarding mental health problems also depended on the root causes of these mental health issues. For some, this was related to their precarious living situations or substance use, while for others it was rather related to trauma in their home country and the migration process. Substance use was mentioned as a coping mechanism for dealing with psychological problems. Depending on the root causes of psychological problems, culturally and linguistically relevant specialised psychological support can be provided. Additionally, some respondents asked for specialised drug treatment, though this is generally not accessible for undocumented migrants.

Many PMWUD indicated that they wanted to **work**, but that they could not do so due to homelessness, substance dependence (or lack of take-home OAT) or the lack of a work permit. The focus groups further revealed vicious circles of unemployment, homelessness and drug use. Hence, there is clear need to decrease barriers towards employment for PMWUD.

Although the majority of participants faced several **legal barriers** toward health care and support services, it became clear that having an asylum or refugee status, as well as having a permanent or temporary residence status significantly decreased these barriers. Yet, a temporary residence permit was often lost or expired, indicating the instability and temporality of the resources that persons with a temporary residence permit can access. Ukrainian participants who migrated due to the Russian invasion had either a temporal or permanent residence status. In Berlin, the local researchers indicated that Ukrainian PMWUD had access to antiretroviral therapy and OAT, in contrast to some other intra-European migrants. In France, the focus group discussed the reception of Ukrainian migrants as a good practice. Indeed, research has shown that Ukrainian migrants were generally better welcomed in EU countries than other intra- or extra-European migrants. European host cities have demonstrated a high level of support toward Ukrainian refugees, for example by accommodating them at private homes. Although this is not a durable solution, it did make immigration for Ukrainian migrants easier in terms of accommodation. They have more access to civic support structures, including housing, child care and financial support. This double standard has led to frustrations among other refugees who did not experience the same hospitality and opportunities (Haase et al., 2023). Yet, the way Ukrainian refugees have been received can also be an example of a good practice that should be further investigated.

In general, it became clear that PMWUD face many barriers towards exercising their basic rights and building a hopeful future. They generally do not want to go or cannot go back to their countries of origin for the reasons that they left their country (war, political prosecution or non-acceptance due to substance use, sexuality or other normative deviations and familial, vocational or financial hardship), in combination with new concerns regarding their living situation and being stigmatized or not having the needed papers to travel. By complicating the opportunities for PMWUD to build up a meaningful future in the countries they stay in, vicious circles of drug dependence, homelessness, unemployment, financial hardship and related crime are perpetuated. Experts and practitioners in the focus groups unanimously plead for more resources to be able to not only provide basic needs of housing and emergency health care that PMWUD are entitled to, but also to increase opportunities for work, mental health support and recovery. They underscored the importance of culturally and linguistically relevant, integrated and holistic support that adequately addresses the multiple and complex needs of PMWUD that are often interrelated and cumulative. Outreach activities were mentioned as an important part of tailored support for PMWUD. Participants further underscored the importance of systematically erasing (legal) barriers to care and providing other needed resources such as employment.

Table 1. Main characteristics/themes discussed in the interviews with PMWUD (n=98)

Community	Migration background and legal status	Substance use	(Support) Needs	Needs fulfilled by (harm reduction) services	Barriers to care and other resources	Encounters with the criminal justice system and law enforcement
Amsterdam						
Intra-European migrants (n=12)*	Poland, Slovakia, Italy, Lithuania, Austria and Bulgaria 24-53 years Mostly European ID's Mostly migrated 'for a better future'	Mostly (crack) cocaine + heroin through injection and cannabis OST Early age of onset, mostly in their home country	Housing Work and education Mental health problems but few support needs	Basic needs Drug use Occasional shelter Medical needs DCR OST Social workers	Lack of insurance for OST Home address for insurance and work Waiting lists (shelter, housing)	Most have been in prison Prison is comfortable in comparison with life on the streets Police encounters are ok
Arabic-speaking persons from the Chemsex community (n=5)	Syria and Lebanon 29-32 age range Recognized as refugees 6-8 years in NL Mostly migrated to flee from war and political prosecution	Mostly occasional sex- and party-related drug use (3-MMC, MDMA, cocaine) Onset in Ams & Lebanon	Loneliness/lack of connectedness as a reason for substance use Mental health problems & trauma Financial support Lack of support services	Student housing and salary Shortage of support	Support services unavailable or not aware of Waiting lists (drug dependency and mental health treatment) Language barriers to treatment and info on drugs and dependency	Not mentioned
Spanish-speaking persons (n=4)	Colombia, Peru and Spain 33-36 years old European ID's Family-related and financial reasons for migration	Smoke or snort (crack) cocaine Inject heroin (n=2) Onset in Colombia and Spain	Dental problems Housing Work Psychological support	Basic needs Drug use Occasional shelter Medical needs DCR Social workers	Not knowing where to go Too much focused on injection (HR services) Bad experiences in the past	No issues
Athens						
Persons from Maghreb Arabic origin (n=6)	Morocco, Algeria and Tunesia 25-40 years old Mostly lost or expired ID's (no official residence permits) Mostly migrated 'for a better future'	Cocaine (in combination with heroin) Depressants (including flunitrazepam) Onset mostly in Greece	Housing Work Lack of support system Legal/administrative support with permits Medical needs	Basic needs Medical support Legal support	Housing and residence permit (social security number and OST) Work permit to job Stigma on substance use to work Negative experiences with organizations and their staff (access to services) Not knowing where to go Stigma on substance abuse (work)	Half have been in prison for drug-related offenses Mostly ok experiences with police
Persons from African origin (n=4)	Ethiopia, Egypt, Sudan and Congo 33-56 years Mostly family related migration Most of them have a valid residence permit	Heroin (Crack) cocaine	Housing Lack of support system Legal/administrative support with permits	Guesthouse Basic needs Psychological and medical support Legal support		Mostly ok experiences with police
Persons with a migration background residing in the Open Drug Scenes (n=10)	Iraq, Iran, Syria, Pakistan, Afghanistan, Bangladesh and Saoudi-Arabia 22-58 years old Mostly migrated due to war and persecution Mostly asylum status	Poly-substance use Sisa Flunitrazepam	Housing Lack of support system Legal/administrative support with permits	Basic needs Medical support Drug use Legal support DCR		Half have been in prison for drug-related offenses Mostly ok experiences with police

Berlin						
Russian-speaking persons (n=8)	Latvia, Ukraine, Moldova, Lithuania, Belarus 32-50 years old Mostly European ID's	OST Lyrica (Crack) cocaine Mostly started in country of origin	Housing Medical needs Legal/administrative support (papers) Work	Mutual support group Community housing Basic needs Medical needs OST Social workers Russian-speaking counsellors and long opening hours DCR	*[2] Not knowing where to find services Language barriers Lack of official residence papers (housing, financial and medical support, employment) Insurance for health needs Stigma on substance use as barrier to care	Most have been imprisoned in Germany, two in Russia Mixed experiences with law enforcement
Persons from Maghreb countries in North Africa (n=10)	Algeria, Morocco and Sudan 21-49 years Mostly fled their countries due to political and familial reasons Mostly no official residence permits	OST (Crack) cocaine Mostly snorted, smoked and sniffed Alcohol Mainly started in Germany	Loneliness as reason for SU Housing Work Mental health support	Shelter in winter Basic needs Limited contact with harm reduction services		Minority has been imprisoned in Germany Mixed experiences with law enforcement
West African persons (n=6)	Republic of Guinea, Sierra Leone, Niger, Mauritania, Ivory Coast, Angola 21-48 age range Varying reasons for migration Mostly no official residence permits	OST (Crack) cocaine (mostly smoked) Cannabis Alcohol Mainly started in Germany	Housing	Shelter in winter Basic needs Limited contact with harm reduction services		Half have been imprisoned in Germany Mixed experiences with law enforcement
Paris						
Georgian persons (n=16)	Georgia 25-62 y/o Mostly migrated for political and financial reasons Mostly no official residence permits Mostly access to health care through AME Supportive social networks	OST Cocaine Heroin Methadone Mainly started in their home country	Housing (minority) Financial support Work Drug use Residence permits	'Hotel' for housing Food tickets/distribution DCR Medical Needs Russian-speaking staff	Language Not knowing where to go Insurance	Due to lack of legal identity documents, drug use, illegally using public transport Accumulation of fines Bad experiences with police in Georgia
Non-Georgian Russian-speaking persons (n=10)	Latvia, Chechenia, Belarus, Ukraine, Moldavia, Lithuania 25-47 y/o Varying reasons for migration Mostly no official residence permits (some EU residents)	OST Limited additional use	Work Legal/ administrative support (papers)	(Temporary) housing Medical needs Basic needs DCR Russian-speaking staff	Stable living situation for job Papers (permits, insurance) to medical care, income and housing Language barriers to care and employment Drug dependency	Majority detained in France or home country Stigma and discrimination by police based on substance use
Somalian persons (n=6)	Somalia 25-35 y/o Mostly temporary residence document Mostly migrated for 'a better life'	Smoke crack cocaine and cannabis Mostly started in Europe (Italy & France)	Housing Residence and work permit	Basic needs (food, shower) Occasional shelter Limited contacts with (harm reduction) services	Residence and work permits to job and housing	Few encounters

* for readability of the table, only the gender-minorities are explicitly mentioned. This comprises persons who identify as transgender (T), transgender female (TF), or female (F). All other participants are cisgender men.

*[2] these findings were consistent across the three communities and are therefor not divided per community

5. Discussion of the main findings

Homelessness and poverty amongst migrants has become a matter of growing concern in many European countries, particularly with respect to asylum seekers and refugees, irregular migrants and, increasingly, economic migrants from central and eastern European countries (Fitzpatrick et al., 2012). Research indicates that drug and alcohol dependency are strongly linked to both the onset and continuation of homelessness (Fazel et al., 2014). Contemporary perspectives view homelessness as the result of a complex interplay between individual characteristics and structural factors, which encompass the presence or absence of a support system (Fitzpatrick et al., 2012). A formal or informal support system may be particularly hard-to-reach for PMWUD (Pouille et al., 2021). Individual factors that are related to homelessness encompass poverty, early childhood adversity, mental health and substance use issues, a history of personal violence, and involvement with the criminal justice system (Fitzpatrick et al., 2012). Participants across the four cities referred to all of the above factors.

Studies on both migration and substance dependence have adopted the hierarchy of needs by Maslow as a useful tool to assess needs of migrants and persons who use drugs (Best et al., 2008; Carta et al., 2005). In Maslow's hierarchy (see Figure 2), basic physiological needs must be met before addressing higher-level needs. While Maslow's needs are considered universal irrespective of nationality, their order may vary and relevant needs may span multiple levels (Carta et al., 2005). While Carta and colleagues (2005) have linked the hierarchy of needs to the complex problems refugees face, Best and colleagues (2008) discussed the relevance of this hierarchy in relation to the needs of persons who use drugs.

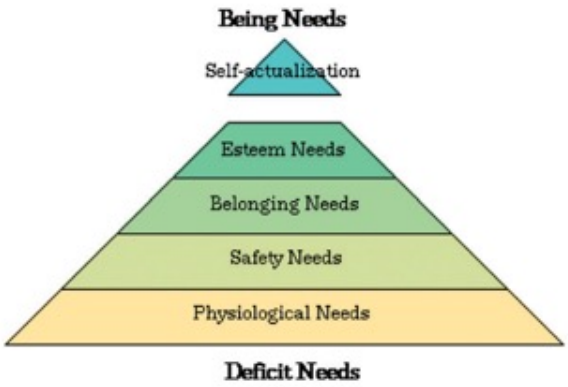


Figure 2. The Hierarchy of needs. Copied from Best et al. (2008)

Physiological needs include food, breathing, water, physical intimacy, and homeostasis (Maslow, 1943). For persons with drug problems, this also includes the maintenance of drug consumption (Best et al., 2008). While access to food and basic hygiene were often addressed, participants in the interviews discussed drug use as a necessity and the lack of a stable home as a pressing support need. Safety needs include financial security, employment, personal security (protection from bodily harm), physical health, and well–being (Maslow, 1943) and are equally unfulfilled among many PMWUD who have difficulties to be employed and display multiple physical and mental health issues. The afore-mentioned order refers to needs of belonging and love which are at risk for PMWUD due to mechanisms of migration and drug use (Pouille et al., 2021). Higher order needs are related to self-esteem and self-actualization (Maslow, 1943).

The results of this CBPR study show that many PMWUD in the European Union are deprived from physiological, safety and belonging needs due to existing barriers on multiple levels. Maslow stated that "if all other needs are unsatisfied, and the organism is then dominated by the physiological needs, all other needs may become simply non-existent or be pushed into the background. It is then fair to characterise the whole organism by saying simply that it is hungry, for consciousness is almost completely pre-empted by hunger" (Maslow 1943, p. 372). Hence, while these lower order needs are presented as the most important ones among the needs of PMWUD, this does not mean that no other needs are at stake. Rather, underlying issues are likely to remain concealed due to these lower order needs and these issues become apparent only when urgent challenges such as substance dependence and homelessness are effectively reduced. Hence, PMWUD will likely present lower order needs as the most pertinent to address and may be more sceptical toward the benefits of addressing higher order needs if they are not compatible with their more pressing needs (Best et al., 2008).

By addressing the challenges of substance dependence, homelessness and trauma that PMWUD face, as well as increasing feelings of hope and belonging (e.g., by offering PMWUD a community and a place to be), opportunities for change and increased wellbeing that enable them to focus on other life domains may arise. This study has shown that harm reduction and other services specific to the needs of PMWUD offer important contributions to the health and wellbeing of PMWUD. The study also showed that these services

hold the potential to offer a myriad of material, social and affective resources (Duff, 2010). These services may offer a continuous presence amidst uncertain, unstable and ambivalent health, living and social conditions of PMWUD, addressing physical precariousness but also issues of belonging and connectedness (Brenman, 2021).

The various intersections of precarity that PMWUD face in urban realities imply they are marginalized in many ways, because they complicate and upset established norms, institutions and what is (not) seen as progress throughout their everyday struggles. This marginalization is the result of structural and institutional forces that shape and perpetuate marginalization in everyday life (Thieme et al., 2017). In that regard, Misje (2021) points out that the precarious inclusion of homeless migrants is often restricted to ensuring basic physical survival, albeit in an unpredictable and uncertain manner. This study confirms that legal access to care for PMWUD comes from a moral imperative to alleviate acute suffering, but insufficiently takes into account comprehensive social rights. Furthermore, access to social rights often depends on multiple requirements, indicating that some persons are considered more 'deserving' of human rights than others (Misje, 2021; Ticktin, 2011). This implicit rationale, which tolerates distinctions in the values of individuals within the same context, seem to be accepted and reinforced by existing regulations within EU countries (Guentner et al., 2016). Ukrainian refugees, for example, have shown to receive much more support in having certain human rights met as compared to other refugees (Haase et al., 2023). Second, persons who formally reside and work in a country and have sufficient financial means, have more access to health care and social welfare services then those who don't. Many PMWUD are struggling financially, physically and emotionally. They face multiple barriers to so-called 'productiveness' (i.e., contributing financially to society through formal work), which has a major impact on ideas of deserving certain social rights (Keskinen et al., 2016). This notion of deservingness may also emerge in the considerations of individual care providers when determining what qualifies as an emergency situation in cases involving PMWUD, possibly contributing to inequity in access to health care and other services for PMWUD (Misje, 2021). Without increasing access to care on a structural, social and personal level, PMWUD are inclined to stay trapped in a vicious cycle of precariousness.

Ensuring access to qualitative and humane healthcare for all PMWUD is a matter of human rights, but could in the long-term also positively affect societies as a whole. First, research indicates that granting access to preventive healthcare for migrants in an irregular situation does not only promote the realization of the right to the highest attainable standard of physical and mental health as established in the International Covenant on Economic, Social and Cultural Rights, but also makes sense economically as it leads to cost savings for governments (European Union Agency for Fundamental Rights, 2015). Second, the challenges that PMWUD face (i.e., barriers to mental and physical health (care), housing, employment, financial resources, belonging, language and knowledge barriers, ...) are also identified as barriers to integration. While some focus groups talked about integration as an important prerequisite for PMWUD to become accepted members of society, it is clear that basic needs to be able to integrate are often not fulfilled among PMWUD. By investing in the fundamental building blocks of integration, governments may increase access to 'productive' members of society (Keskinen et al., 2016; Kraler et al., 2022).

Finally, the harmful consequences of drug criminalization that have a tremendous impact on vicious circles of drug dependence, stigmatization, inequality and hamper opportunities for harm reduction and recovery call for an open debate on decriminalization of drug use from various perspectives. This discussion should prompt researchers and policymakers to move away from the traditional reluctance to address this subject, which has its roots in long-standing prohibition traditions (Decorte, 2011; Rieder, 2021). A substantial body of research has highlighted the positive outcomes associated with regulated decriminalization of drug use, particularly in reducing the compounded marginalization experienced by persons with drug dependence, especially those already marginalized in society like PMWUD due to various forms of discrimination (Bratberg et al., 2023; Human Rights Council, 2023). Therefore, we probe policy makers and researchers to keep the debate regarding criminalization of irregular migration and homelessness alive, since it has major impact on the access to rights for PMWUD and the vicious circles of precariousness that PMWUD may face (Commissioner for Human Rights, 2010; O'Sullivan, 2012).

6. Limitations and recommendations for further research

Some limitations of this research need to be acknowledged. The first set of limitations relates to the CBPR approach. CBPR is designed to involve and collaborate with individuals whose life experiences are the focus of the study, both in planning and conducting the research process (Bergold & Thomas, 2012). Yet, this was not fully possible.

First, the research proposal was written before any community researchers were identified, limiting their input in the first phases of the research process. Second, since this was a European project including different European countries, there were multiple language barriers to address. The local researchers all spoke English and also spoke the primary language of the cities included. The community researchers often spoke the mother tongue from their country of origin, together with the local language of the cities. This allowed them to sample and conduct interviews with persons in their shared mother tongue. However, since the academic researcher at the coordinating institution spoke English, communication mostly happened in two stages: between academic researchers and local researchers, and between local researchers and community researchers. The community researchers were engaged in the research process by the local researchers, who provided their input to the academic researcher and the other way around. Some community researchers were directly involved throughout the research process, but usually these were community researchers who spoke English and whose social and societal situation enabled them to be included in the research process. This led to a third limitation. CBPR is supposed to serve the communities that the research is about. When conducting CBPR, authors urge researchers to reflect on how 'the community' is defined (Bergold & Thomas, 2012). Community in this study could relate to cities (participants from Amsterdam, Athens, Berlin and Paris can be considered a community from a European perspective), to the shared experiences of being a person who uses drugs, to a shared migration background, to the lived experiences as someone with a (specific) migration background and drug use. In the strictest sense, this study would imply that community researchers are persons who use drugs with a migration background in vulnerable situations. Yet, this study shed light on the precarious situations many of these people are in. It also showed that, when people are trying to survive on a day-to-day basis, there is little room for other engagements. The local researchers encountered these difficulties when looking for community researchers to strengthen the research team. In the end, the community researchers were all people with lived experience as a migrant from one of the included communities or as a person with lived experiences on drug dependence. Some of them were indeed PMWUD, but some were not. To be transparent about who the community researchers were, the introduction of the results of the interviews in each city contains some information on the community researchers. Future research could engage even more in the participatory process with PMWUD from the beginning till the end, by doing the research on the pace of participants and adjusting it to their needs. Fourth, to conduct this research in four European cities, local researchers (who were practitioners in the field) in each city were trained in the CBPR method and how to coordinate the research in their city. They were also trained how to perform the focus groups, to conduct the interviews and train the community researchers for the interviews. They were provided with training tools in multiple languages to do so. In the end, this means that both the coordinating and community researchers were people with a lot of professional and lived experience, but with less experience as researcher. This is reflected in some of the data. Likewise, the academic researchers were more theoretically trained. They were from Belgium and had limited contextual knowledge of the situation in the cities included in the study. Although the collaboration between the academic, local and community researchers allowed for a blend of different forms of expertise, the fact that each researcher also had blind spots and limited experiences in other forms of expertise than their own may have had an impact on the data collection and analysis. Lastly, the fact that all data had to be translated may have distorted some findings.

Furthermore, we urge the readers to be cautious about the concept of 'community'. For pragmatical and practical reasons, we chose to focus on three communities in each city. These communities, however, were often broadly categorized and comprise a very heterogeneous group of people including many other intersecting aspects of their identity. Since some communities included small samples, the results should be interpreted as relevant for the participants from 'this community' (that may or may not feel like a community to the participants themselves) rather than for 'the community' as a whole.
This warning to not generalize the results is applicable to the entire research sample.

Though we were able to conduct 98 interviews with PMWUD in four cities, this is just a small number compared to the total population of persons with a migration background who use drugs. Purposive sampling focused on three communities in each city, but in relation to strategies of snowball sampling, venue-based and gatekeeper recruitment this may have led to results that are particular to the recruitment strategies that were used (e.g., the extent to which participants were in touch with certain services) (Muhib et al., 2001). Further research among a diversity of populations could provide more information on how common these results are.

Finally, even though we did additional efforts to include women or persons with another gender than cisgender men in this research, the sample of persons who did not identify as cisgender men was very limited. This is not surprising, since cisgender women are statistically less likely to develop problematic substance use when compared to cisgender men (Meyer et al., 2019; UNODC, 2022). Both women with and without a migration background tend to be underrepresented in substance use treatment services. Gender-minorities may also encounter additional challenges related to cultural influences and gender-based stigma that discourage them from disclosing substance use (McCarron et al., 2018; Meyer et al., 2019). Because the sample of gender-minorities is limited and diverse and since the interviews also uncovered few gender-specific aspects (because it was not the scope of this research and because participants did not bring it up themselves), few statements could be made in this regard. Future research should also focus on gender-minority PMWUD to uncover how the added layer of belonging to a gender-minority impacts their experiences and what services can do to be more accessible to these persons. Other recommendations for further research involved the further disentanglement of legal barriers and how they could be solved from a legal and sociological perspective. The effectiveness of identified ‘good practices’ should further be explored and longitudinal research may enable to uncover what decisions practitioners and policy makers make today may have an impact on the lives of PMWUD tomorrow.

7. Conclusion

Every individual's entitlement to the highest achievable level of health, set out in UN treaties and European Law, is a universal privilege that is not contingent on a particular (legal) status. As laid out in Human Rights law, housing and access to services are underlying conditions of health. According to the Committee on Economic, Social and Cultural Rights of the UN, healthcare facilities, services and goods should be available in adequate quantities and need to be accessible (in terms of information and physical access), affordable for all, culturally sensitive (in accordance with medical ethics and gender and cultural considerations), and of high quality. Discrimination based on any status should be strictly prohibited (PICUM, 2022).

This study showed that – in spite of these globally accepted and applicable provisions – PMWUD face many challenges when it comes to accessing healthcare rights in Europe. While basic needs such as food and emergency health care are often fulfilled thanks to accessible regulations and available services, housing appeared to be a major challenge for PMWUD. Furthermore, the lack of health insurance due to requirements some PMWUD cannot attain, as well as confusion and individual interpretations of policies regarding what 'emergency health care' comprises of, impedes access to mental health care, substance use treatment services and other health care service. Additionally, we identified several challenges regarding financial resources, social network, work and social support. These challenges are the result of an interplay of micro(individual PMWUD and practitioners), meso- (communities of PMWUD and services) and macro-level processes (socio-political context, health systems and broader policy) (De Kock & Pouille, 2022).

While many support needs of PMWUD remain unaddressed, there are also multiple support needs that are encountered thanks to harm reduction and other support services. These services aim to offer low threshold, integrated and holistic support to PMWUD in a culturally and linguistically sensitive manner. Continuity and collaboration between services and inclusion of community workers in the service are mentioned as important ways to do so. Resources for these services are needed to enable them to address the rights of PMWUD, as well as to set up a sustainable policy framework.

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Attachment

Interview guideline SEMID-EU

Italics = instructions for interviewers

Numbered questions in bold: important to ask

Bullet questions = probing questions: can be asked to encourage the participant to go more in-depth, should only be asked when participants have not answered these questions in one of their answers before

To be filled in by the interviewer after the interview

- Name or alias community researcher: .....
- Code of the respondent (City_ yymmdd_communityabr_M/F/X_alias): .....
- Duration of the interview (fill in afterwards): ..... minutes
- Any comments about the interview: .....
  .....
  .....
  .....

1. How would you like to be named in this study (alias)?

This can be any name, the surname of participants, a made up name,...

2. How old are you?

..... years old

3. Do you describe yourself as male, female, non-binary or other?

4. What is your country of birth?

5. What was your main reason for migration?

Financial reasons, family reunion, refugee,...

6. What is/are your current nationality/nationalities?

What nationalities do they have on their passports? Foreign, national or a double nationality?

7. How long ago did you arrive in this country (i.e. local country)?
How long do you wish to stay in this country?

8. What identity card do you have?

Cross which one is relevant.

An national ID of the local country	
An national ID of a country inside the EEA (European Economic Area)*	
A national ID of a country outside the EEA	
No official ID **What is the reason you have no official ID?** (e.g. because it is lost or expired)	
Other?	

9. **What is your current status of residence?**

   Official citizen (with nationality of the country of residence)/ a permanent or temporary residence permit/ no (legal) documents/other

10. **Can you tell me more about your current living conditions?**

    - *Where do you mostly spend the night?*

      Does this place have access to a shower or a place to bathe? Is it comfortable in terms of heating and electricity? Does it feel safe?

    - *Who do you live with?*

11. **As this research is designed to get insight into the needs of people who use drugs, I would like to hear a bit more about your drug use in the last 30 days. Can you give me some more information on your drug use, specifically in the last 30 days?**

    Get insight into what drugs they have been using, how much (frequency and amount), drug delivery methods and conditions of use (e.g. where they use drugs).

    - Which drugs (including alcohol) have you been using in the last 30 days?
    - How often have you used them?
    - How did you use these drugs?

Cross the relevant substances in the table and indicate the frequency and way of use.

	Cross if used	Frequency (Multiple times a week, weekly, monthly,...)	Way of use (Smoking, snorting, injecting, oral,...)
Alcohol			
Depressants (Benzodiazepines, Barbiturates, and other sedative drugs)			
Heroin			
Cocaine (in its different forms, eg. also crack)			
Stimulants (e.g. amphetamines)			
Ecstasy/MDMA			
Hallucinogens (e.g. LSD)			
Cannabis (marihuana, hasj, weed,...)			
Methadone			
Buprenorphine			
Volatile substances (glue, inhalants,...)			
Other:			

- Where do you mostly use drugs?

  Get insight into drug consumption conditions.

- What are your main drivers for using alcohol and other drugs?

12. When and where (country) did you first use drugs?

13. I would like to talk to you about the most important needs you experience and to what extend you receive help with these needs. Can you tell me about your most important support needs at the moment?

E.g. financial support, mental or physical health support, support regarding substance use, legal or administrative support, social support,....

13. a. To what extent do you get help/support for these needs

Get insight into important support resources (persons, services,...) and the lack thereof.

- *Are there any pressing support needs that you don't have any support for?*
  - *Which ones?*
  - *How come?*

    Get insight into barriers: are they not available, exclusion criteria, fear or distrust,...

14. **To what extent have you been in touch with drug services in this city?**

    (E.g. harm reduction services, addiction services (outreach or residential),…)

    - *Can you tell me more about these services?*
    - *To what extent were these services helpful to you?*
    - *What made them (not) helpful?*

    If they haven't been in touch with drug use services:

    - *How come you have never been in touch with drug services?*

15. **Before we go any further, is there anything else you find important to share concerning your needs and how this city's services answer, or fails to answer to these needs?**

Deepening questions

You have already answered several questions regarding your migration background, living situation, drug use and support needs. To get a better insight into the needs of migrant people who use drugs, we want to ask you some additional questions. Can we continue with some additional questions? Yes/no

Now we want to get into certain themes more deeply. The themes are: social network, basic needs, medical needs, emotional wellbeing and law enforcement and justice. Are there any of these themes that you find important to address first because these are particularly relevant or important to you (go to question)?

16. **Regarding your social network, who do you mostly spend your days with?**

    Get insight into network: romantic partner, family (parents, siblings), contact with own community,…

    - *To what extent can you count on these people for support?*
    - *Is there anyone counting on your support for food, housing,… ? Who?*

      Get insight in children under their custody (How many? Do they live with the participant?) or other people they care for? (Might already have been answered in question

17. **To what extent do you feel like you have access to basic needs such as housing, water, food?**

17. **a. To what extent have you received professional support for basic needs such as access to food, water and housing?**

    Get insight into (the adequacy of) available services and access (barriers).

    - *Are these services helpful to you? Why (not)? How?*
    - *What keeps you from getting help for these basic needs?*

18. **What medical needs do you have?**

    - *Have you been tested for HIV, Hepatitis or TBC?*
    - *If you have been tested positive for any of these, did you receive any follow-up care?*

18. **a. To what extent have you received help for these medical needs?**

    - *By what services (e.g. hospitals, harm reduction services,…)?*
    - *Are there any needs unmet and if so, why (access barriers)?*

19. **How would you describe your emotional and psychological wellbeing?**

    Get insight into mental health status. If needed, you can give examples like: do they often have a bad mood, feel sad, feel stressed, do they have nightmares or sleeping problems due to psychological state of mind,…

    - *What needs do you have regarding your emotional and psychological wellbeing?*

19. **a. To what extent have you received support for your emotional and psychological wellbeing?**

    Get insight into the adequacy (helpful or not), availability of and access to psychiatric and psychological care.

20. **Can you tell me more about possible encounters you had with law enforcement (police and the justice system) in this country?**

    - *For what reason(s)?*
    - *Were these encounters related to your drug use or migration background? How?*

      E.g., drug-related crimes or crimes to finance drug use, due to illegal status,…

    - *Did these encounters result in official charges?*
    - *How did you experience these encounters?*

20. **a. To what extent have you received support from law enforcement and the justice system?**

21. **Is there anything else you want to share with us regarding the needs of migrant people who use drugs and available services?**

Round up the interview:

- **Thank the person for their time and make sure they have received their financial reimbursement**
- **Give the contact details of the local and community researchers for follow-up from their data**
- **Ask to share the flyer with anyone else they know that could participate in the interview**
- **Fill in the information about the interview on the top of the interview guideline**