

Equitable Substance Use Treatment for Migrants and Ethnic Minorities in Flanders, Belgium: Service Coordinator and Expert Perspectives

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ABSTRACT: Despite mounting evidence of disparities in health service provision for migrants and ethnic minorities (MEM) across EU countries, there has been limited research into how services (meso) and policy (macro) can contribute to reducing these disparities. In Flemish (Belgian) substance use treatment (SUT) policy making, no systematic attention is given to MEM. Nevertheless, preliminary studies have identified some disparities, especially among non-Belgian MEM. For this paper we studied the factors related to these disparities and ways forward based on 21 semi-structured interviews with SUT coordinators and experts. The low representation of MEM populations in psychiatric hospitals due to language exclusion criteria stands out as the main disparity. Moreover, respondents indicated that exclusion may be anticipated by general practitioners in the referral process, causing additional disparities. The exclusion of MEM from policy making processes, waiting lists and the structure of the federalized Belgian health system are identified as indirect macro contributors to disparities. Respondents specified four main ways to reduce disparities in SUT among MEM: targeted treatment and policy making, installing diversity policies in SUT services, enhancing training and education, and community-based treatment.

KEYWORDS: Migrants, disparities, substance use treatment, equity, qualitative methods

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Introduction

All EU member states recognize individuals' right to the highest attainable standard of physical and mental health care enshrined in the UN's International Covenant on Economic, Social and Cultural Rights (1966), the Refugee Convention (1951) and other international agreements. This right has recently been enshrined as a key principle in the European Pillar of Social Rights.¹

Yet, UN ambassadors, the European Court of Human Rights, the European Committee of Social Rights and the Council of Europe's Commissioner for Human Rights have all expressed concerns about breaches of this right to health care among MEM¹ in Europe.^{2,3} Dauvin et al⁴ posited that equitable health care consists of (i) equal access for equal needs, (ii) equal treatment for equal needs, and (iii) equal outcomes for equal needs. Whitehead pointed out that health inequities—as opposed to disparities—are unnecessary, avoidable, unfair, and unjust.⁵ It is therefore vital to know the reasons for or factors related to disparities, to establish whether or not they are inequities.

Despite the mounting evidence of disparities in health service provision across EU countries,^{6–8} health research and policy making mainly focus on single-disease⁹ and client-oriented¹⁰ approaches (micro), rather than on what is needed in services (meso) and in structural policy (macro) measures. Whereas countries such as the USA and the UK have issued binding statements recognizing health inequities among MEM—a necessary starting point to tackle them¹¹—very few EU

countries have such a statement. Although the European Commission issued the communication “Solidarity in Health: Reducing Health Inequities in the EU” (2009), it is not legally binding, nor does it contain binding actions.

Although there is a growing consensus that the prevalence of substance use among MEM is low when they arrive in the EU and increases over their time of stay in the receiving EU country,^{12,13} too little is known about the prevalence of substance use among MEM populations in Europe. There is no data on their substance use in Belgium, for example.¹⁴ However, data about prevalence alone “*is limited in its usefulness unless it is matched with consideration of different treatment types and their relative intensity, and/or explored as a function of geography and subpopulation.*”¹⁵

With regard to this subpopulation, the European Monitoring Center for Drugs and Drug Addiction (EMCDDA) notes that migrants “*may be at risk of developing drug problems*” and “*there is a need therefore to increase awareness of vulnerabilities and reduce social exclusion of these people.*”¹⁶ Nevertheless, the European Drug Report¹⁶ does not observe migration or ethnicity related phenomena. We established¹⁷ that the main reason for this shortcoming is the low quality of necessary migration and ethnicity related data concerning treatment need (prevalence) (eg, in the national health services) and demand (eg, treatment demand indicator). Moreover, as argued by Measham et al,¹⁸ substance use treatment policies are predominantly tailored to male and white populations. An analysis of Flemish substance use treatment policy making observed that there is little to no targeted attention for MEM in this policy domain.¹⁹



An analysis of 2012–14 Belgian treatment demand (TDI) data²⁰ demonstrated that clients with EU nationalities (excluding Belgians) and females with non-EU nationalities were underrepresented, compared to their presence in the Belgian population. Moreover, clients with non-European nationalities were significantly less likely to be referred to treatment by general practitioners. Also, treatment episodes involving non-Belgians significantly more often took place in outpatient (mainly opioid substitution) treatment, whereas Belgians were more often referred to residential treatment settings.

Although this study has identified some disparities, the factors related to these disparities remain unknown. One study did venture to contextualize these disparities, but did not attempt to explain specific disparities.²¹ Moreover, to our knowledge, no research has so far been done into the policy needs in the domain of SUT, as identified by coordinating staff members and experts in the SUT or migration field in Belgium. The health-care system is itself a social determinant of health, influenced by and influencing the effect of other social determinants.²² Therefore, in this paper we study SUT coordinators' and experts' views on two main research questions:

1. What factors are related to the disparities observed in TDI data²⁰ and the neglect of MEM in SUT policy making¹⁹?
2. What could be done in the future to reduce these disparities?

Method

Setting and participants

We recruited participants primarily in East-Flanders (1 of the 5 Flemish provinces in Belgium) because it has both a good representation of high and low threshold SUT services and high societal diversity in terms of MEM presence. The researcher contacted all members of its overarching mental health care network, which includes representatives of all SUT services in the area.²³ Subsequently, coordinators of all SUT services in the area were contacted in order to recruit respondents from low and higher threshold service types as well as in- and outpatient treatment. In addition, experts in the domain of substance use and migration were contacted purposively because they were expected to have a broader oversight of the phenomenon in Flanders.

All of these people were sent an invitation to participate, and at least 3 reminders. Additional respondents were identified by means of snowball sampling among the respondents. Twenty-one individuals participated (see Table 1). Two of these participants have a migration background.

Data collection

Following the example of previous research into adjacent domains,^{24,25} semi-structured individual interviews were

used; the interviewees' professional backgrounds differed substantially, and our intention was to differentiate results across settings (e.g., outpatient versus inpatient services), as a means of increasing internal validity (falsification per setting and interviewee background). The semi-structured interview guide included vignettes (see Table 2) with 4 quotes from previous research.^{19,20} The interviews were carried out by the researcher.

The study is layered and has both an interpretative and descriptive side to it. It is primarily an interpretative analysis, because findings from a previous study are the point of departure (see vignettes in Table 2). There is, however, also a descriptive and explorative perspective because in interpreting the potential factors related to the observed disparities, we do not depart from theory or other research. Moreover, with the eye on internal validity, the first question concerning the statements reflected in the vignettes was whether respondents consider the issue a disparity or not and why (not). To avoid the establishment of spurious relations, the results of these interviews are matched to previous literature in the discussion.

After the introduction of the research project by the researcher and an introduction of themselves by the respondents, respondents were asked how they defined equitable substance use treatment (this part of the interview is not reported on here). The second and longest part of the interviews consisted of the presentation of the vignettes.

The use of vignettes regarding similarities and differences in treatment across Belgians and non-Belgian was based on Kluge's research²⁶ and Sandhu and colleagues²⁷ experiences with this method in their research on increasing access, quality, and appropriateness of health services for immigrants in Europe. This method was chosen to avoid socially desirable answers and to focus the interview on the observed disparities. After presenting each of these vignettes 2 main questions were asked:

1. Can you explain this statement based on your experience/expertise?
2. In your experience, how can this disparity be tackled?

Due to covid-19 contact restrictions, 16 interviews were conducted online via MS Teams and video recorded whereas 5 interviews were conducted in a quiet place in the workplace of the respondent and audio recorded. The informal part of the interviews was shorter due to the online format. Nevertheless, the online format generally did not impact the quality of the interviews. Technical problems were only occurred during 1 interview (limited connectivity). Informed consent was provided verbally and recorded at the beginning of each interview after having discussed the information leaflet that was sent by e-mail before the interview. Interviews lasted about 1.5 hours and were conducted from May to July 2021.

Table 1. Respondents.

IDENTIFIER	PROFESSION	ORGANIZATION TYPE
Respondent 1	Coordinator, medical care	Asylum authority
Respondent 2	Coordinator	Outpatient services
Respondent 3	Policy advisor, health	Government
Respondent 4	Former coordinator	Psychiatric hospital
Respondent 5	Coordinator, research	Asylum authority
Respondent 6	Chief physician	Psychiatric hospital
Respondent 7	Coordinator	Research center, health
Respondent 8	Expert, MEM	Expertise centre, substance use
Respondent 9	General practitioner	NA
Respondent 10	Coordinator	Mental health network
Respondent 11	Expert, health systems	Expertise center, health
Respondent 12	Former coordinator	Outreach NGO
Respondent 13	Coordinator, intercultural mediation	Government
Respondent 14	Team coordinator	Mental health service
Respondent 15	Coordinator	Psychiatric hospital
Respondent 16	Coordinator	Psychiatric unit, hospital
Respondent 17	Coordinator	Mobile team
Respondent 18	Coordinator	Methadone substitution treatment
Respondent 19	Outpatient case manager	Hospital
Respondent 20	Expert, substance use	Asylum authority
Respondent 21	Coordinator	Crisis intervention service

Table 2. Vignettes.

1. Treatment episodes involving people who do not have Belgian nationality take place significantly less often in residential treatment (therapeutic communities, psychiatric [units of] hospitals). Treatment episodes with these populations take place significantly more often in low threshold outpatient treatment (e.g., methadone substitution). Therefore, nationality and treatment type are significantly related.
2. Clients with a non-European nationality are significantly less likely to be referred to SUT by a general practitioner compared to those with a European nationality. Therefore, nationality and referral type are significantly related.
3. Women with a non-EU nationality are almost absent in Belgian SUT.
4. Migrants and ethnic minorities are only described to a limited extent in SUT related policy documents (concept note recovery in particular).

Data analysis

All interviews were transcribed ad verbatim and NVIVO 11 was used for data management, coding and analysis. Considering that this study has both an interpretative and descriptive side, the researcher used a combined inductive and deductive (framework) coding strategy.²⁸ The strategy consisted of 3 phases. First, all information in the interviews was coded to the statements in the 4 vignettes (frames). Additional information besides the 4 quotes was coded in vivo. Second, information within the codes related to the 4 statements was coded in vivo based on grounded theory.²⁹ Third, grounded

codes were gathered in overarching axial codes. All quotes in the results section were translated from Dutch to English. The results section is subdivided in a part on understanding disparities (the 4 quotes) and identified ways forward.

Results

Understanding disparities: Underrepresentation of non-Belgians in residential treatment

Vignette 1: *Treatment episodes involving people who do not have the Belgian nationality significantly less often take place in residential treatment (therapeutic communities, psychiatric [units of] hospitals). Treatment episodes with these populations take place*

significantly more often in low threshold outpatient treatment (eg, methadone substitution). Subsequently, nationality and treatment type are significantly related.

Respondents left no doubt over for the main factors related to the underrepresentation of non-nationals in residential substance use treatment (SUT). At least 18 respondents emphasized that individuals who are deemed not to speak the language are excluded from entering most residential treatment services.

People who do not speak the language cannot enter the residential sector. We are criticized because of that but it's simply because until now we have not found methods to integrate people who do not speak the language in group therapy. R15

Whereas some state that this is blatant discrimination others provided a more nuanced statement.

We had someone who spoke English. A colleague went in search of treatment abroad for a patient who was in fact living and residing here. It was hard. The opinions on how to deal with this were divided but, in my opinion, exclusion in treatment based on a language barrier is complicity. R16

I do think we still have a lot of work in this area (. . .). These people are simply here, you have to deal with it. It is insufficient to say, "they don't speak the language" or "we can't work with them because they don't adhere to therapy." You really must adapt. R4

About one third of the respondents specified that MEM presence likely differs across different types of residential settings. Accessibility for instance likely varies across psychiatric units of hospitals (where translators are made available and subsidized) compared to psychiatric hospitals where translators are usually not available.

We are very frustrated because when somebody does not speak Dutch we have to refer them to psychiatric units of hospitals and that's where it stops. That's very limited. With all due respect for the professionals in these units, their work is insufficient. It's a prolonged crisis unit (. . .). In three weeks' time you cannot expect big therapeutic insights or processes of change. You can call any hospital or therapeutic community: if you don't speak Dutch, you won't get in. R19

Nevertheless, respondents who work in residential settings do not always realize that this is a ground of exclusion.

Our inclusion criteria are mainly based on the clinical assessment, on whether a certain psychopathology would for instance impede their residence. Does someone have sufficient cognitive skills? Language. . . I didn't think about it yet. Language can indeed be a factor that makes us doubt whether it will work or not. R21

Other characteristics such as not having health insurance are also a reason for exclusion of potential clients.

In specialist care it's 'not done' to have asylum applicants. It is really expensive for a hospital to admit someone who is not covered by a health

insurance. It can cost you 500 to 1000 euros a day to reserve a bed for someone who does not pay. If the person does not pay, the account just stays open and becomes a unpaid invoice for the hospital. R15

Several respondents report that besides language and health insurance as exclusion criteria,

Besides exclusion criteria as a reason for underrepresentation of MEM, respondents point out reasons at the client level, respectively cultural barriers, and a lack of knowledge about services.

Palestinians for instance often do not want to see anyone. If they go to a psychologist than that's preceded with a long trajectory and nobody knows. That's one of the disadvantages of living in a collective [in a reception center]: there's a lot of social control. Everyone knows what the others do, where they go etc. R1

I do think that it's difficult for them [MEM] to know the ins and outs of the health system. I think people who do not have the Belgian nationality often have instable housing or have only arrived recently. For various reasons, it's harder for them to know how to get referred in the health system. R11

Understanding disparities: Non-Europeans are less referred to treatment by general practitioners

Vignette 2: Treatment episodes with clients with a non-European nationality are significantly less referred to SUT by a general practitioner in comparison with those with a European nationality. Subsequently, nationality and referral type are significantly related.

The 2 main identified factors related to low referral of non-European clients by GP's were GP anticipation of exclusion on the one hand, and low knowledge of culture sensitive problem formulation and treatment options on the other hand. Respondents indeed note that the primary exclusion from residential treatment may happen at the level of referral. If general practitioners expect that clients will not be admitted, they will probably not refer clients in the first place.

They know what the answer is going to be: "if the person does not speak the language, we cannot admit him." (. . .) In that case you can only support physical detox and that's when we say "let him go to a psychiatric unit of a hospital" because then there's at least some attention for somatic issues. R6

I know that currently general practitioners no longer refer to our mobile teams because they know that the waiting lists are way too long. Clients often have to wait about a year. R10

I can imagine that it might be easier to support a referral process with someone who is closer to your own culture but I also think they [GP's] anticipate that the family for instance will not cooperate. So I do think that some categories of evaluation enter this process without having really discussed them but based on some kind of archetype of the 'non-western client' that won't fit in the dominant treatment model resulting in the idea not to waste too much energy on them. R6

Client related explanatory factors were not having a GP and the fact that non-European nationals may less easily go to a GP with such a problem or define it more vaguely once they do.

The idea of having a general practitioner is something characteristic to our culture. Those people often think “when I have a problem I’ll go in search of a doctor and for the next problem I’ll search another one.” R17

There are two sides two the story. Someone can come by with vague complaints and in that case it’s not easy for a GP [to refer]. R19

Understanding disparities: Non-European women are almost absent in Flemish treatment episode data

Vignette 3: Women with a non-EU nationality are almost absent in Belgian SUT.

Eleven respondents hypothesize that substance use may be more hidden or taboo among woman due to their key role in the household or a larger cultural taboo concerning substance use among women.

I think there’s much more taboo concerning substance use among all women, certainly among those belonging to cultural minorities. R11

In some countries the stigma is bigger, for instance when it’s not accepted by a religion or a government. (. . .) So is it because they use less substances or because. . . they don’t dare to come here [the service] or because they are prohibited to come here, or because they are afraid to share it? R18

Most participants nuance that woman in general are underrepresented in SUT compared to men which is why this is likely also the case among non-European nationals. They further alert that little is known concerning the prevalence of substance use among the latter women which is why it remains unclear whether we can or cannot consider this underrepresentation to be an inequity.

If we would discover that men and women use equal amounts of alcohol but we only detect and refer men to treatment, that would be an inequity. If we would discover—and that’s my hypothesis—that both groups use different substances, then it might not really be an inequity. R20

Understanding disparities: The absence of policy attention for MEM

Vignette 4: Migrants and ethnic minorities are only described to a limited extent in SUT related policy documents.

The main reason reported for the absence of MEM in SUT policy documents was that clients themselves are insufficiently involved as stakeholders. Policy in this domain in Flanders is created by consulting SUT stakeholders who are mainly the coordinators of services. Moreover, MEM are insufficiently represented in these stakeholder groups.

In Flanders there’s a habit to recommend people to the [ministerial] cabinets. Services select some key figures who present themselves as having sufficient expertise or who in fact have expertise and also people who have been in the system long enough to give impulses to policy. Those people are put together and they write statements such as the recovery concept note that become guiding for policy. So, among themselves there’s already a bit of a battle: whose voice will be heard and what will be considered [in policy]? In this scenario, the voices of ethnic minorities are absent unless when they can present themselves as stakeholders. R11

Respondents additionally stress that targeting MEM in policy is a politically sensitive subject which is why they are not considered in SUT policy making.

I’ve seen that in some countries they are simply included in health care. But in Flanders it is a sensitive topic. If you talk about ‘preferred language’ that’s already a bridge too far while I think it could help to think about that. R13

It’s pushing away sensitive societal issues. I can imagine perfectly that it’s the result of political considerations or even self-censorship not to describe topics of which they know they can fuse political turmoil. R3

Respondents agree that it is currently not a policy priority because stakeholders do not value targeting MEM. Some disagree that it should be a policy priority because there are many other pressing issues such as getting funding. Others do however point out the absence of MEM in policy documents as a serious shortcoming.

If I’d have to prioritise, it would not be a priority for me. For me it’s more of a priority to have clear-cut policies which is not possible at this moment because of the Belgian political structure. R15

Waiting lists

Half of the respondents note that most Flemish mental health and SUT services have long waiting lists. These waiting lists result in less referral and more exclusion criteria. It is however difficult to pinpoint this problem because there is no monitoring of waiting times at the national level.

In Belgium, the existence of waiting lists is ignored at the national level. Mental health care services do not register waiting times. In many other countries waiting times are objectified, they know perfectly how long you have to wait for, say, a cancer screening. R11

If you want to be admitted it often takes several months. But once you reach that point, okay, we can keep them motivated for a bit but if you have to keep them motivated for a long time. . . you often loose them. R1

Even the newly installed mobile (crisis) teams which were installed as low threshold community-based treatment have long waiting lists which is a problem for offering continuous care.

Waiting lists of half a year or a year, that’s a long time for referring someone. Therefore, when we’ve concluded a trajectory with these people it’s hard to refer them, it’s not easy. R19

These long waiting times imply that MEM are not prioritized.

When beds become scarce, we can pick who we admit (. . .). We have about 600 requests a year but we only admit 150 per year. (. . .). When you can choose between a Flemish boy from [Flemish village] who has a mother and father or a homeless Moroccan. The choice is easily made so to speak. It doesn't have anything to do with racism, it's just how it is. R15

The structure of Belgian (mental) health care

Many respondents criticize the structure of Belgian mental health care. The relation between the Flemish (regional) and Belgian (federal) responsibilities is often unclear, resulting in dysfunctions such as no oversight over regional coverage of mental health care including SUT or little sustainable policy making.

The organization of health care makes it all quite difficult because everyone can decide on their own. The federal level, they can do what they want. I mean, every psychiatric hospital can say "I'm going to open a substance use treatment unit" or "I am going to close one" without considering whether other services are available or whether there is over-supply. They can just do what they want. R15

The fact that substance use related matters are divided across the federal and the regional policy levels has some perverse effects. For instance, the federal government refuses to cover prevention practices organized by services that are strictly related to SUT because prevention is a Flemish policy competence while health is indeed a federal responsibility.

Intercultural mediators also work in community health centers outside the hospitals. However, the federal level is not responsible to finance, say, substance use treatment because that has all been transferred to the communities. So, we cannot act on that level. R3

Moreover, intercultural mediators are only active in federally subsidized services such as hospitals and rarely in psychiatric hospitals because the latter are funded at the Flemish level.

Everything that concerns prevention in our mental health network is not really evolved because the government doesn't fund us for that. So, everything that happens concerning prevention is based on good will and free time of professionals. (. . .) So the fact that Flanders points at the federal level and the federal level asks Flanders is a problem, while at the same time they both demand we collaborate. R17

Most respondents state that SUT services should be organized at, or at least coordinated by 1 policy level: the Flemish or the Belgian level. This would enable benchmarking, monitoring and implementing sustainable policy. Subsequently, it would enable to analyze the situation of MEM in SUT better and take targeted measures in case needed.

It has to be just one policy level, then you can say okay substance use treatment has residential beds in hospitals and in specialist care, there's outpatient beds etc. Then you can say, "okay, do we have enough? Do we have the correct ones?" (. . .) Now you can't study that because it's organized at two policy levels. R15

Ways forward for equitable SUT: Targeted policy making

Most respondents are in favor of targeted treatment initiatives when general treatment services prove to meet the needs of MEM insufficiently.

Policy needs to be focussed on the broad population but there are three parts: universal, then a second financial part: good coverage and good protection of socio-economic vulnerable groups who have difficulties with out-of-pocket payments. But then there also need to be targeted initiatives and outreaching to minority populations. R11

Some respondents are in favor of the idea of installing a separate treatment service or at least some programs within generalist services for people who do not speak the language.

I do think we need specific residential services for people with other nationalities or. . . cultures. I think we need space for that in the residential treatment setting. R18

With a mix of experienced professionals in treatment, we don't have to start anew, we can just translate things. We could run this with the existing services. R12

A respondent exemplifies how this is done in the only targeted mental health service for refugees in Flanders.

We don't do group therapy with these people, but we work one on one. But when we have for instance movement therapy, we just include this target group. Of course you need a therapist that has sufficient knowledge to be able to include someone with a migration background. R4

Nevertheless, not all respondents are in favor of such an approach. Several respondents highlight that the government expects that universal treatment will suffice for MEM. There appears to be a dilemma between meeting diverse needs at client or case level or recognizing at the policy level that a universal approach does not suffice.

Government actually expects that we have a generalist setting where we do everything, so I'm not sure if we need a separate offer. I think it's necessary to work more closely at the case level. R17

I don't think it'll help to have just one service with expertise. Being culture sensitive must penetrate all services. It needs to be inclusion and not just one service. R2

As exemplified below, taking a stance as a professional in this dilemma often depends on personal views on migration related issues.

One of the first questions I get when giving lectures in hospitals is "why do these people don't adapt?" or "why can't these people adapt?." But what does adapting mean? "They have to follow the programme just like other clients," they say. But that is not the case. "Why wouldn't it be like that?," they ask. That's where you can start working with the questions of what another cultural context is, what it means, look at it, at what we know about that. In literature we see that professionals really must adapt their care. R4

Some respondents note that in the past there was much more attention to targeted services whereas nowadays the political point of departure is rather that universal services should be able to serve all populations.

When I started out in 2009–2010 centers for mental health in Flanders and Brussels really had policies concerning these target groups. They had separate units that specialized in working with refugees etc. But then politics moved away from this approach. The idea is that universal care is sufficiently equipped to include these groups. But again, we observe that it doesn't really work in all regions. R20

Ways forward for equitable SUT: Diversity and staff policies

At least 4 respondents note that societal diversity is not at all reflected in their workforce. Subsequently, the implementation of a diversity policy is understood by many respondents in terms of staffing policy: recruiting personnel with a migration background. Most respondents emphasize that it can help to create trust and recognizability. Nevertheless, some also caution that recognizability may for some people lead to mistrust because of a fear of being known in the community. Most respondents emphasize that more attention to these issues is needed in human resources management.

In the end, it's remarkable that in our service we don't have anyone with a migration background. It's a pity because I think it can be enriching. R19

Of our 60 employees, there's no one [with a migration background]. R2

It's not always easy. I'd sometimes ask clients whether they wanted me to include someone with a similar migration background in the conversation but they'd answer "okay but not if it's this or that guy" (. . .) I think it's clan business, some are more progressive for instance. R2

Many respondents refer to the fact that an explicit diversity policy is needed at the organizational level. Mainly residential services are pointed out as the service category that is least committed to implementing such policies. One respondent exemplifies that if specific efforts are in place, discrepancies in workforce diversity can be countered.

Culture sensitive care has to be included in your organizational policies and has to penetrate all parts of the organization. But that culture does not exist yet, certainly not in the residential mental health settings. R10

The last couple of years we searched actively for people with a diploma and a non-European migration background. R4

Ways forward for equitable SUT: Education and training

More and better education of (future) service providers is considered key by a large majority of the respondents. Education

concerning societal diversity and its consequences in SUT can be part of initial training as well education when entering a service or continuous education in the service.

When new colleagues start at the hospital they have to take some classes and culture sensitive care could just be a part of that. R10

Permanent training of personnel would be an added value so people can understand for instance what Islam is, what it means. We can no longer say "okay, I've graduated as a care provider but I've never heard about the other cultures that exist in our society." R2

Ways forward for equitable SUT: Building bridges and real community-based work

Half of the respondents report that building bridges across services and between services and communities is key in providing equitable services to MEM. One respondent for instance exemplifies how contacts with an asylum center alerted a service concerning a drug related problem in the community. Respondents working in the asylum sector on the other hand confirm that this contact with SUT services is very much needed but often undesired by these services because of the exclusion criteria (eg, not speaking the language).

There are people working for the federal asylum center for instance who call us once in a while, we have good contacts.

It has been hard to collaborate with mental health care partners. I think that's because during the past decennium, in all Flemish regions they have had waiting lists. So that means they do of course not cater the needs of asylum applicants. R20

Several respondents however note that the real community work needed for building bridges between services and with communities requires a change in funding models. Whereas service funding now is still mainly performance oriented (see supra), funding should also cover following up on clients in the community, outside the service and not always with a direct clinical result.

Connecting with the communities by means of key figures takes time, it really takes time. So if the government would say "okay, as care providers you have to do more concerning diversity," they also have to give us more funds (. . .). We can't change anything if we must stay at our desks. Our contracts are still very much related to what we do at our desks. The outreach function must be bigger. R2

We [residential] are funded per person so that means that if you have 30 beds they're preferably filled. If one bed is empty you will get less funding so that means you have little leeway in terms of organization. R15

We [outpatient] are funded per consultation. When we go to prison or we accompany someone somewhere, we don't get funding. We have to have a certain number of consults per year, so the time we put in those things, we can't put in consultations. R18

The 3 respondents who are well acquainted with the theme of substance use among asylum applicants note that there is a strong need of building bridges by means of *partnership agreements* between SUT services and services who are in contact with the target group.

Local agreements of collaboration or agreements between asylum centers and providers in the neighborhood could help to enhance referral (. . .). If you put them together, so they can get to know each other, they'll see, okay, this is what we can offer, these are our limitations but okay you can work at better referral. R8

Discussion

This study's main goal was to identify the factors related to evidenced disparities in substance use treatment for non-nationals in Flanders, Belgium at meso (organizational) and macro (policy) level and to identify ways forward to reduce these disparities at these levels. The main answers to our twofold research question are schematically summarized in Figure 1.

At the meso level this study establishes that in SUT services and MEM communities the following factors contribute to 2 observed disparities. First, less referral by GP's is related to the anticipation of exclusion by GP's and less contact with GP's among MEM. Second, the underrepresentation of non-EU women in SUT was linked to the hidden and taboo nature of substance use and possibly to lower prevalence of substance use among women. The 2 latter disparities do however require further research to establish whether they are to be considered inequities or not.

The disparity that stands out and that has been pointed out in previous Belgian and European research^{20,21,30-32} is the underrepresentation of non-Belgians in residential SUT treatment. The main identified reason for this disparity is that **language is an exclusion criterium** in residential treatment. Moreover, as in previous research participants reported the inability to include MEM who do not speak the language in group therapy and the difficulty in obtaining interpretation services.³²

The underrepresentation of non-Belgians and the exclusion of people who do not speak the language in psychiatric hospitals raises questions concerning the nature of, and the dominant focus on residential treatment in Flanders and Belgium. Although the policy focus in Flanders moved from residential to community based treatment recently³³ this has insufficiently been translated in the practice of treatment.

Indeed, **residential treatment services remain protagonists** in governmental funding meaning that speech-based therapy is dominant whereas support in and to communities, close to the environment and living world of potential, current and previous clients remain limited.³⁴ This type of SUT is however vital for especially vulnerable populations including some MEM populations. Indeed treating people in residential settings and sending them back to the very conditions that made them sick³⁵ likely negatively affects clients' both general wellbeing and substance use.

The **structural causes of disparities that were identified (ie, waiting lists, the structure of Belgian health policy making and performance-oriented funding)** are not directly related to migration or societal diversity but do have an impact on not prioritizing or even considering these target groups in policy making. This means that targeted action alone will not suffice to overcome these disparities. Indeed, as postulated by Marmot and Bell,³⁶ focusing solely on the most disadvantaged will not reduce health inequities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.

Moreover, **the omission of migrants and ethnic minorities in SUT policy making appears to be a major root cause of disparities at the meso organizational level.** Indeed, whereas previous research focused on how macro level disparities become embodied at the micro level,³⁷ this study observes that macro level disparities or omission of targeted action is embodied at the meso organizational level. A lack of funding for instance results in waiting list and these waiting list in turn result in the fact that residential settings are less likely to include MEM.

Targeted policy making could for instance include the necessary monitoring of MEM in SUT to undertake action,³⁸ defining quota for MEM in SUT services personnel, regulating exclusion criteria and creating guidelines concerning diversity in professional education. Indeed, a recent report¹ equally demonstrated that the main causes of inequities in the access to healthcare in the EU are due to underfunding, denying health coverage, out-of-pocket payment, the lack of targeting vulnerable populations, health professional shortages, waiting lists, and voluntary health insurance.

The **presented disparities at the organizational level were however nuanced by several respondents.** The underrepresentation of non-Belgians in residential treatment for instance likely differs in psychiatric hospitals—where language is often an exclusion criterium—compared to psychiatric units of hospitals, where language is not an exclusion criterium. Moreover, the factors related to the fact that GP's are less often indicated as a referral source in treatment episodes with non-Europeans compared to Europeans can have many different reasons ranging from low diversity sensitiveness to anticipating waiting lists or exclusion based on the language criterium. Moreover, future research must look into the ratio between personal preferences as a main root cause versus organizational and policy related root causes because it determines to what degree a disparity is in fact to be considered and inequity.³⁹

Limitations

There are several limitations to this study. First, the main goal of examining factors related to disparities observed in a previous study has per definition biased the results by limiting the study to these disparities instead of other possible disparities

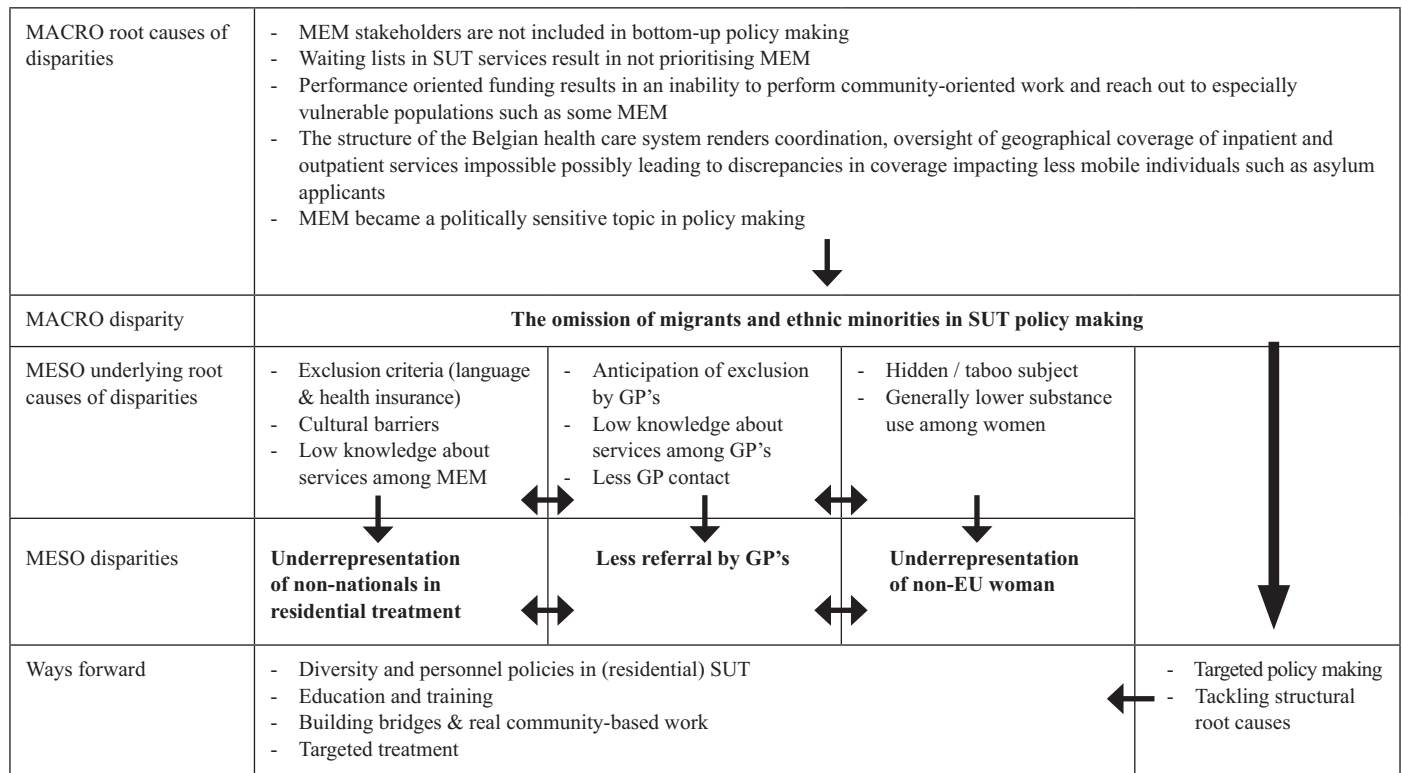


Figure 1. Disparities, root causes, and ways forward for equitable SUT for MEM.

observed by the respondents. However, by asking probing questions, participants were able to clarify whether they considered the disparity an inequity or not. Second, the purposive sampling method and focus on service providers in one Belgian region, limits the ability to generalize the results beyond the study participants and beyond this specific region.

Third and last, the United Nations High Commissioner for Refugees (UNHCR) advised consulting the target groups and investigate their views on mental health issues.⁴⁰ Subsequently, as this study does not include their perspective, it cannot speak to differences in terms of professionals' perspectives as opposed to the perspectives of MEM.

The fact that respondents were coordinating staff and experts implies that there may have been less attention for the **micro level of the clients**. Future research should therefore focus on including specific MEM populations to investigate what they identify as the root causes of disparities and possible ways forward. Indeed, as noted by Alegria et al³⁹ "*disparities arise when disadvantages in the health care system interact with those in the community system.*" This implies that besides the necessary action that should be taken at the organization and policy levels, the micro level of the client should of course also remain a concern. However, we specifically focused on meso and macro levels here because the micro level is all too often the dominant focus in contemporary health disparity research.⁴¹ Moreover, there is an urgent need for research that identifies the prevalence of substance use among various

migrants and ethnic minorities so that treatment needs, and demand can be compared.

Conclusion

Disparities in substance use treatment for migrants and ethnic minorities—mainly among non-Belgians—have been identified in Flanders, Belgium. The low representation of non-Belgians in psychiatric hospitals was identified in this study to be mainly due to the exclusion of potential patients who do not speak the language or do not have a health insurance, and is thus to be considered an inequity. This low representation was also linked to cultural barriers and low knowledge about services among both MEM and GP's.

The exclusion of MEM in policy making, waiting lists, performance oriented funding, the dispersed structure of the Belgian health care system and the negative political climate concerning MEM were identified as macro level factors that indirectly influence treatment disparities.


Experts and coordinating staff members in this study point out 3 main ways forward to decrease disparities in SUT among MEM: installing diversity policies in SUT services, enhancing training and education and community-based treatment. Respondents equally suggest that a treatment setting adapted to language needs of non-Belgians could be a way forward. Moreover, respondents point out that the structural root causes for the omission of these target groups in SUT policy making should be tackled. Indeed, bottom-up policy making that

excludes MEM, waiting lists, performance-oriented funding and the structure of the Belgian health system indirectly contribute to not targeting MEM in SUT policy making. Universal health care service provision should indeed be capable of serving all types of populations, but when disparities arise, it is necessary to take targeted action to reduce them.

Author Contributions

CDK conceptualised the study, conducted the interviews and framework analysis and was responsible for the write up of this paper

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