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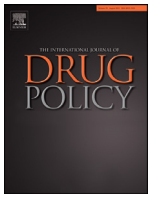

Research Paper

Drug use and access to drug dependency services for vulnerable migrants who use drugs in the European Union: Consensus statements and recommendations from civil society experts in Europe

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ABSTRACT

Background: The number of migrants in the European Union (EU) has been growing, including migrants at risk of using drugs. Little information is available on the actual drug use among first-generation migrants who use drugs in the EU, nor on their access to drug dependency services. This study aims to reach consensus among experts in the EU on the current situation regarding vulnerable migrants who use drugs in the EU and to develop a set of actionable recommendations.

Methods: Between April and September 2022, a panel of 57 experts on migration and/or drug use, working in 24 countries, participated in a three-stage Delphi study to develop statements and recommendations about drug use and access to healthcare services for migrants who use drugs in the EU.

Results: High levels of agreement were reached on the 20 statements (mean=98.0%) and 15 recommendations (mean=99.7%). The recommendations focus on four main topics; 1) increasing data availability and quality, to inform guidelines; 2) increasing the availability of drug dependency services for migrants, including screening for mental health issues and involving migrants who use drugs in the development of services; 3) eliminating country and service level barriers for accessing these services, as well as providing migrants who use drugs with suitable information, and combating stigma and discrimination; 4) the need for increased collaboration among and within EU countries regarding healthcare for migrants who use drugs, at the policy level as well as the service level, including civil society organisations, peer navigation and multilingual cultural mediators.

Conclusion: Policy action and increased collaboration are required by the EU as a whole and by individual EU member states, in addition to collaboration among healthcare providers and social welfare services, to increase access to healthcare services for migrants who use drugs.

Introduction

Europe has a long history of migration, including both into the European Union (EU) and between European Union Member States. In 2021, 61.2 million migrants were reported to be living in the EU, with 23.7 million (5.3%) being non-EU citizens, and 37.5 million (8.4%) were born outside of the EU (European Commission, 2021). Certain migrants experience increased vulnerability to adverse health outcomes, due to the impact of social determinants of health such as poverty, inadequate housing, limited education, and discrimination (World Health Organi-

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zation, 2008). Although there is general agreement that substance use prevalence is lower among first-generation migrants compared to non-migrants, data on the levels of illicit drug use, referring to drugs for which non-medical use has been prohibited by international drug control treaties (Degenhardt & Hall, 2012), among migrants in the EU are scarce and inconclusive (De Kock, 2022a). Several studies found lower levels of drug use among migrants compared to the native-born population (Carlander et al., 2021; Guardia et al., 2017; Ingrosso et al., 2014; Maremmani et al., 2021), while some found higher levels (Saigí et al., 2014; Wenz et al., 2016) and some found higher levels for some types of drugs but lower for others (Calvo et al., 2021; De Kock et al., 2020). However, these studies varied greatly in inclusion of types of drugs and profiles of migrants who use drugs, both regarding the area of origin as well as personal factors (e.g., experiencing homelessness, suffering from infectious diseases etc.), making it difficult to compare between studies.

Compared to the native-born population, several risk factors make migrants particularly vulnerable to developing a pattern of problematic drug use, which is defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as "recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems), or is placing the person at a high probability/risk of suffering such harms" (EMCDDA, 2022a). These factors include traumatic experiences pre-migration (e.g. war/violence in country of origin, discrimination based on sexual identity), during the migration journey (e.g. dangerous travel and violence, including race- and gender-based violence), as well as post-migration, including trauma from racial discrimination and stigma (Kirkinis et al., 2018), social disengagement (e.g., loneliness and feeling disconnected (Lindert et al., 2021)), unemployment, poverty (Mezuk et al., 2019) and arriving alone in the host country (Lemmens et al., 2017).

Availability and accessibility of drug dependency services for migrants in the EU is limited. The latest data from 2013 revealed that among 180 addiction treatment service centres in European capitals, only 18 (10%) offered services for refugees/asylum seekers and 8 (4%) do so for undocumented migrants.(Welbel et al., 2013) In Germany(Rommel & Köppen, 2016; Schulte et al., 2016), Spain(Saigí et al., 2014) and France,(Jauffret-Roustide et al., 2017) first-generation migrants were underrepresented in drug dependency services, while in Sweden,(Grahn et al., 2014) drug dependency service use did not differ between migrants and the native-born population. Even when drug dependency services are available to migrants, they often face barriers accessing these services, the main ones being poor knowledge about treatment services (De Kock, 2022b), language barriers (De Kock, 2022b; van der Gouwe et al., 2022) and a lack of social protection (e.g., health insurance and other social security benefits) (De Kock, 2022b; Deimel, 2013). In addition, fear of experiencing stigma and discrimination (Lindert et al., 2021), including deportation (Deimel, 2013), and previous negative experiences with drug dependency services in the country of origin (Kuhn et al., 2018) prevent migrants from accessing these services once in the EU.

The EU has been witnessing a growing number of migrants since 2015 (McAuliffe & A. Triandafyllidou, 2021), including vulnerable migrants at risk of using drugs (EMCDDA, 2022b; Tibi-Lévy et al., 2020). Currently, many migrants have been entering the EU from Ukraine, which is among the countries with the highest levels of injecting drug use worldwide and expected to increase as a result of the ongoing war with Russia (United Nations Office on Drugs and Crime, 2022). Globally, self-reported use of drugs and alcohol among migrants and refugees increased by 20% as a result of the COVID-19 pandemic (World Health Organization, 2022b). However, little information is available on the actual drug use among, and characteristics of, first-generation migrants who use drugs in the EU, as well as on the use of and access to drug dependency services. Therefore, this study aims to reach consensus among experts on the current situation regarding migrants who use drugs in the EU and to develop a set of actionable recommendations to improve this population's access to drug dependency services.

Methods

Study design

The Delphi methodology was used for this study with the aim to fill current knowledge gaps on drug use and access to drug dependency services for vulnerable migrants who use drugs living in the EU by achieving consensus on the main risk-factors for drug use among migrants and major barriers in accessing healthcare. This study was carried out as a part of the EU-funded project "SErvices for vulnerable MIgrants who use Drugs in the EU (SEMID-EU)". In this study, we used the IOM definition for migrants to establish the inclusion of any type of migrants irrespective of their legal situation or reasons for migration (United Nations, 2023). We specifically focussed on vulnerable first-generation migrants, given that risk and protective factors for engaging in drug use differ from that of subsequent generations due to the migration experience and status. Vulnerable migrants are defined as migrants that as a result of their drug use, migration background or other characteristics are particularly vulnerable and face structural, social and personal access barriers to having their universal human right met, such as food, housing, work and healthcare and social services (United Nations, 1948).

Delphi expert panel member sampling

First, the SEMID-EU team members working with migrants and people who use drugs were invited by the core research team to take part in the Delphi expert panel. Next, in an effort to include experts from different primary work fields (e.g., advocacy, research, policy and healthcare provision), a snowball sampling approach was employed, such that this group was asked to suggest additional panel members from their professional networks based on their engagement with migrants and people who use drugs. Finally, the *Correlation – European Harm Reduction Network* (C-EHRN), a civil society network and centre of expertise in the field of drug use, harm reduction and social inclusion, approached all member organisations and encouraged all people who are considered to have relevant expertise in migration and/or people who use drugs in the EU to participate in the study. To further validate the expertise of the invitees (n=114), the study was described to them with the following instructions: "If you consider your professional training lived experience and/or expertise applicable to the subject matter of this global consensus statement project, we encourage you to participate in the panel."

A panel of 57 experts working across 24 countries participated in round one, with response rates of 84% (n=48) and 92% (n=44) in the second and third rounds, respectively. Slightly more than half of the panellists identified as women (54%). The most common primary employment sectors were civil society (46%) and academic (26%) organisations, with the common primary fields being healthcare providers (23%) or public health researchers (18%). Almost two-thirds of the panellists were working in western Europe (37%) or southern Europe (26%). The Delphi panel characteristics are shown in Table 1.

Data collection

This Delphi study consisted of a first survey round including 17 draft *statements*, a second round of amended *statements* and draft *recommendations*, and a final, third survey round including both the revised consensus statements and recommendations. We used the QualtricsXM® platform for survey administration (between two and five weeks per round). Level of agreement with the statements and recommendations (i.e., Agree, Somewhat agree, Somewhat disagree, Disagree) was measured with 4-point Likert-type categories; a fifth 'not qualified to respond' option was provided. In round three, response categories were

Table 1
Expert panel characteristics (N=57).

Characteristic	n (%)
Gender	
Man	24 (42)
Woman	31 (54)
Non-binary or gender diverse	1 (2)
No response	1 (2)
Primary sector of employment	
Civil Society	26 (46)
Private	2 (4)
Academic	15 (26)
Public	9 (16)
Other	4 (7)
No response	1 (2)
Primary field	
Advocacy	11 (19)
Clinical research	3 (5)
Health department or ministry	1 (2)
Health and drug policy	7 (12)
Healthcare provider	13 (23)
Public health research	10 (18)
Harm reduction	4 (7)
Social work	3 (5)
Legal aid	2 (4)
Other	2 (4)
No response	1 (2)
Region where working[*]	
Central and Eastern Europe	8 (14)
Western Europe	21 (37)
Northern Europe	12 (21)
Southern Europe	15 (26)
No response	1 (2)

Note: Percentages may not sum to 100 due to rounding.

[*] The countries included in the sample were classified as follows: Central and Eastern Europe (Albania, Czech Republic, Hungary, Romania, Serbia, Slovenia, Ukraine); Western Europe (Belgium, France, Germany, the Netherlands, Switzerland); Northern Europe (Denmark, Estonia, Ireland, Lithuania, Sweden, United Kingdom of Great Britain and Northern Ireland); Southern Europe (Cyprus, Greece, Italy, Malta, Portugal, Spain).

reduced to the binary structure of Agree/Disagree maintaining the 'not qualified to respond' option. Panellists could provide comments and suggest edits to individual statements and recommendations in text boxes, which followed each of the statements and recommendations in rounds one and two. Overall comments could also be provided at the end of the survey for all rounds.

The first-round draft consensus statements developed by the core team (LvS, JVL, TMW, CAP, MB, IB) were informed by a scoping review of the literature. Draft recommendations in round two emanated from the panellists' feedback on the round one statements. Between rounds, statements and recommendations were modified by the core research team based on the panellists' comments. Summaries of changes between rounds were made available to panellists in text boxes next to each statement and recommendation in the subsequent round. To ensure a common understanding of the statements and recommendations, definitions were included in the survey for potentially ambiguous terms (see Box 1).

Delphi data analysis

Across the three rounds, we ran frequencies of all statements and recommendations and analysed the qualitative data (i.e., open-ended text-box comments). After review and discussion, suggested edits were incorporated into the statements and recommendations for the next round. Quantitative analysis of the final round three results involved assigning each statement and recommendation a grade to indicate the level of agreement, utilising a system used in similar Delphi studies(Lazarus et al., 2022; Rubino et al., 2020) in which 'U' denotes unanimous (100%) agreement; 'A,' 90%–99% agreement; 'B,' 78%–89% agreement; and 'C,' 67%–77% agreement.

Results

Overall, agreement on the statements and recommendations increased over survey rounds. In round two, three new statements (S2, S5, S10) were added based on the panellists' input. In the final round, all *statements* reached 93% agreement or higher (mean=98%), and all *recommendations* reached at least 98% agreement (mean=99.7%). Two statements had a level of disagreement of 7% (S4 and S8), and for seven statements the "not qualified to respond" option was selected by three or more panellists (S5, S8, S13, S14, S18 and S20). Ten statements scored an A grade (90%–99% agreement) and ten a U grade (unanimous agreement). Nearly all recommendations (13) reached a U grade, while two scored an A grade with 98% agreement (R12, R14). We report the final levels of agreement for the final statements in Table 2 and the final recommendations in Table 3.

Limited information on drug use among migrants

The panel agreed that many migrants who use drugs in the EU have specific physical, mental, and social well-being needs related to having migrated (S1). However, it was agreed that differences exist in drug use patterns and access to services between different migrant groups and different EU countries (S2, S3). Although the majority agreed that prevalence of drug use among migrants compared to that of the host country's population is not sufficiently documented (S4), panellists agreed that risks related to the use of non-medical use of medicines and illicit substances may be disproportionately higher among migrant groups (S5) and that information on migration status can inform efforts to improve access to drug services (S6). Therefore, unanimous agreement was reached on the recommendations that an EU expert committee on migration and health should be created addressing mental health and drug use (R2), and that evidence-based, peer-involved national and EU guidelines be developed on migrant and drug services (R5).

Availability of healthcare services for migrants who use drugs

The panel unanimously agreed that migrants who use drugs in the EU are often underrepresented in high-threshold drug addiction services (S14). The panel recommended that a basic set of healthcare services should be made easily and freely available to all migrants (R7), underscored by the unanimous agreement that human rights, including the right to health, of all migrants within the EU should be respected, regardless of their legal status (R1). In addition, migrants who use or have used drugs should be involved in the development and implementation of drug services (R6). Regarding risk factors, traumatic lived experiences and lack of a supportive social network were agreed to be drivers for engaging in drug use for migrants (S7, S8). Therefore, the panel recommended that healthcare services serving migrants should offer screening for mental health issues, including trauma, and provide low-threshold integrated care or refer to appropriate treatment and support (R4).

Access to healthcare services for migrants who use drugs

Regarding barriers for accessing healthcare services, unanimous agreement was reached that a lack of awareness of the availability of services (S9) and criminalization of drug use in either the host country or the country of origin may prevent migrants from accessing services (S10). Therefore, the panel agreed that when entering a country, refugees should have access to information about drug services and drug laws (R14). Other barriers for accessing healthcare are language, religious and cultural issues (S11), experience with or concerns about being stigmatized and discriminated against (S16, S17) and negative experiences with addiction services in migrants' country of origin (S18). In

Table 2
Statements on migrants who use drugs in the EU.

Statement	A	D	NQ	Grade
S1. Many migrants who use drugs in the European Union (EU) have specific physical, mental, and social well-being needs that are related to having migrated.	98%	2%	1	A
S2. Migrants who use drugs are not a homogenous group and there are subgroups (e.g. by gender, socio-economic status and ethnic background) that have less access to drug services than others.	100%	0%	1	U
S3. Different migrant groups in the 27 EU member states may have specific drug use patterns that necessitate different health and social policy responses.	100%	0%	1	U
S4. The prevalence of drug use among migrants in the EU compared to that of the population of the host country is not sufficiently documented.	93%	7%	1	A
S5. The risks related to illicit drug use including overdose, infections such as HIV and viral hepatitis, violence, poverty, and unstable housing may be disproportionately higher among migrant groups.	100%	0%	1	A
S6. Information on the migration status of underserved groups of drug users can inform efforts to improve access to drug services.	98%	2%	2	A
S7. Traumatic lived experiences of refugees in their country of origin or as a result of the migration process can act as an important driver for drug use.	98%	2%	2	A
S8. Arriving in the host country alone, without having a supportive social network, is a risk factor for engaging in drug use.	93%	7%	3	A
S9. A lack of awareness of available healthcare services is a common barrier to access to drug services among migrants.	100%	0%	0	U
S10. The criminalisation of drug use in a migrant's host country and/or country of origin, including fear of being reported to the police/authorities when interacting with drug services, may be a barrier for accessing addiction and harm reduction services.	100%	0%	0	U
S11. Language, religious and cultural issues form common barriers to healthcare access among migrants.	98%	2%	0	A
S12. Increasing the amount of peer navigation and number of multilingual cultural mediators to support migrants who use drugs in EU member states will increase access to care for this population.	100%	0%	0	U
S13. Addiction services available in EU countries are often not sensitive to the specific needs of migrants.	98%	2%	3	A
S14. Migrants who use drugs in the EU are often underrepresented in high-threshold drug addiction services compared to their proportion of the total population of the host country.	100%	0%	3	U
S15. Service providers in EU member states are not always aware of the legal requirements, if any, that clients must fulfil to access drug services.	97%	3%	5	A
S16. Experienced stigma and discrimination related to drug use and/or migration status are factors that impede migrants from accessing healthcare services, including addiction and harm reduction services.	100%	0%	0	U
S17. Migrants who use drugs and who have concerns about being stigmatised and discriminated against due to their ethnic and racial background engage less in healthcare services.	100%	0%	0	U
S18. Bad experiences with addiction services in the country of origin may lead migrants to engage less with addiction care in the host country.	100%	0%	4	U
S19. Community services play an essential role in engaging migrant populations and people who use drugs in healthcare services, who are often considered "hard-to-reach" by health systems.	100%	0%	3	U
S20. The collaboration among EU countries regarding the mass migration owing to the war in Ukraine, including people that use drugs, shows the importance of engagement with civil society organisations.	95%	5%	3	A

A: Agree, D: Disagree, NQ: not qualified to respond. Grades: U denotes unanimous (100%) agreement; A, 90%–99% agreement; B, 78%–89% agreement.

addition, there was agreement that addiction services are often not sensitive to the specific needs of migrants (S13) and that service providers are not always aware of the legal requirements that clients must fulfil to access drug services (S15). To tackle some of these barriers, unanimous agreement was reached that translation services should be offered free of charge to migrants entering healthcare services (R9), that campaigns and interventions are needed to reduce all forms of stigma, discrimination, and racism (R15) and that legal barriers and strict rules preventing migrants from using harm reduction and addiction services should be eased or removed (R11). Therefore, the panel recommended that health authorities and other research funders should continue to commission studies on drug policies affecting access to care in the EU (R10).

Improving access to healthcare by increasing collaboration

Unanimous agreement was reached that increasing the amount of peer navigation and multilingual cultural mediators, as well as the use of community services, increases access to care for migrants who use drugs (S12, S19). Therefore, the panel recommended that all EU member states invest in the training of staff of addiction and harm reduction services, peer navigators and multilingual cultural mediators, focusing on the practical, emotional, cultural and language needs of migrants who use drugs (R8). To increase access to healthcare for all, the panel recommended that outreach services should pay special attention to reaching sub-populations of migrants that use drugs that are under-represented in healthcare services (R13). The panel agreed that engagement with civil society organisations is important, as shown by the collaboration among EU countries regarding the mass migration owing to the war in Ukraine (S20). Therefore, the panel agreed that the EU should invest in platforms bringing together organizations supporting migrants who use drugs (R3). Finally, the panel recommended that to increase access to healthcare services for migrants who use drugs, services should employ a holistic approach including assistance with legal and bureaucratic issues (R12).

Discussion

A group of experts on migration and/or drug use in Europe reached consensus on 20 statements related to migrants who use drugs in the EU and on an actionable set of 15 recommendations to improve access to drug dependency services for migrants who use drugs. Broadly, the recommendations focus on four main topics: 1) the need for better data availability and quality on migrants who use drugs and access to healthcare for this population, to inform guidance and support; 2) increasing the availability of drug-related services for all migrants who use drugs; 3) increasing the access to healthcare services for migrants; and 4) the increased need for collaboration among and within EU countries regarding healthcare for migrants who use drugs, including cross-sectional collaboration.

Table 3
Recommendations on migrants who use drugs in the EU.

Recommendation	A	D	NQ	Grade
R1. The human rights, including the right to health, of all migrants within the EU should be respected, regardless of their legal status.	100%	0%	0	U
R2. The EU should create an expert committee on migration and health to address mental health and drug use by sharing and disseminating good practices.	100%	0%	1	U
R3. The EU should invest in platforms bringing together organizations that support migrants who use drugs.	100%	0%	1	U
R4. Healthcare services, including harm reduction and addiction services, serving migrants should offer screening for mental health issues, including trauma, and provide low-threshold integrated care or refer to appropriate treatment and support.	100%	0%	1	U
R5. Evidence-based, peer-involved national and EU guidelines should be developed on migrant and drug services.	100%	0%	0	U
R6. Migrants who use or have used drugs should be involved in the development and implementation of drug services.	100%	0%	1	U
R7. A basic set of healthcare services, including addiction and harm reduction services such as drug consumption-rooms, should be made easily and freely available to all migrants, regardless of their legal status.	100%	0%	0	U
R8. All 27 EU member states should invest in the training of staff of addiction and harm reduction services, peer navigators and multilingual cultural mediators, focusing on the practical, emotional, cultural and language needs of migrants who use drugs.	100%	0%	1	U
R9. Translation services should be offered free of charge to migrants entering healthcare services, including harm reduction or addiction services.	100%	0%	0	U
R10. Health authorities and other research funders should continue to commission studies on drug policies affecting access to care in the EU and its member states.	100%	0%	0	U
R11. Legal barriers and strict rules preventing migrants from using harm reduction and addiction services should be eased or removed.	100%	0%	1	U
R12. Drug use related services for migrants should employ a holistic approach including assistance with legal and bureaucratic issues.	98%	2%	0	A
R13. Outreach services should pay special attention to reaching sub-populations of migrants that use drugs that are under-represented in healthcare services.	100%	0%	0	U
R14. When refugees enter a country, they should have access to information about drug services and drug laws.	98%	2%	0	A
R15. Campaigns and interventions are needed in all EU member states to reduce all forms of stigma, discrimination and racism, targeting both service providers and migrants who use drugs themselves.	100%	0%	1	U

Key: A, Agree; D, Disagree; NQ, not qualified to respond; U, unanimous (100%) agreement; A, 90%–99% agreement; B, 78%–89% agreement.

Findings from this study highlight the lack of data on migrants who use drugs and the need for more indicators to inform efforts to improve access to drug dependency services for this group. This is in line with the first objective of the UN's Global Compact for Migration, which is to collect and utilize accurate and disaggregated data as a basis for evidence-based policies (Global Compact for Migration, 2018). A 2019 WHO European region report states that less than half of the region's member states (25/53) had any type of refugee and migrant health data available (World Health Organization - Regional Office Europe, 2019), and even when data are available it needs to be considered that the often often do not cover all regions and all types of migrants (e.g., undocumented migrants). To increase data availability and quality, the WHO European region developed a guideline on collection and integration of data on refugee and migrant health in Europe (World Health Organization - Regional Office for Europe, 2020), which mainly focusses on integrating migration health data into national health information systems but has the potential to link migrant data to drug-related information.

The European Commission states in the *European Pillar of Social Rights* that "Everyone has the right to timely access to affordable, preventive and curative health care of good quality (European Commission, 2017)." The World Health Organization's "Cube Diagram" has been widely used to visually represent the level of Universal Health Coverage (UHC) on a country level. The framework includes three axes presenting a) the population covered, b) the services covered, and c) the proportion of costs covered (World Health Organization, 2012). In 2019, the WHO European region had the second-highest score on the UHC Service Coverage Index, scoring 79 compared to the global average of 67 (World Health Organization & World Bank, 2021). Despite close to universal population coverage in the EU, in some European countries, certain categories of migrants (i.e. without documentation or insurance) are not legally entitled to use healthcare services (Palm et al., 2021). For example, in Germany EU-citizens who cannot provide for their own living costs are denied health coverage and undocumented migrants will be reported to the immigration police when applying for health coverage (Webb et al., 2022). The services covered for migrants in countries where they are entitled to healthcare have often been limited to emergency care (Baggaley et al., 2022). In addition, some drug-related services, such as detoxification programs for alcohol and drugs, are often not included in standard benefits packages (Palm et al., 2021). Finally, for some services in some EU countries, user charges apply- creating a possible barrier to access for migrants who use drugs. For example, in France most services in the statutory health insurance system use cost-sharing, disproportionately affecting certain vulnerable groups such as people suffering from mental health problems (Palm et al., 2021). The EMCDDA has identified 121 practices focusing directly or indirectly on drug-related responses for migrants and ethnic minorities in Europe (De Kock, 2022a). Examples of such practices are provided in the EMCDDA report; however, no information is provided on the implementation and results of these interventions and only a minority of the practices are evidence based.

Even when healthcare services are available for migrants who use drugs, various types of barriers, such as cultural, linguistic, or legal can prevent migrants who use drugs from accessing them. A European study from 2012 showed that 40% of drug-related services did not have interpretation services available (Kluge et al., 2012). A strategy to increase access and optimize benefits for migrants who use drugs is the involvement of peers in developing, implementing, and evaluating services, which was also recommended by experts on substance use disorders in humanitarian settings (Greene et al., 2021). When providing peer support programs it is important to provide peers with suitable training and to pay them for their services (Miler et al., 2020). In addition, when working with peers from the same country it should be safeguarded that in case of a conflict or oppressive situation in the country of origin, peers are not on opposite sides. In the EU, although there

Box 1
Terms and definitions used in the Delphi statements and recommendations.

Term	Definition
Migrant	All first-generation migrants, including undocumented migrants and refugees.
Peer navigation	Direct assistance to migrants who use drugs in finding their way through health systems and services by people having lived-experience with migration and drug use.
Multilingual cultural mediators	Individuals who serve as a link between different cultures and social systems and understand the value systems and languages of both cultures.
High-threshold drug addiction services	Services with restricted use that are not easily accessible for everyone (as opposed to easily accessible "low" threshold services, with very few use restrictions and a client perspective to service provision).
Community services	Services including members of the community of migrants, people who use drugs or both groups.

are ongoing research projects, the authors of this study have not identified any peer-reviewed studies about support needs and appropriate services for migrants who use drugs that have included the perspective of this group. In the USA, Bhutanese and Iraqi refugees were asked to suggest interventions addressing substance abuse among refugees and highlighted the high risk of stigma and the importance of treating individuals with dignity (Mirza et al., 2017). In addition, they mentioned peer counselling as a possible effective intervention (Mirza et al., 2017). To increase access, panellists agreed that a more holistic approach to service provision, by integrating drug dependency services with other health and social services should be employed. This is in line with the WHO's updated recommendations on simplified service delivery and diagnostics for hepatitis C infection (World Health Organization, 2022a), the WHO Global Health Sector Strategy on HIV, viral hepatitis, and Sexually Transmitted Infections ("Global Health Sector Strategies on, Respectively, HIV, Viral Hepatitis and Sexually Transmitted Infections for the Period 2022-2030," 2022) and the WHO Framework on integrated, people-centred health services (World Health Organization, 2016).

Strengths and limitations

The use of the Delphi methodology is a major strength of this study, in that it comprises a set of tools to collect, assess and revise expert insights on issues requiring informed consensus to inform policy or other actionable (e.g., programmatic, clinical) objectives. The overall increased level of agreement per round, in many cases reaching unanimity, shows that the process of incorporating panellists' feedback resulted in successful refinement of the statements and recommendations. In addition, the high response rates across all three survey rounds are indicative of the expert panel's commitment to the process and supports confidence in the study findings.

The Delphi panel composition can present limitations to the study findings. For example, although the panel was diverse in terms of gender and field of work, Eastern European EU countries were underrepresented; yet, the largest volume of drug use is in this part of Europe. Nonetheless, most drug-related services for migrants are located in western European EU countries (De Kock, 2022a); thus, in terms of experts by EU region, the Delphi sample might be considered appropriate in this regard. Participation was limited to English speakers, but the Delphi panellists collectively worked in 24 different countries. As such, we propose that the findings will be applicable to a wide range of European cultures and country contexts. Finally, it is possible that some of the terminology used in the statements may have been subject to varying interpretations by the experts. To reduce this risk ambiguous terms used in the statements were defined for the participants (see Box 1).

Conclusion

We developed a set of actionable recommendations on drug dependency services for vulnerable migrants in the European Union, with very high levels of agreement from the panellists. The recommendations focused on increasing data availability, development of supporting materials and collaboration among EU countries, as well as cross-sectional collaboration, eliminating country- and service-level barriers for accessing drug dependency services for migrants, and increasing awareness of the availability of and willingness to participate in these services among migrants. Action needs to be taken by the EU as whole, individual EU countries, and healthcare providers to increase access to healthcare services for migrants who use drugs. The set of 15 recommendations resulting from this rigorous Delphi process provides guidance for such action to be undertaken.

Data sharing statement

De-identified data can be shared upon request from the corresponding author for fair use purposes.

Ethics committee approval

The Ethics Committee of the Hospital Clínic of Barcelona provided an exception from ethical review for this study.

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Declarations of Interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.drugpo.2023.104087.

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