

Projectmedewerker “Herstelkapitaal bij druggebruikers met een migratieachtergrond: een analyse van gebruikersperspectieven (REC-MIB)”
Doctoraatsbursaal - 100% - Faculteit Psychologie en Pedagogische Wetenschappen - PP10 - Orthopedagogiek

In het kader van het onderzoeksproject “Herstelkapitaal bij druggebruikers met een migratieachtergrond: een analyse van gebruikersperspectieven” zijn we op zoek naar een voltijds onderzoeker. Dit onderzoek wordt gefinancierd door het FWO. Het wordt uitgevoerd binnen de Vakgroep Orthopedagogiek (Prof. Dr. Wouter Vanderplasschen) in samenwerking met het Institute for Research on Criminal Policy (IRCP) (Prof. Dr. Freya Vander Laenen), UGent. Het onderzoek heeft tot doel inzicht te krijgen in herstel van verslaving bij personen met een migratieachtergrond, de relatie tussen sociaal kapitaal en herstel van verslaving bij deze doelgroep, ervaren dubbel stigma binnen hun herstelproces, en de bruikbaarheid van cultureel aangepaste geestelijke gezondheidszorg bij het ondersteunen van duurzaam herstel.

JOUW OPDRACHT

- Je staat in voor het uitvoeren van de verschillende werkpakketten binnen dit onderzoeksproject. Meer specifiek gaat het om zowel kwantitatieve dataverzameling en -analyse – o.a. door middel van een vragenlijst – alsook een kwalitatief onderzoeksstuk – door middel van kwalitatieve interviews. Op aanvraag (via onderstaande contactpersoon) is een samenvatting van het onderzoeksvoorstel te verkrijgen.
- Als onderzoeker ben je verbonden aan de Vakgroep Orthopedagogiek van de Universiteit Gent.
- De aanstelling start op 1 april 2018 voor de duur van 4 jaar.

JOUW PROFIEL

- Diploma van master in de humane wetenschappen (Psychologie, Pedagogische Wetenschappen, Sociologie, Criminologie, ...)
- Ervaring met praktijk/onderzoek omtrent verslaving en/of personen met een migratieachtergrond strekt tot aanbeveling
- Je hebt bij voorkeur ervaring met kwantitatief én kwalitatief onderzoek
- Je kan zelfstandig werken en je kan vlot wetenschappelijke teksten schrijven
- Zeer goede kennis van Nederlands en Engels is vereist
- Je kan vlot samenwerken in een multidisciplinair onderzoeksteam

INTERESSE?

Je kan je interesse voor deze vacature laten blijken door voor 23 februari 2018 volgende zaken te mailen naar Prof. Dr. Wouter Vanderplasschen (wouter.vanderplasschen@ugent.be):

- sollicitatiebrief
- je CV, inclusief een overzicht van de behaalde studieresultaten

MEER INFORMATIE

Voor meer informatie in verband met deze vacature kan je contact opnemen met Prof. Wouter Vanderplasschen (Wouter.Vanderplasschen@UGent.be, +32 09/331 03 13).

PROJECT OUTLINE

Recovery capital among substance users with a migration background: An analysis of user perspectives (REC-MIB)

1. State of the art

Kelly and Hoepfner (2015: 9) describe recovery from substance dependence as “a dynamic process characterized by increasingly stable remission resulting in and supported by increased recovery capital and enhanced quality of life”. This definition emphasises the process-oriented and dynamic character of recovery and the fact that it does not consist of a single event or a single goal. The life-course model distinguishes between early recovery (less than one year, ≤ 1); sustained recovery (one to five years, < 5) and stable recovery (more than five years, ≥ 5) (Betty Ford Institute, 2007). Recovery capital consists of the sum of personal, social and community resources that can be used to (or block) support to initiate and sustain recovery from substance dependence (Best et al., 2010; Granfield et al., 2001). The concept originates from the notion of social capital, postulated by Bourdieu (1986) and elaborated upon by Putnam as ‘those features of social organisation, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated actions’ (Putnam, 1995: 66). The basic assumption of recovery capital is that the personal capacity to recover from problem substance use, is only a function of the resources that a person has developed and maintained within the context of social realities taking into account social inequalities (Cloud et al., 2008). Consequently, social capital feeds into personal capital as a part of recovery capital. Recovery capital has been studied in diverse but mostly white and native user populations (Hennessy, 2017). However, the structural (social networks) and cognitive or attitudinal (shared norms, trust, reciprocity) components of social capital have been studied extensively in sociological studies of persons with a migration background, but so far not within the interdisciplinary study of addiction recovery. The main focus in social capital research is on the opportunities of ethnic diaspora as a form of social capital stimulating employment and bounding social connectedness and how personal social capital differs in and across new and established communities (Dahinden, 2013; Danzer et al., 2011; Grzymała-Każłowska, 2005). Scholars argue that aside studying the nature of ethnic social capital in these communities, diversity in networks, and the possibilities aside ethnic capital should be studied, including the influences of social exclusion, stigma (Amin, 2005) and economic disadvantage (Letki, 2008) on diversified social capital. Research indicating that social exclusion and perceived discrimination in persons with a migration background are positively related to increased ethnic identification (Greig, 2003; Portes et al., 2001; Torrekens et al., 2015; Zetter et al., 2005) and reactive ethnic identity formation (Çelik, 2015) demonstrate that perceived exclusion and discrimination impact on the nature of social capital in persons with a migration background.

Disadvantages among persons with a migration background in Belgium are documented in education (Agirdag et al., 2011; Boone et al., 2014), housing (Van den Broucke et al., 2015), the labour market (Verhaeghe et al., 2016; Verhaeghe, 2013), elderly care (Lodewijckx, 2014) and justice (Mutsaers, 2013), especially among newly arrived persons with an intra-European migration background. Low participation is also documented in substance abuse treatment (SAT) (Derluyn et al., 2008; Rouws, 2007; Vandeveldt et al., 2003). In Flanders, the low participation of persons with an intra-European migration is especially apparent in SAT across the treatment spectrum, and especially in therapeutic communities (Blomme et al., 2017). Concerning the low participation in SAT, there is a growing consensus in international literature that studies have focused abundantly on personal and culture specific factors (e.g. religion and family ties) as well as on prevalence of use in specific groups, while research has neglected structural factors and social mechanisms such as problem user’s socioeconomic status, social capital (De Kock, Decorte, et al., 2017; Krieger, 2012; Viruell-Fuentes et al., 2012) and the impact of perceived and structural discrimination and stigma (Adamson et al., 2011). This focus on

personal and culture-specific factors is reflected in theory on culturally competent (Cros et al., 1989) (mental) health care, often arguing for the incorporation of personal (Dauvrin et al., 2017) and culture-specific factors in treatment (Bhui et al., 2007; Degrie et al., 2017), while overlooking the social capital component in both the professional and the client. However, no systematic literature is available concerning culturally competent SAT and its relation to addiction recovery theory. Theories on substance use and mental health (a risk factor for problem use) in persons with a migration background, point out that (see figure below) having a primarily ethnic network buffers for substance use initiation (Lorant et al., 2016), increased substance use (Gibbons et al., 2016), depressive symptoms (Ikram et al., 2016), and psychological distress (Heim et al., 2011; Phinney et al., 1997) especially when faced with perceived discrimination (Gibbons et al., 2016; Heim et al., 2011; Ikram et al., 2016). However, these results would appear to conflict with the premises of well-established recovery capital research (Best & Laudet, 2010; Cloud & Granfield, 2008; Granfield & Cloud, 2001; Kelly & Hoepfner, 2015). Since it conceives of diversified social networks (Bathish et al., 2017) (as opposed to isolated and primarily ethnic networks) as an essential component of sustainable recovery from substance dependence.

In addition, social disadvantage such as lower education and higher unemployment rates, is larger among persons with a migration background when compared to general populations (Carliner et al., 2016; Otiniano Verissimo et al., 2014; Savage et al., 2014) and this in turn is related to increased recurrent treatment episodes in SAT (Storbork & Room, 2008; Berends et al. 2016) and is a risk factor for problem use. Lastly, literature on perceived double stigma (Ciftci et al., 2013; Clement et al., 2015; Gary, 2005) indicates that the documented problems related to stigma and social exclusion caused by mental health issues (Andrade et al., 2014) are larger in persons with a migration background. They suffer from a perceived double stigma caused by perceived discrimination in combination with a mental health stigma in both general society as well as in the perceived ethnic community. This issue has however not been studied in the population of users with a migration background.

In conclusion, there is lack of research 1) on addiction recovery in persons with a migration background, 2) on the relation between social capital and addiction recovery in this population (predicated as it is on employment, housing and social connectedness), 3) on the impact of perceived double stigma on recovery, and 4) on the appropriateness of theories of culturally competent mental health care and SAT particularly, in supporting sustainable recovery in users with a migration background. Given this caveat, we formulate three hypotheses and associated research questions and objectives (see infra: Objectives). This research intends to fill a gap in literature and is particularly relevant in the light of the documented structural and perceived socio-economic disadvantage among persons with a migration background in Flanders.

2. Objectives: Hypotheses and research questions

We aim to address following research questions based on three core hypotheses:

H1: The social component of recovery capital (social capital) is precarious among substance users with a migration background, especially in users with an intra-European migration background.

Q1: What is the nature of social capital in users with a migration background in early (<1 year), sustained (1-5 years) and stable recovery (>5 year). Q2: Is social capital different between substance users with an intra- and non-European migration background (taking into account years of residence and migration history)? Q3: What are factors that support recovery among substance users with a migration background in different stages of recovery?

H2: Socio-economic disadvantage, social capital (social network, social and ethnic identity) and double stigma (perceived discrimination and stigma) have a strong impact on pathways to recovery among substance users with a migration background (De Kock, Hauspie, et al., 2017).

Q4: How do socio-economic disadvantage, social capital (social network, social and ethnic identity) and double stigma (perceived discrimination and stigma) impact addiction recovery among substance users with a migration background?

H3: Theories of culturally competent mental health care and SAT particularly, are insufficient in overcoming the barriers to recovery among substance users with a migration background.

Q5: How do components in and variations among theories of culturally competent mental health care and SAT particularly correspond to recovery oriented theory and the specific recovery needs –with regard to recovery capital in particular, among users with a migration background?

3. Methodology

Study design: The study uses a mixed methods design and consist of: 1. A two-fold literature review (WP1) including a. the conceptualisation of socio-economic disadvantage, social capital (social network, social and ethnic identity) and perceived double stigma (perceived discrimination and stigma) in the light of supporting recovery capital in SAT, among persons with a migration background. b. A systematic literature review of theories on culturally competent mental health care and SAT particularly, aimed at defining the necessary components in and variations among theory, published between 2007 and 2017 (Bhui et al., 2007), 2. A two-fold interview with 120 users (WP3&5) with a migration background consisting of a quantitative validated questionnaire (Best et al., 2016) and a semi-structured qualitative interview. 3. Comparing the components in and variations among theories of culturally competent SAT (systematic literature review) with recovery successes and needs in users with a migration background (as reported in the interviews).

Data collection: The study will involve 120 study participants. Participants will be interviewed once: they will be asked to first fill out a questionnaire (see infra) (approximately 25 minutes), afterwards, a qualitative interview follows (approximately 70 minutes). Eligibility of study participants is based on three criteria: 1. Having/had a lifetime dependence of an illicit substance or alcohol; 2. Classifying themselves as in recovery or as recovered; 3. Classifying themselves as having a migration background (excluding Belgium's neighbouring countries). We intend to reach 40 study participants for each stage in recovery (early, sustained, stable) and will apply stratified sampling for reaching equal amounts of users with an intra-European and non-European migration background, each group corresponding to Flanders population statistics in 2016, across Belgian municipalities, to avoid sampling bias. Targeted recruitment of study participants will take place in six recruitment waves defined in the recruitment protocol (see WP3&5). We foresee to collect 20 interviews in each pre-organised wave in a period lasting three months. The recruitment waves will be aimed at geographically clustered Flemish centre municipalities and their surrounding municipalities plus Brussels. The waves are determined as follows: wave 1 - Genk, Hasselt; wave 2 - Gent, Sint-Niklaas, Aalst, wave 3: Antwerpen, Turnhout; wave 3 - Roeselare, Kortrijk; wave 4 - Leuven, Mechelen, Brussel; wave 5 - Brugge, Oostende. Each wave will follow a predetermined stratified recruitment plan including: (1) Folders, mailshots, adverts and personal follow-up contact with all SAT services in the area, selected community and health organisations; (2) Personal contacts in community, religious, sports, local youth, student and local health organisations; (3) Personal contacts in areas and at events frequented by users with a migration background conform the ethically approved research protocol (Heim et al., 2011) (see infra) and with informed consent of organisations at hand; (4) Snowball sampling via recruited participants. Parallel to the geographically organised waves, other recruitment channels will include: (1) Networked Twitter re-tweets, (community recovery) Facebook pages, mutual aid group general services, national and regional user and recovery representative organisations. (2) Consultation of key informants and gatekeepers known from previous research (De Kock, Decorte, Schamp, et al., 2016; Derluyn et al., 2008; Vandeveldt et al., 2003); (3) Subsampling in an ongoing European research project (REC-PATH)

about recovery pathways and societal responses in Belgium and other countries (Best et al., 2017). The recruitment protocol will be developed in WP2, assessed and redirected after wave 3 (WP3), in WP4. After providing informed consent to gatekeepers or to the researcher, potential respondents will be screened by telephone on the inclusion criteria, their recovery pathways and socio-demographic characteristics before they can be selected for study participation. Translators will be employed (WP2) to assist during interviews in another language than Dutch, French and English. Interviews will take place in a location chosen by the study participant (e.g. the research institute, treatment centre, public place, the participant's home). If a face-to-face interview is not feasible (e.g. distance to the research institute), telephone or Skype interviews will be used. Participants receive a 15 euro supermarket voucher, as an incentive for study participation.

The interview instrument will consist of a quantitative (25m.) and a qualitative (70m.) part. The twofold interview will last for approximately two hours. The instrument will be piloted with at least three participants (WP2). The quantitative part is based on the REC-PATH survey (Best et al., 2016; Best et al., 2017; Groshkova et al., 2013), but will be significantly reduced (WP2), in favour of the qualitative instrument to gain in-depth understanding and to counter pitfalls in applying validated quantitative measures in new cultural groups. Moreover, a qualitative social network mapping tool (see infra) will allow in-depth understanding of the link between social network, social and ethnic identity, analysis of formal characteristics of network structure, sectors pertinent to different life areas and how actors identify in these different contexts. The quantitative instrument will contain following items (Best et al., 2017):

- Demographics SONAR (Best et al, 2014)
- Recovery Capital (Groshkova, Best & White ,2013)
- Recovery Group Participation Scale (Groshkova, Best & White, 2011)
- Social Identity Preference (Buckingham et al., 2014)
- Illicit drug use SONAR (Best et al., 2014)
- Life in recovery (FAVOR, 2013)
- Substance Abuse Self-Stigma Scale (Luoma et al., 2013)
- Alcohol and prescribed medicine use (SONAR)
- Perceived stigma
- Perceived Devaluation Discrimination Scale (PDDS) (Link, 1997)
- Treatment history in community, residential and criminal justice settings (Lubman et al., 2015)
- Social exclusion, General Social Exclusion Scale (Jehoel-Gijsbers & Vrooman, 2007)

Following items will be supplemented: 10-item self-categorising ethnic identity scale and 10-item selfcategorising familial identity scale (Dimitrova et al., 2015); Satisfaction with Life Scale (Vázquez et al., 2013); Perceived discrimination (Gibbons et al., 2016), time in Belgium and housing situation (family, neighbourhood, community). The REC-PATH, French and English versions of the questionnaire (see supra: Collaboration) will be used when needed. The questionnaire will be followed by an open ended qualitative interview, preferably right after filling out the questionnaire or at a different time of choosing of the participant (e.g. in case the time schedule, physical or mental state of the participant does not allow for a one-hour interview, or if the translator's time is limited).

The qualitative instrument will be a lifeline interview guide (Berends, 2011) and will contain: (1) A set of probing questions for clarifying items in the quantitative questionnaire to nuance nominal answers related to perceived discrimination and stigma, social exclusion, social and ethnic identity (Van de Vijver et al., 2015). (2) A qualitative Social Identity Map (Bathish et al., 2017; Safar, 2011) focusing on: number of important people, family relations, proportion of users in network, proportion of people in recovery, social support, multiple group membership, as well as life domains (finances, employment, education and training, recovery status, contact with criminal justice system). Social network will be visualized collaboratively with the participant in VennMaker software. (3) Eliciting vignettes of hypothetical situations based on our previous research in this target group (De Kock, Schamp, et al.,

2017) to identify critical events and recovery pathways including recovery status, treatment engagement and knowledge about existing treatment options (Best et al., 2017). (4) Eliciting vignettes of hypothetical situations concerning components in and variations among theory of cultural competent mental health care and SAT, to identify how these are experienced by participants.

Data analysis (WP6-8): The main aim is to uncover changes from active addiction to recovery, distinctions and complexities in recovery pathways for users with an intra-European (n=60) and non-European (n=60) migration background (taking into account years of residence and migration history), with particular attention for the impact of socio-economic disadvantage, social capital (social network, social and ethnic identity) and double stigma (perceived discrimination and stigma). Phase 0: The sample will be described making use of descriptive statistics of demographics, illicit drugs use, alcohol and prescribed medicine use, treatment history, years of residence and migration history. Phase 1: To capacitate grounded and in-depth understanding of the interviews, qualitative analysis (WP6) will be a priority before quantitative analysis (WP7). Qualitative analysis (in Nvivo 11) will consist of respectively: 1.1 A preliminary phase of grounded coding by three team researchers for reaching intercoder agreement (independent from quantitative outcomes); 1.2 In-depth thematic analysis (for preliminary answering Q3&Q4) and axial coding by the main researcher; 1.3 Internal triangulation of data between recovery stages, types of substance used, other emergent variations; 1.4 Comparison between data on users with an Intra-European (n=60) and non-European (n=60) migration background (taking into account years of residence and migration history) (for preliminary answering Q1&2). Based on this analysis, 1.5 several possible mechanisms of change (including the hypothesised mediating factors of socio-economic disadvantage, social capital [social network, social and ethnic identity] and double stigma (perceived discrimination and stigma) will be developed. These mechanisms of change are the basis for the development of multi-level hierarchical regression models (see Phase 3). Phase 2 - Quantitative data exploration: For testing H1 and answering Q1 and Q2 standard factor-analysis and paired-sample t-tests (e.g. intra-European / Non-European, residence periods, early / sustained recovery) will be employed. Significant relations for preliminary answering Q3 will be explored making use of standard chi-square analysis and Pearson's r correlation analysis and will be enriched with qualitative data. Phase 3 - Quantitative modelling: A grounded and hierarchical regression model (see Phase 1) will be developed to statistically evaluate the combined impact of socio-economic disadvantage, social capital (social network, social and ethnic identity) and double stigma (perceived discrimination and stigma) on pathways to recovery (H2, Q4). This is a method used previously for uncovering moderators for decreased mental health in this population (Heim et al., 2011), but not for initiating and sustaining addiction recovery in this population

A last phase, phase 4 (WP8) will consist of qualitatively comparing the components in and variations among theory on cultural competent mental health care and more specifically SAT, as synthesized in our systematic literature review (WP2) to the needs and decisive factors of successful recovery among participants as identified in phase 3 (WP3&5), and for answering Q5 (H3).

Anticipated pitfalls: Several pitfalls are anticipated during data collection and analysis as well as in our methodology. First, self-selection of participants regarding their recovery stage as well as regarding the migration background will cause bias. However, self-selection is well established in drug research and in hard to reach populations, and we will limit bias by means of the recruitment protocol on the one hand and internal validity checks in data on the other hand (e.g. social and ethnic identity measures, years of residence and probing questions concerning recovery pathways and current substance use). Second, the cross-sectional design might prevent from drawing firm conclusions regarding causality of the hypothesised and other contextual mediating factors. We counter this limitation qualitatively by means of the longitudinal life-line approach during the interview, and quantitatively by comparing persons in different recovery stages, examining whether the hypothesized factors and other contextual mediating factors predict changes in levels of increased substance use and recovery initiation. Third, during the analysis special attention will go out to the fact that effects

of social relationships can be bi-directional, complex, and work to heal or harm (Bathish et al., 2017). Fourth, the qualitative instruments are meant to counter the fact that short-item quantitative measures, are limited in their ability to describe complex and heterogeneous concepts as social and ethnic identity. Fifth, substance users with a migration background are a particularly hard to reach population. Moreover, employing a researcher without a migration background could be said to hamper recruitment and in-depth data-collection. However, we argued elsewhere that with an experienced researcher, the respondents will more likely be truthful about this taboo topic, when compared to a co-ethnic researcher. Also, we have built in the research design intermediate milestones per 20 interviews (per wave [see supra]) as well as an intermediate phase for assessing the respondent pool and consequent adaptation of recruitment strategies (WP4). The team has experience in data gathering in this population and has published on overcoming barriers of language, target group reach and eliciting techniques during interviews with persons with a migration background (De Kock, Decorte, Vanderplasschen, et al., 2016; De Kock, Schamp, et al., 2017).