SUBSTANCE USE DISORDERS IN HUMANITARIAN SETTINGS

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This chapter discusses the risk factors for and vulnerability to substance use disorders among forcibly displaced populations, as people who are forcibly displaced are among the marginalized groups that suffer physical and psychological trauma and elevated levels of socioeconomic vulnerability, which elevates their risk of developing mental health and substance use disorders.

The research presented in this chapter shows that substance use patterns among displaced populations are heterogenous and not dissimilar to those observed among the general population. People who are forcibly displaced may develop a resilience to substance or drug use, carry over their drug use patterns from their place of origin, adapt to the drug use patterns of their new location, or intensify their initial pattern of drug use. For these reasons, knowledge of the unique challenges faced by forcibly displaced populations is fundamental in understanding the specific needs for the prevention of substance use and treatment of substance use disorders within humanitarian settings. Even if the needs of people who are forcibly displaced do not generally differ a great deal from those of the general population, special efforts are needed if those needs are to be addressed in the context of limited health infrastructures and constrained social and economic resources.

SOCIOECONOMIC DISADVANTAGES AND DRUG USE DISORDERS

Although people in higher socioeconomic groups have a greater propensity to initiate drug use than those in lower socioeconomic groups, people in lower socioeconomic groups pay a higher price for drug use as they are more likely to progress from drug use to drug user disorders. Population groups that face socioeconomic disadvantages such as poverty, conflict and a lack of opportunities for education and employment are particularly vulnerable to mental health problems and drug use disorders. Socioeconomic disadvantages can also limit the access of disadvantaged or marginalized population groups to health, health promotion, prevention and drug treatment services.[a]

[a] UNODC, *World Drug Report 2020*, Booklet 5, *Socioeconomic Characteristics and Drug Use Disorders* (United Nations publication, 2020.

The vicious cycle of socioeconomic disadvantages and drug use disorders

Source: UNODC, *World Drug Report 2020*, Booklet 5, *Socioeconomic Characteristics and Drug Use Disorders.*

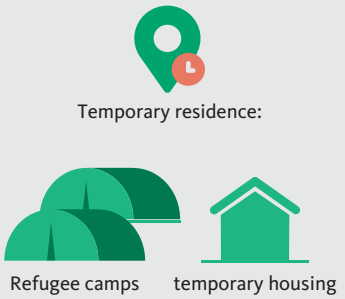
More than 100 million people displaced by humanitarian emergencies in 2022

Humanitarian emergencies can be caused by epidemics or natural disasters such as earthquakes, tsunamis, flooding and drought, some of which are the result of climate change.[1, 2]

They can also be cused by human-made events such as armed conflict, violence and related forced displacement, accidents and fire. Other, more complex emergencies can be caused by a combination of natural and human-made factors. All types of humanitarian emergencies disrupt and threaten the safety, health and well-being of communities and populations and usually require immediate action and international support to protect the affected population.[3] Overall, the elderly population may be more affected by humanitarian emergencies, but women, children, ethnic and religious minorities and gender-diverse groups are most at risk of suffering from the adverse consequences of being displaced for a prolonged period.[4, 5]

Humanitarian emergencies lead to large numbers of people being forced to leave their home or country and becoming displaced, either temporarily or over a protracted period. Displaced populations are not homogenous and may include refugees, asylum seekers, stateless people or internally displaced persons, that is, people who are forced to leave their home but who remain within their own country.[6, 7] The number of people who were forcibly displaced worldwide in

HUMANITARIAN EMERGENCIES, DISPLACED PEOPLE AND SETTINGS IN WHICH THEY ARE PLACED



HUMANITARIAN EMERGENCIES AND SETTINGS:

Natural disasters: earthquakes, tsunamis, flooding, drought or famine, or epidemicss

Human-made: armed conflict, civil unrest, violence, human rights violations, persecution or the forced displacement of a population group (ethnic or religious)

DISPLACED POPULATION REQUIRING PROTECTION AND SUPPORT:

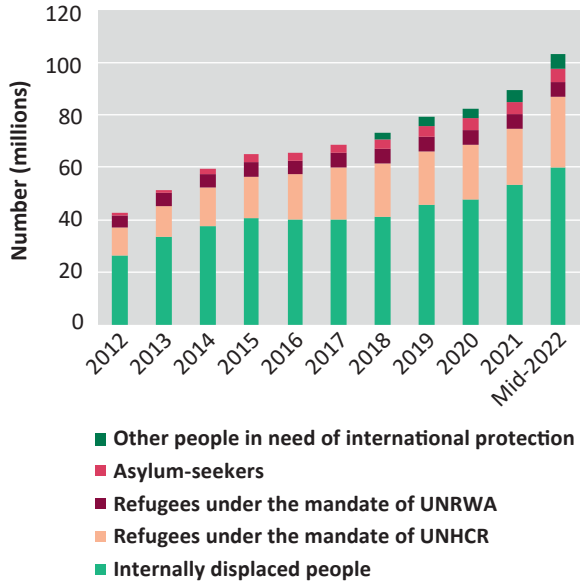
Internally displaced population, refugees, asylum seekers and stateless persons

SETTINGS IN WHICH DISPLACED POPULATION IS PLACED:

Places of temporary residence (refugee camps or internment camps), temporary housing or makeshift settlements for externally or internally displaced people, and sometimes with host communities

Source: UNODC elaboration.

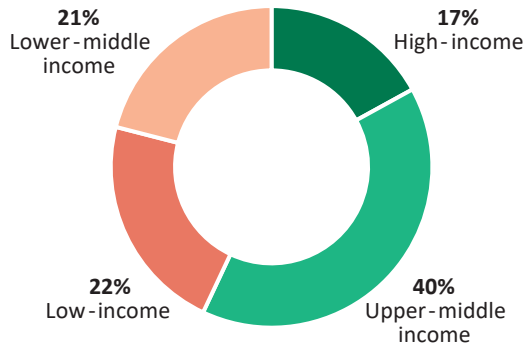
FIG. 7 People forcibly displaced, 2012–2022



Source: UNHCR, "Global Trends Report in Forced Displacement in 2021" (Geneva, Switzerland: UNHCR, 2022).

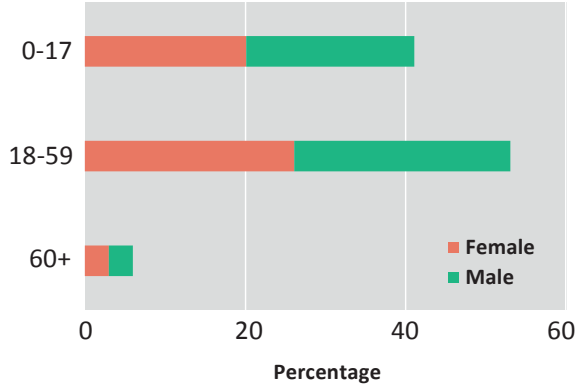
Note: The data shown for 2022 comprise data available until mid-2022, except for the data on internally displaced persons, which comprise data available until the end of 2021. UNRWA is the United Nations Relief and Works Agency for Palestine Refugees in the Near East.

FIG. 8 Distribution of forcibly displaced people, by income level of host country, end of 2021



Source: UNHCR, "Global Trends Report in Forced Displacement in 2021" (Geneva, Switzerland: UNHCR, 2022).

FIG. 9 Global distribution of forcibly displaced people, by age group and sex, 2021



Source: UNHCR, "Global Trends Report in Forced Displacement in 2021" (Geneva, Switzerland: UNHCR, 2022).

the first six months of 2022 exceeded 100 million, which was more than double the nearly 43 million people who were forcibly displaced in 2012 and which was the largest number since the Second World War.[8]

The majority of people who are displaced by humanitarian emergencies are hosted in low- and middle-income countries. Although children (0–17 years) comprise 30 per cent of the world's population, they account for 41 per cent of all forcibly displaced people.[9] In 2022, an estimated 274 million people were considered to be in need of humanitarian assistance and international protection as a result of being forcibly displaced, a significant increase from the 235 million in the previous year, which was already the highest figure recorded in recent decades.[10]

People displaced within their own countries owing to armed conflict, generalized violence and human rights violations continue to constitute the majority (60 per cent) of the forcibly displaced population worldwide.[11]

At the end of 2021, the Syrian Arab Republic (6.6 million people), the Democratic Republic of the Congo (5.3 million people) and Colombia (5.2 million people) were among the countries that each had about 10 per cent of the global population of internally displaced persons.[12] In many countries in Latin America, in recent years, a substantial number of people have also been forcibly displaced as a result of violence perpetrated by organized crime groups.[13, 14]

Displaced people suffer elevated levels of social and mental health problems

Although the social and health problems experienced by people who have been forcibly displaced are not necessarily different in nature from those experienced by the general population, people who have been forcibly displaced experience elevated levels of such problems, including mental health stressors.[15] Most people affected by emergencies witness or personally experience stress, trauma, including the loss of their home and livelihood, family separation, and even violence and torture. Therefore, it is not unusual for displaced people to suffer from elevated levels of distress, including feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability and anger, although such issues may be temporary in nature.[16]

Moreover, people who have been displaced and are living in a new environment or social context may have to deal simultaneously with pre-existing social and health issues and post-displacement stressors, including stigma.[17,18] As has been observed in other population groups, there also tends to be a high degree of heterogeneity in the prevalence of mental health disorders, including substance use disorders, among displaced people.[19] Conceptually, the social and mental health problems that displaced people experience may either be pre-existing conditions exacerbated by a humanitarian emergency or the result of the protracted displacement of such people from their home environment and issues related to their placement elsewhere, both in the short and long term.[20]

Social and mental health problems faced by displaced people in humanitarian settings, by stage

	Possible pre-existing conditions	Conditions precipitated by being displaced (immediate and medium term)	Conditions resulting from protracted displacement (medium to long term)
Social problems	Low social capital, poverty, discrimination as marginalized groups	Family separation, parenting under stress, lack of safety, loss of livelihoods, disrupted social networks, low trust, limited resources, lack of food, water or shelter	Overcrowding, parenting under stress, lack of privacy, and the undermining of community or traditional support/norms and social capital (structural and cognitive)
Mental health problems	Mental health disorders such as depression, schizophrenia and the harmful use of alcohol or drugs	Grief, acute stress reactions, depression and anxiety, and PTSD; harmful patterns of substance use; no access to or continuation of treatment services	Anxiety and depression owing to the uncertainty of the situation or future prospects, stigma and fear of losing legal status (e.g. as a refugee) when seeking support for substance use problems

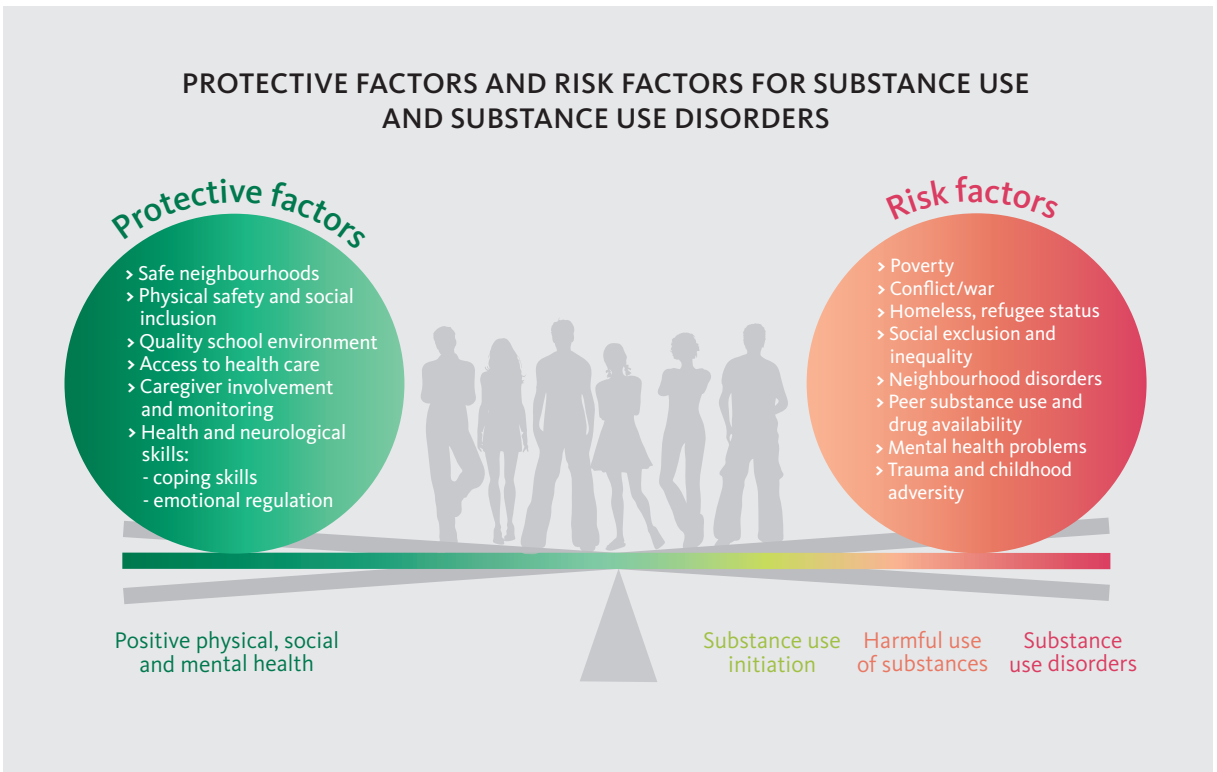
Source: Adapted from "Mental health in Emergencies" (WHO, 16 March 2022).

Displaced people experience an elevated level of vulnerability to substance use disorders

The individual, family and environmental risk and protective factors for and the aetiologies of initiation into substance use, the transition to harmful use of substances and the development of substance use disorders among displaced people are not necessarily different from those among the population at large.[21] [22] As the literature shows, significant individual, family, community and broader neighbourhood-level characteristics are in general associated with drug use and drug use disorders.[23, 24] In addition to family and individual risk factors such as pre-existing mental health issues, adverse childhood experiences such as abuse, emotional neglect and trauma are strongly associated with mental health disorders, including substance use disorders.[25, 26, 27] It is the critical combination of the presence of risk factors and the absence of protective factors that make a person vulnerable to initiation of substance use and progression to substance use disorders.[28]

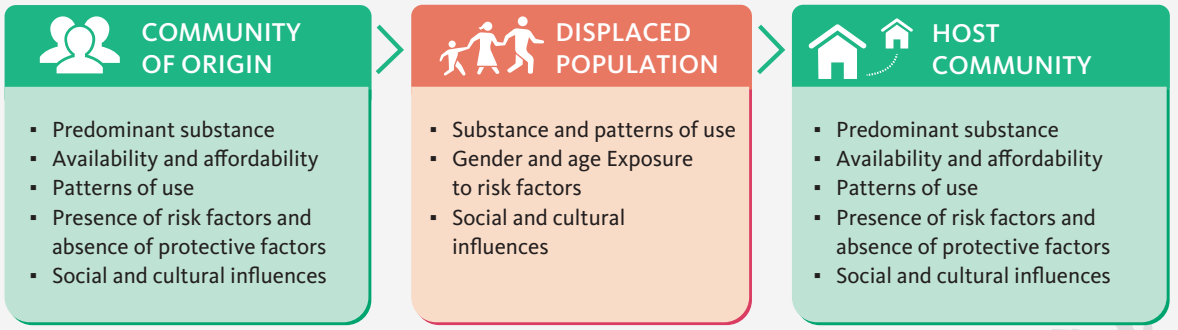
Compared to the general population, displaced populations experience an elevated level of vulnerability to substance use and substance use disorders. This may result from greater exposure to the risk factors for substance use and substance use disorders, such as family disruption and elevated levels of stress, and the absence of protective factors, such as monitoring by caregivers or a safe neighbourhood. Moreover, given that a sizeable proportion of displaced people are children, the adverse experiences they suffer and the trauma of displacement can also make them vulnerable to substance use and mental health disorders.

In addition, for displaced populations, the initiation of or the transition to harmful use of substances is complex and appears to reflect a combination of pre- and post-displacement exposure to risk and protective factors and patterns of substance use.[29] The initiation



Source: UNODC, *World Drug Report 2018*, Booklet 4, *Drugs and Age*.

FACTORS THAT INFLUENCE SUBSTANCE USE AND PATTERNS OF USE AMONG DISPLACED PEOPLE



Source: UNODC, *World Drug Report 2018*, Booklet 4, *Drugs and Age*.

to substance use and transition to harmful use of substances may also be influenced by exposure to risk factors such as trauma or traumatic events at different stages of the displacement process and during adaptation to a new environment. Post-displacement factors that may underlie the transition to substance use include a combination of psychosocial distress and stressors, such as changes in social norms and social networks, socioeconomic adversity, inequality, disrupted social networks and family support, and marginalization.[30, 31, 32, 33, 34, 35, 36]

Conversely, protective factors, including social and psychological adequacy, social norms and social and family support systems, as well as integration into the host community, can prevent substance use among displaced populations. Furthermore, the refugee or immigrant paradox, also referred to as the "healthy immigrant effect", has been observed among displaced populations, whereby immigrants or displaced people tend to use substances at levels lower than or similar to those of the host population, despite being exposed to various sociodemographic risk factors.[37, 38, 39]

Anxiety, depression and post-traumatic stress disorder are common among displaced populations

Displaced people may experience varying degrees of mental health disorders, from mild to severe. Among those affected by conflict, the burden of mental health disorders is generally extremely high. Nearly one in five people in conflict settings were estimated to be suffering from depression, anxiety, PTSD, bipolar disorder or schizophrenia in a systematic review carried out in 2019 of 129 studies conducted in 39 countries.[40] By comparison, in the same year, one in eight people worldwide was living with a mental health disorder, while about 4 per cent of the global population was estimated to be suffering from an anxiety disorder and 3.6 per cent was estimated to be suffering from depression.[41]

In another review, more than three quarters of the people who had been internally displaced by local conflicts in Iraq, the Philippines and South Africa were estimated to be suffering from PTSD.[42, 43] Moreover, nearly half of the internally displaced persons screened in the Philippines were suffering from severe anxiety[44] and severe depression.[45] Elsewhere, about 4 per cent of young internally displaced persons studied in Nigeria

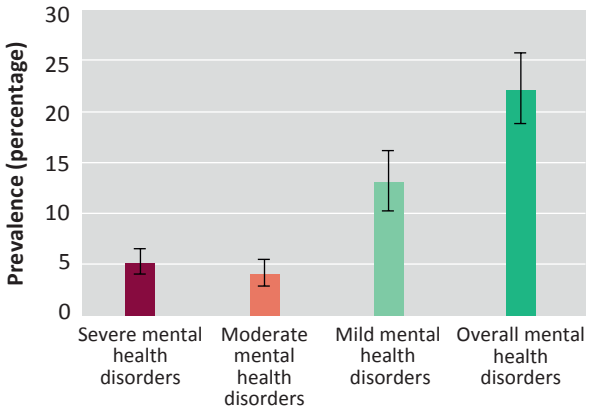
were diagnosed with severe anxiety, 25 per cent were diagnosed with moderate anxiety and 35 per cent were diagnosed with mild anxiety.[46] Another study, conducted in three cities in Colombia among the population displaced as a result of armed conflict, reported a high prevalence of mental health disorders and substance use. The past-year prevalence of mental health disorders among the study participants was 7.3 per cent in the case of PTSD, 7.1 per cent in the case of major depression and 4.2 per cent in the case of separation anxiety disorder. The diagnosis of any mental disorder was associated with being a woman and experiencing more than one forced displacement.[47] Other studies have also revealed a high prevalence of mental health disorders among displaced populations in different settings.[48, 49, 50]

Diverse patterns of substance use observed among displaced populations are not generalizable to all displaced populations

A number of studies have examined the prevalence of substance use and substance use disorders among displaced people in humanitarian settings. Most of those studies have been conducted using small, non-representative samples in different regions and have demonstrated diverse patterns of substance use among displaced populations that are not generalizable per se. Displaced populations are also diverse in nature and vary in demographic composition. The extent of substance use among displaced people, therefore, also reflects the extent and patterns of use among those demographic groups in general; for example, an overall higher prevalence of substance use among men than among women and children. In general, the extent and patterns of substance use and substance use disorders among people in humanitarian settings may be influenced by the predominant type of substance use in either their home or host country or by changes in the availability and affordability of substances.[51, 52]

One systematic global review of the literature on substance use among displaced populations, including refugees, internally displaced persons and asylum seekers, showed that the prevalence of hazardous or harmful use of alcohol ranged from 4 to 36 per cent; the prevalence of alcohol dependence ranged from less than 1 to 42 per cent; and the prevalence of drug dependence ranged from 1 to 20 per cent, highlighting the substantial heterogeneity in patterns of substance use across the studies.[53] Substance use disorders were considered more prevalent among displaced populations living in refugee camps than among displaced populations living in community settings. The studies included in the systematic review did not, however, report validated measures of the prevalence of drug use among the displaced population.[54]

FIG. 10 **Extent of mental health disorders among population affected by conflict, 2019**



Source: Fiona Charlson et al., "New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis", *The Lancet* 394, no. 10194 (July 2019), pp. 240–248.

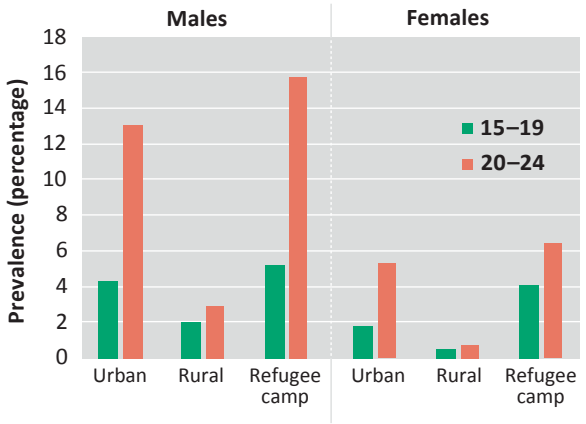
Note: People in conflict settings are a subpopulation of those displaced.

Drug use can be higher among displaced populations living in urban refugee camps than among refugees living in community settings: selected case studies

Among Palestinian young people (aged 15 to 19 and 20 to 24) living in the West Bank and East Jerusalem in 2014, the prevalence of substance use among those living in refugee camps was reported as comparable

with that among other Palestinian young people living in urban areas, but higher than substance use among those living in rural areas.[55] A total of 6.5 per cent of male and 3.5 per cent of female young Palestinians had used any drug, including cannabis, inhalants, the non-medical use of pharmaceutical drugs, heroin or cocaine, on at least one occasion.

FIG. 11 Lifetime drug use among Palestinian young people in different settings, by age group and by sex, 2014



Source: Peter Glick et al., "Health Risk Behaviours of Palestinian Youth: Findings from a Representative Survey", *Eastern Mediterranean Health Journal* 24, no. 2 (1 February 2018), pp. 127–136.

A study carried out in 2017 of high-risk drug use among Palestinians living in Gaza and the West Bank revealed that about 1.8 per cent of the male population aged 15 and above were high-risk drug users; tramadol and pregabalin were reported as the most commonly misused substances among this group. The majority of high-risk drug users in the study, living in Gaza and the south and middle regions of the West Bank, had refugee status and were either living in the urban centre or a refugee camp in those areas.[56]

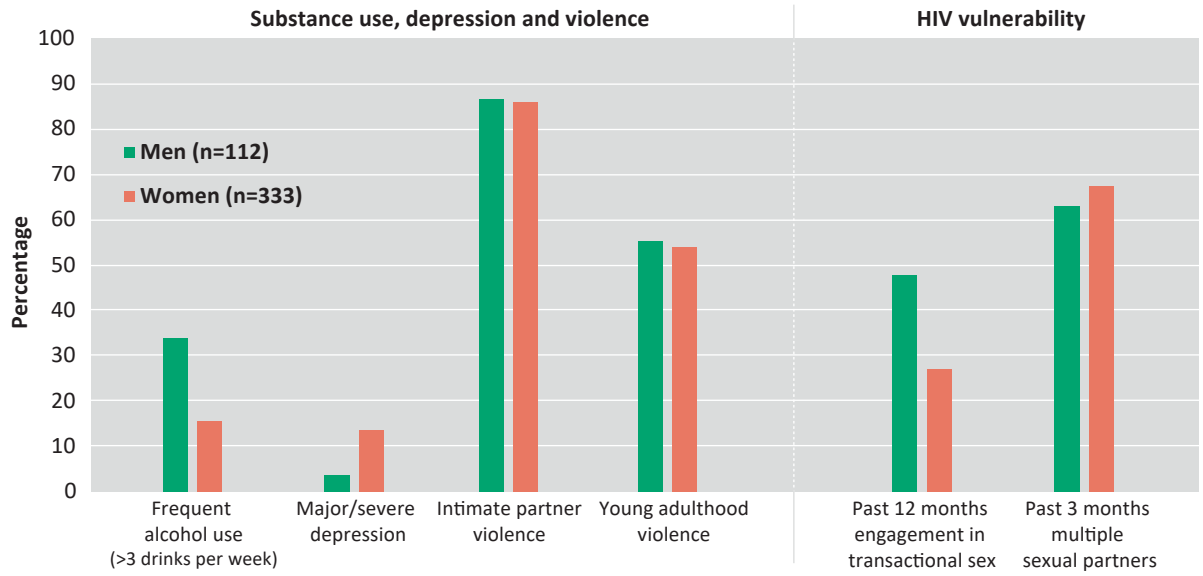
In a cross-sectional study conducted over six months in 2015, the lifetime use of substances was estimated to be higher among Palestinians born in Lebanon who were residing in refugee camps in that country than among Palestinian and Syrian adults (aged 18 and older) who had recently been displaced from the Syrian Arab Republic and were now living in refugee camps in Lebanon.[57] The same was true of the moderate and high-risk use of cannabis and cocaine in the previous three months; women had lower lifetime use of substances and substance use in the previous three months than men. It seems that the Palestinian refugees who had been born in Lebanon and who were residing in refugee camps there had adopted the substance use patterns of the host community, whereas those who had recently been displaced there from the Syrian Arab Republic partly demonstrated pre-displacement patterns of substance use and partly demonstrated the refugee paradox.

An assessment carried out in 2018 of refugees from South Sudan and Somalia living in camps in Uganda also showed that although substance use among refugees predated their displacement, in the wake of weakened parental and community control resulting from that displacement, substance use patterns among young displaced people, in particular those in urban camp settings, echoed the substance use patterns common in the host community. In urban areas of Uganda, alcohol, cannabis and khat (also known as miraa) were reported as the three most commonly used substances.[58, 59] Somali refugees in Ethiopia have also been observed to have transitioned from occasional pre-displacement use of khat to more regular or daily use of the substance following their displacement.[60]

In another study conducted in 2018 among internally displaced population groups living in camps in north-central Nigeria, about 10 per cent of the study participants had used substances (alcohol, non-medical use of tramadol, tranquillizers, amphetamines and cannabis) in the past year.[61] The extent and pattern of substance use among the displaced population did not differ from the general population in the same geographic zone, although nearly 5 per cent of the displaced people who reported using substances suffered from substance use disorders – a proportion higher than that observed in the host population.[62] The harmful use of substances among the displaced people in the study was considered a coping mechanism to deal with the traumatic experience of being forcibly displaced.

Another study, conducted in 2018 among young refugees (aged 16 to 24) living in urban camps in Uganda, reported a high prevalence of and association between

FIG. 12 Association between substance use (alcohol), depression and violence, and HIV vulnerability among young refugees in Uganda, by sex, 2018



Source: Carmen H. Logie et al., "Examining the Substance Use, Violence, and HIV and AIDS (SAVA) Syndemic among Urban Refugee Youth in Kampala, Uganda: Cross-Sectional Survey Findings", BMJ Global Health 7, no. Suppl 5 (July 2022).

Note: Substance use comprises only alcohol use.

substance use, violence and vulnerability to HIV and AIDS (SAVA syndemic) among the study participants.[63] There was also a strong association between frequent alcohol use, interpersonal violence, including young adulthood violence (at 16 years of age or younger), severe depression and transactional sex with multiple partners.[64]

Displacement caused by humanitarian emergencies can exacerbate pre-existing drug use patterns

Patterns of drug use demonstrated by Afghan refugees reflect those of their origin and host communities

Opium use has long been reported as being common among the Afghan population. A review published in 2014 revealed that opium use among Afghan refugees in the Islamic Republic of Iran and Pakistan has mirrored the pre-displacement pattern.[65] In the years following displacement, however, the pattern of opiate use among Afghan refugees changed: the use of opiates increased among Afghan youth and women, which was attributed in part to changes in social norms and in part to an intensification of their pre-displacement patterns of drug use;[66] there was a transition to the use of heroin in the form of "kerak" (a concentrated form of heroin used in the Islamic Republic of Iran)[67] and the initiation of injecting heroin use (in Pakistan and the Islamic Republic of Iran); and these patterns of use were continued upon repatriation to Afghanistan.[68, 69, 70]

An assessment conducted in 2018 among Afghan refugees living in Pakistan found that the use of cannabis, opium, heroin and methamphetamine was common. It was also found that the transition to injecting heroin use and, later, to the use of crystal methamphetamine among those refugees was associated with their mixing with the host community. Although the extent and patterns of use of various drugs among Afghan refugees were not quantified, they were assessed to be in line with those among the host population.[71]

High levels of substance use reported among the displaced population in Colombia

A study mentioned above, conducted in three cities in Colombia among the population displaced as a result of armed conflict, reported a high prevalence of substance use in addition to mental health disorders. The study showed that the annual prevalence of alcohol, tobacco and cannabis use among the study participants was respectively 46, 33 and 3 per cent. However, the pattern of substance use among the displaced population was similar to that reported among the general population in Colombia.[72]

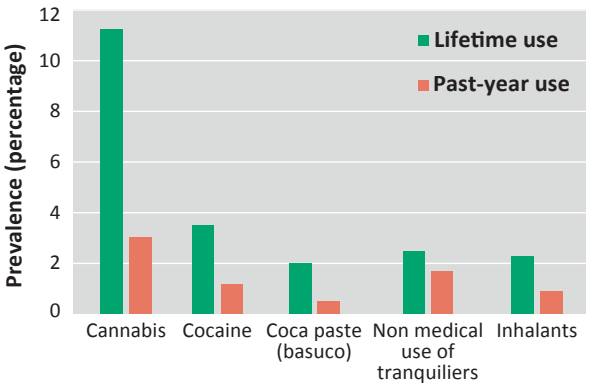
People who were displaced by Hurricane Katrina and who experienced high resource loss were more likely to increase their drug use

A study among low-income African Americans who used drugs and who were displaced to Houston, Texas, from New Orleans, Louisiana, before and after Hurricane Katrina hit New Orleans in August 2005[73] showed that those who had left the city before the hurricane hit were 1.5 times more likely to have increased their drug use than those who had been evacuated afterwards. Those who had left New Orleans before the hurricane were considered to have greater monetary resources and relational social capital than those who had left after the hurricane hit, enabling them to establish connections and maintain a relatively stable supply of drugs.

High resource loss[74] was associated with an increase in drug use among all the study participants displaced by the hurricane, whether they had left before the hurricane hit or had been evacuated afterwards. This perceived resource loss may have reflected their emotional and social attachments to the home neighbourhoods that they were forced to abandon. In line with their previous pattern of use, most of their increase in drug use was reported to be of cannabis, but there were also modest increases in the use of "ecstasy", tranquillizers and cocaine or "crack" cocaine.

Conversely, those who had been evacuated after rather than before the hurricane hit and had therefore been highly exposed to the disaster, were twice as likely to have decreased their drug use as those who had been moderately exposed to the disaster. As part of a context-related adaptive process, respondents who had been highly exposed to the disaster appeared to have adapted to their changing social environment by decreasing their drug use. The disruption and lack of accessibility of the drug market in New Orleans, in combination with the exposure of the displaced population to a new drug market or opportunities in Houston, could have contributed to their decreased or increased drug use.

FIG. 13 **Extent of drug use among the displaced population in three cities in Colombia, 2017**



Source: Castaño et al., "Trastornos Mentales y Consumo de Drogas En La Población Víctima Del Conflicto Armado En Tres Ciudades de Colombia." *Biomédica* 38 (28 August 2017): 77–92.

Adolescents displaced without their families are susceptible to higher drug use

In a study conducted in 2021 among adolescent asylum seekers (aged 11 to 18) residing in asylum centres in Serbia, about 13 per cent reported that they used alcohol, and 5 per cent reported that they used cannabis. The adolescents also reported using a range of other drugs, including amphetamines, cocaine, tranquillizers and LSD. Patterns of use across age and gender were not necessarily different from those in the host population, but older study participants (aged 15 to 18) reported using substances more than younger participants, and more boys than girls reported using different substances. Moreover, adolescents who had

travelled with strangers used substances (alcohol and other drugs) significantly more than those who had travelled with members of their family, indicating that the company of family members can be considered a protective factor against alcohol and drug use among displaced adolescents.[75]

Availability and accessibility of mental health services, including drug use disorder services, remain a challenge for displaced people

The availability and accessibility of mental health services, including drug use disorder treatment services, remain a challenge in most humanitarian settings. As a result of ongoing emergencies, violent conflict and a lack of infrastructure for providing such services, people who are internally displaced, for instance, often have limited, if any, access to health-care services.[76] Refugees face further barriers to accessing mental health services and services for the prevention of substance use and treatment of drug use disorders. Difficulties for refugees in accessing drug treatment services can stem from issues related to navigating a new and unknown health-care system, an insufficient command of the language of the host country, different views to those held in the host country about substance use disorders and their treatment, and a lack of trust in such services.[77] Moreover, the services available may not provide culturally sensitive interventions that encourage access to care within a religious and cultural context for the displaced population.[78] Furthermore, the availability of drug treatment and mental health services, especially in low- and middle-income countries, where the majority of displaced people are hosted, is often just as limited for the host population itself as for the refugee or displaced population.[79, 80]

People who have been displaced as a result of a humanitarian emergency and who use drugs or suffer from drug use disorders may experience a double stigma that acts as a barrier to accessing and utilizing substance use disorder treatment and other services. This may be the result of being part of a population group that may not be accepted by host communities or recognized by national Governments and health systems, as well as the stigma they may face because of their substance use. The intersectionality of belonging to different groups affected by marginalization and discrimination (for example, being a female refugee from an ethnic minority with a substance use disorder) may further increase stigma and suffering and act as an additional barrier to accessing and utilizing services.[81]

The actual number of recently displaced Ukrainians who use drugs and have accessed low threshold and infectious disease services in bordering European Union countries has been reported as lower than originally projected. Most of the people displaced from Ukraine were women and two thirds of those who accessed opioid agonist treatment services in Poland, for example, were women. This has raised questions regarding the availability and accessibility of gender-responsive services for women, given that the displaced women are often accompanied by children and therefore require a range of social support services in addition to opioid agonist treatment.[82]

Since humanitarian emergencies may change pre-existing risks and patterns of substance use and substance use disorders, services and interventions for people displaced by humanitarian emergencies are effective only if they address pre-existing conditions, conditions induced by emergency situations and conditions induced by being in a prolonged humanitarian crisis.

Although there have been increased efforts to integrate mental health, neurological and substance use disorder services in humanitarian settings into refugee primary health-care services over the past 10 years, overall service utilization rates for mental health and substance use disorders do not appear to have increased.[83, 84, 85] Health-care service utilization rates have been reported as being particularly low for common mental health disorders such as depression, anxiety, PTSD and substance use disorders. This may be related to the existence of different health-seeking behaviours for those disorders among refugees or because such services are often offered outside of formal health-care settings, notwithstanding the low levels of availability or uptake of such services in host communities.

Need for prevention and treatment interventions for people forcibly displaced		
Addressing pre-existing conditions	**Addressing needs in emergency situations (immediate and medium term)**	**Addressing needs in a protracted displaced situation (medium to long term)**
Addressing existing substance use disorders, precipitation of withdrawal or continuation of treatment, e.g. access to opioid agonist treatment, identification and management of withdrawal, overdose prevention, identification and management of overdose	Linking people with existing prevention and treatment servicesthat address initiation of substance use, progression to harmful use of substances and continued care for those with pre-existing substance use disorders	Long-term support; age-appropriate prevention interventions and treatment programmes; and management of social and mental health issues among the displaced and the host population.

Source: UNODC elaboration.

Source: WHO and UNODC, *International Standards for the Treatment of Drug Use Disorders: Revised Edition Incorporating Results of Field-Testing* (Geneva: WHO, 2020).

In general, the paradigm of services for the prevention of drug use and the treatment of drug use disorders is the same as in any population, in line with the public health principles of drug service provision.[86, 87] Under the holistic pyramidal structure, brief, low-level universal services and resources are made available to most people in need, at the bottom of the pyramid, and more specialized interventions be provided for those with a particularly high level of need, at the top of the pyramid.[88] There is also a consensus among experts that key principles for delivering substance use disorder treatment in humanitarian settings should, as in other settings, be centred around community engagement, the building of trust, integrated service delivery models, the reduction of stigma, the consideration of culture and context in service delivery, and an ethical, "do no harm" approach.[89]

In the context of humanitarian emergencies, the provision of food and shelter are typically prioritized. Often, the psychosocial issues experienced by displaced populations are indicators of the collective trauma and distress that they have experienced.[90] Therefore, ignoring these aetiologies in the prevention of substance use and the provision of mental health interventions can have unintended consequences, such as exacerbating existing psychosocial problems for the displaced population. As mentioned above, prevention programmes follow the same paradigm of interventions that are age-appropriate and culturally sensitive.[91, 92] Moreover, for children who have been exposed to stressful situations, such as humanitarian settings, the need for strong, healthy, nurturing caregiver relationships assumes even greater importance than in normal circumstances.[93] In this context, family programmes that build skills among parents and children and help to protect children from current and future challenges they may face in stressful situations in humanitarian settings are of the utmost importance.[94, 95, 96, 97]

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