www.druginfo.adf.org.au

DrugInfo Clearinghouse
409 King Street West Melbourne
Victoria 3003
Email: druginfo@adf.org.au

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June 2006

Prevention Research Quarterly

Current evidence evaluated

Newly arrived refugees and drug prevention

ISSN 1832-6013

ADF Australian Drug Foundation
• preventing drug problems •

State Government Victoria
Premier's Drug Prevention Council

Contents

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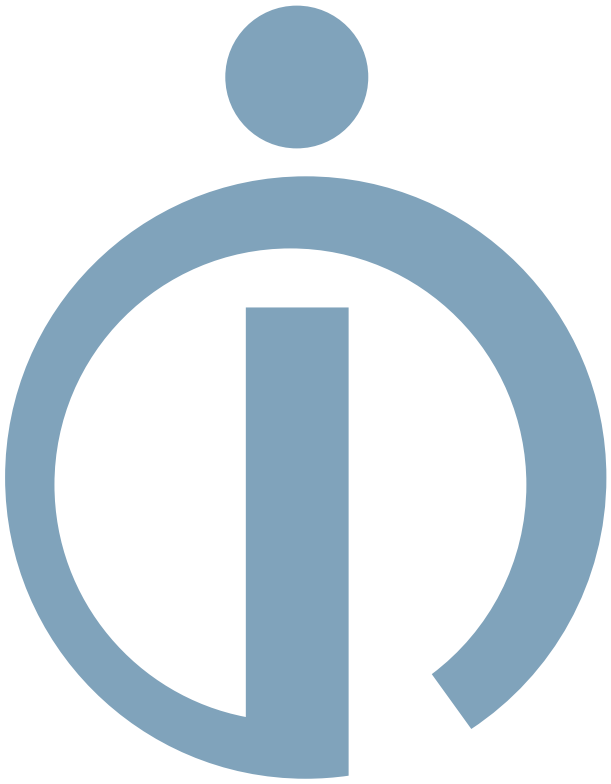

Prevention, newly arrived refugees and substance misuse

by Netzach Goren, Senior Research Officer, Centre for Youth Drug Studies, Australian Drug Foundation

Approximately three years ago, *Prevention Research Quarterly* examined drug and alcohol prevention issues for communities characterised by cultural and linguistic diversity (Rowland, Toumbourou & Stevens 2003, report number 8). The current report extends this examination to newly arrived refugees.

Given the increasing number of refugees who have resettled in Australia (Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) 2006), it is necessary to examine alcohol and drug issues within this group, and to determine which prevention strategies should be implemented to assist those in need.

The report explores reasons and potential prevention strategies for drug misuse among newly arrived refugees. Analyses of these issues are informed by international research and the small body of literature related to newly arrived refugees in Australia. Also included in the report are analyses of ten telephone interviews, conducted with key informants employed within the health and drug services who work closely with communities from the Horn of Africa.

Why the Horn of Africa?

The largest group of newly arrived refugees in Australia in recent years has come from the region commonly referred to as the "Horn of Africa" (DIMIA 2006). The Horn of Africa, or Somali Peninsula, is a peninsula on the coast of East Africa; the easternmost projection of the African continent. The term also refers to the greater region that includes the countries of Djibouti, Ethiopia, Eritrea and Somalia; Sudan and Kenya are sometimes included as well (Wikipedia 2006). In this report, "Horn of Africa" is used to refer to the countries of the region including the Sudan.

The refugee experience

It is estimated that there are 9.2 million refugees globally. Forty-seven per cent of them are children (that is, under age 18) and approximately half are aged between 18 and 59 years. In Africa, the continent that represents the largest component of the Australian Humanitarian program for young people (aged 12–24 years), more than 50 per cent of refugees are under 18 years of age (UNHCR 2005).

The United Nations (1951) convention relating to the Status of Refugees defines a refugee as:

> Any person who, owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country.

In contrast to emigrants who choose to leave their country, refugees need to escape their homeland, usually in fear of their lives. Having lost loved ones, possessions, a sense of identity and a home, many refugees are then forced to reside in refugee camps for periods ranging from several months to years.

There, they often live in dangerous and inadequate conditions (Beattie & Ward 1997; Eisenman, Keller & Kim 2000; Johnson 1996). For instance, among the accounts from some of the 330 000 southern Sudanese refugees who fled to Uganda during 1996, there are stories of young children who were separated from their families and experienced traumatic events such as deaths of friends and families, war, torture, desert treks with insufficient food and water, fear of violence and limited food in the refugee camps (Bates, Baird, Johnson & Lee 2005).

Reports focusing on newly emerging communities from Africa in Australia have confirmed that many people from these communities (for example, Somali, Sudanese and Ethiopian) have had direct or indirect experiences of trauma (Mottola 2004; Tulba Malual 2004). Although arrival at their new home alleviates immediate safety concerns, it can lead to a new set of stressors. Refugees experience difficulties associated with adjustment to a new culture and its values, and day-to-day difficulties such as adapting to different codes of dress, food, laws, language difficulties, employment-related issues and lack of understanding of social services (Holtzman & Borneman 1990; Sowey 2005; Westermeyer 2000).

Although, globally, alcohol and drug use have long been recognised as significant issues among refugees (Malzberg 1956; Malzberg 1963; Yee & Nguyen 1987; D'Avanzo, Fry & Froman 1994; van de Wijngaart 1997), in the following sections, we will try to explore how the refugee experience may heighten risk for misuse of drugs and alcohol.

Prevalence of substances misuse among newly arrived refugees

While most of the prevailing Australian research associated with intake of drugs and alcohol has been focused on mainstream society (for example, AIHW 2005), little is known about the prevalence of substance misuse within emerging communities of newly arrived refugees. The majority of studies investigating these issues have focused almost exclusively on CLD communities, rather than on newly arrived refugees. Such studies (for example, Beyer & Reid 2000; Reid, Crofts & Beyer 2001; Rowland, Toumbourou & Stevens 2003) have usually employed qualitative methodology and therefore the prevalence of drug and alcohol use within these communities is still unknown. Overall, conclusions from these studies suggest a lower prevalence of substance use among CLD communities, when compared with mainstream society. Yet, with no actual data on prevalence, more work is needed to explore the extent of substance mis/use within emerging communities of newly arrived refugees.

Refugees and substance use—possible links

The aim of the following section is to explore potential factors that may heighten the risk of misuse of drug and alcohol amongst newly arrived refugees. Given the limited local research findings regarding the link between refugee status and substance misuse, most of the literature review provided is based on international research. Furthermore, as many of the risk factors and difficulties faced by new immigrants may be comparable with those facing newly arrived refugees, we will try to identify factors that may be unique to newly arrived refugees.

As the literature suggests, many refugees have experienced different forms of trauma. For instance, between 5 and 35 per cent of the world's refugees are estimated to have been tortured (Eisenman, Keller & Kim 2000). Generally, exposure to trauma increases the risk for post traumatic stress disorder[1] (PTSD) (Agaibi & Wilson 2005; Cohen & Hien 2006; Olff, Langeland & Gersons 2005; Regan, Erwin, Hamer & Wright 2005; Santa Ana, Saladin, Back *et al.* 2006). Higher prevalence of PTSD among people who have endured an extreme life experience, compared to the general population, has been found in a large body of literature, and this also applies to refugees (Beiser, Dion & Gotowiec, 1995; Corales

1 A psychological condition occurring after a highly stressful event (such as combat, violence, or a natural disaster) beyond the usual human experience. It is usually characterised by anxiety, flashbacks, hypervigilance, recurrent nightmares and avoidance of reminders of the event.

2005; Eugenio 2005; Heptinstall, Sethna & Taylor 2004; Kinzie, Boehnlein, Leung *et al.* 1990; Savin, Sack, Clarke *et al.* 1995; Thabet, Abed & Vostanis 2004). For instance, Mollica, Wyshak & Lavelle (1987) investigated the prevalence of PTSD among Southeast Asian refugees in an Indochinese medical clinic. They found that patients had experienced a mean of 10 traumatic events, in addition to two torture experiences. Many patients met criteria for comorbid diagnoses of PTSD and depression as well as medical and social disabilities associated with their previous trauma. Interestingly, the literature also points to a link between PTSD or trauma and substance use (Chilcoat & Breslau 1998; Najavits, Weiss & Shaw 1997; Stewart 1996). For instance, a large number of clients in substance abuse clinics were found to meet criteria for the diagnosis of PTSD or to have a history of multiple traumas (see Najavits, Weiss & Shaw 1997). As previous history of trauma and diagnosis of PTSD are more common among refugees, and these confer an increased risk for drug abuse, this may be a first indication that refugees are at risk for substance misuse.

Previous international research has identified increased stress as a factor in the daily lives of new immigrants and CLD communities. This was mostly attributed to the problems associated with adjustment and acculturation to their new society (Cwikel & Rozovski 1998; Hattar-Pollara & Meleis 1995; Short & Johnston 1997). Another line of research has reported that individuals exposed to stress are more likely to abuse alcohol and other drugs (Dawes, Antelman, Vanykov *et al.* 2000; Kosten, Rounsaville & Kleber 1986). As mentioned above, refugees face many adjustments and obstacles upon arrival in their new host country. As such they are under a great deal of stress, which may contribute to their vulnerability to substance use.

Overall, while considering stress as a risk factor for misuse of drug and alcohol, the reader should bear in mind that stress is produced and exaggerated by other factors that affect the lives of newly arrived refugees, such as familial problems or unemployment. These factors will be discussed shortly. Indeed, it is important to emphasise that high stress levels are reported as a major issue for newly arrived African refugees in Australia, mostly attributed to unemployment (Tulba Malual 2004). In conclusion, although stress is a risk factor for misuse of drug and alcohol, it is not unique to the emerging communities of newly arrived refugees in Australia.

Unemployment and under-employment are other risk factors that were discussed previously with regard to CLD communities in Australia (Reid, Aitken, Beyer & Crofts 2001; Reid, Crofts & Beyer 2001; Rowland, Toumbourou & Stevens 2003). Unsurprisingly, refugees generally have a higher rate of unemployment than immigrants or Australian-born people (Stevens 2004) and it is especially high among some of the African communities (Tulba Malual 2004). This has been attributed to poor English-language skills, lack of appropriate occupational skills for an industrial society, lack of interviewing skills and recency of arrival (for a comprehensive review see Sowey 2005). While little is known about the link between drug use and unemployment among newly arrived refugees, one study found that recent job loss predicted increase in khat[2] use among Somali refugees (Turning Point 2005) . Interestingly, these researchers found that recent unemployment also led to experimentation with other drugs.

In their excellent report regarding prevention issues for CLD communities, Rowland, Toumbourou & Stevens (2003) indicated that parental and family connectedness and caring, and satisfaction with parental relationships, are important protective factors against drug and alcohol use. Furthermore, these and other researchers (for example, Beyer & Reid 2000; Groves 1993) also indicated that drug use may stem from internal problems in families from CLD backgrounds, such as isolation and separation, or loss of parental control. Similarly, many newly arrived refugees experience family traumas such as the death of one parent, or familial discord. As there is some evidence to suggest that early parental death can provoke the initiation of drug use and lead to future dependency (Groves 1993; Louie, Krouskous, Gonzalez & Crofts 1998; Von Sydow,

2 A stimulant derived from the leaves of the shrub *Catha edulis*.

Lieb, Pfister, Hoffler *et al.* 2002), disruption to family life can be considered another factor that heightens refugees' risk for drug use.

Adjustment to a Western society and removal from the traditional family structure can also lead to degeneration of remaining family relationships, and possible marital discord (Groves 1993; also see Sowey 2005). These issues have been found to increase the risk for drug use among individuals from both CLD background and newly arrived refugees, locally and internationally (Groves 1993; Tulba Malual 2004; van de Wijngaart 1997, respectively).

Reid, Crofts and Beyer (2001) indicated that ethnic communities in Victoria tended to under-utilise drug treatment services, due to a feeling of shame, fear of stigma, or lack of translation services. In addition, lack of translated material was also mentioned as a factor that may prevent drug users from CLD backgrounds from attending treatment services (Reid, Crofts & Beyer 2001; Rowland, Toumbourou & Stevens 2003). Findings from other studies that focused on newly arrived refugees found that these emerging communities generally faced similar problems (for example, Green 2004). For instance, according to Coker (2001), many health workers are not trained to deal with the specific needs of refugees. Furthermore, refugees often do not understand how to use the medical services in their new host country and therefore they under-utilise these services. Based on these findings, McCormack and Walker (2005) suggest that refugees may be more likely to self medicate. For example, a United Kingdom study (Ross Dawson 2003) identified the use of khat among refugees from the Horn of Africa as a way of coping with the cumulative stress associated with their new environment.

Further, the majority of drug prevention messages are communicated to the public in English, and so many refugees may not be aware of the drug services available. In addition, in many instances, approaching any drug services they are aware of may be considered unacceptable according to the cultural norms of different refugee groups (Silove, Steel, McGorry & Mohan 1998). Whereas community members previously may have approached community leaders to discuss their difficulties, this opportunity may not be available in their new environment. Lack of knowledge about drug-related services may also mean minimal exposure to information about the harmful effects of drugs. Lack of understanding of the Australian medical system, inability to meet medical expenses, and language barriers all contribute to the under-utilisation of drug services by emerging communities of newly arrived refugees.

Practitioners' views

A total of 10 telephone interviews was conducted with drug and alcohol workers and with general health practitioners from Melbourne and Sydney. Interviewees were encouraged to share impressions from their own perception, professional experience or direct observation. The first issue that practitioners were asked to comment on concerned the prevalence of substance use among refugees. Overall, the majority reported difficulty estimating the prevalence of substance use among emerging communities. They attributed this to the fact that it is particularly difficult to research newly arrived refugees, especially around sensitive issues such as drug use. Yet, some practitioners did argue that substance use (especially alcohol and cannabis) has increased among some communities from the Horn of Africa, and especially among the Somali community. A practitioner who works closely with some African communities shared the following information:

> … in all of those communities people have mentioned drugs as a major concern … the parents are very worried about young people about school age getting into drugs, mainly cannabis … When I speak to the young people, they also say that it's everywhere. Dope everywhere ... And of course alcohol is very commonly used as well. So it has been an issue of major concern.

Another practitioner who supports young newly arrived refugees with legal issues noted that within this specific group there was a significant problem with substance use, especially intake of alcohol and cannabis. Finally, as another practitioner stated, drug and alcohol use may be an issue for the second

generation of newly arrived refugees who may adopt some of the "bad habits" of the general population.

In a similar vein to the literature, all practitioners were quick to note that mental illness was relatively highly prevalent among newly arrived refugees and that, in many instances, clients reported symptoms associated with PTSD, such as flashbacks, nightmares, and also depression or anxiety related symptoms. However, two of the practitioners stressed that, in most cases, newly arrived refugees experienced difficulties such as unemployment or social isolation that were not present in their lives prior to their arrival in Australia, and were unrelated to previous exposure to traumatic events.

In terms of the link between substance use, mental illness and newly arrived refugees, the majority of practitioners agreed with the findings from the literature. Yet, when they were asked to indicate whether their experience in the field had given them any insights into this relationship, most were ambivalent. They related drug-use prevalence to the relatively low numbers of newly arrived refugees who attend drug services. Interestingly, one of the practitioners indicated that some of refugees may abuse pharmaceuticals due to lack of knowledge:

> I can see in women that have been more than a year here, they report symptoms of post traumatic stress … they would come and complain about nightmares or flashbacks, and also about depression. They don't call it depression; they say they have "Zat". Then, they might go to the doctor and get medication, and they have medication and they don't know what it is. Sometimes they don't understand the amount that they have to take and that might be dangerous.

All practitioners acknowledged that stress was an issue that refugees faced, and they related it to two main factors: a) the refugee experience prior to arrival to Australia; and b) the adjustment experience in their new host country. Practitioners also identified the link between stress and substance use and argued that it is important to include stress management components in workshops for newly arrived refugees. This may decrease their risk for drug misuse and may also assist them in coping with other stressors.

Consistent with the research, practitioners also noted that issues such as lack of awareness of drug services and preventative medicine, shame and stigma may prevent newly arrived refugees from receiving support or appropriate treatment. The following comments from a drug and alcohol counsellor demonstrated these issues:

> The issue is that these communities are so closed; things like mental health issues, drug use, pregnancy, it doesn't filter out. They do not even want to talk about mental health or drug issues. They might say 'we are sad, we cry a lot' but they will never say it's a mental health problem. When they come to the centre where I work, they mainly come because they have an immediate health problem. They don't have an understanding of preventative health and that is because when they were in the refugee camp, they would go to the doctor when they were sick but they didn't go for checkups. For example, many of them do not know that drug problems can be treated.

Changes in dynamics within families of newly arrived refugees and low employment rates were also recognised by practitioners as potential risk factors for misuse of substances. Interestingly, only two of the practitioners thought that low employment rates could heighten the risk for these behaviours. This was especially with regard to feelings of not being able to contribute and not having a sense of belonging. In addition, one of the practitioners stated that language barriers led to lack of success during high school which, in turn, reduces opportunities within the labour force. This, he suggested, often leads to involvement in illegal activities including drug use.

Family-related issues appeared to be very important risk factors, according to the practitioners. The majority of practitioners thought that if a family is not protected or there is familial discord, it is vulnerable and potentially open to outside influences. As a result, the children may have access to drugs and alcohol.

For instance one practitioner noted that:

> … they're young men, they're unattached or they have no family. What they discover are the cheap food and ready company, and then they discover the cheap alcohol and it can be a bit tricky for some of them after that.

In contrast, another practitioner stated that family disruption is less of an issue:

> Not necessarily. I think it's down to … a combination of social and individual factors because some people with families … drink too much as do some refugees without families.

When asked about potential protective factors, three main factors were raised: healthy social network, religion and education. Further aspects that can be regarded as protective factors, such as exposure to preventative information about drug and alcohol, will be discussed shortly. A counsellor who frequently works with newly arrived refugees described some of the protective factors:

> I think a good social network that isn't drinking can contribute as it prevents from social isolation (that may lead to substance use). If the social network is drinking that's not a protective factor. Religion can come into play here, simply because it's very anti drug and alcohol use. A lot of the Sri Lankan clans here are Hindu and they tend not to drink by and large, so that tends to discourage drinking.

The following practitioner had a different view about this issue:

> I think it's a package really, like a social package. So people who have got money to live on, stable accommodation so they don't have to think about moving … if they've got good community support and other family that is integrated and supportive, then all of those things will probably reduce the tendency to buy drugs, either the tendency to start or limit the amount of use. I believe it's the same for everybody and in fact on all the drugs and alcohol, tobacco, prescriptions, sedatives … all of those problems tend to cluster in the same groups of people.

Finally, the following quotes summarise and provide a description of some of the barriers in refugees' lives, in the eyes of a practitioner:

> I think that the trauma of leaving the country because of war and then there's the trauma of moving countries and … family stress and family breakdown … that is the other thing they mention to me a lot, that there's a lot of strife between generations and that those kids don't get to move out of home. The usual community spirit is not there because the old people, maybe they are not here and if they are here, they can't keep an eye on the kids all of the time. There's a few people, like from the Somali community, who would say, 'Yeah, you know at home everybody would look after the kids and … if there was a kid doing something wrong anyone would tell them off so they can't do that. Now things are different'.

Prevention: A review of the literature

In a review of the literature conducted by Rowland, Toumbourou & Stevens (2003) that also integrated telephone interviews with practitioners in the field, provision of further translated information and education about drugs for CLD communities was recommended. Practitioners in this study stressed the need for provision of more youth-oriented, factual information regarding the harmful effects of illicit drugs. In addition, they also recognised the importance of delivering information about legal drugs, such as over-the-counter medication, alcohol and tobacco, for older members of CLD communities (Rowland, Toumbourou & Stevens 2003). Similarly, Fountain, Winters & Patel (2003) suggest that educational campaigns within refugee communities may be useful to raise awareness of drug-related issues.

In a recent Tasmanian study investigating drug and alcohol use among newly arrived young African refugees, it was found that participants' knowledge of alcohol and marijuana safety issues was minimal (Mario-Ring, Belay, Nyiransabimana, Otto *et al.*

2005). In terms of youth services, participants lacked awareness about, and expressed minimal trust of, drug and alcohol services. It was recommended that services should integrate young African people as employees, and further promote themselves within African communities. The researchers emphasised the importance of further education provision regarding drug and alcohol issues to young African people. Based on their findings, Mario-Ring *et al.* (2005) also espoused more support for African young people in schools and more effort to supply employment opportunities for this group. Finally, it was also recommended that counsellors, particularly in schools, should receive training on refugee and trauma-related issues (Mario-Ring *et al.* 2005).

Sangster, Shiner, Sheik & Patel (2002) investigated issues relating to drug services for ethnic minority communities in Britain, and emphasised certain areas requiring change. The study highlighted the need to integrate people from different cultural backgrounds into drug service staff, including management structures. In addition, the authors recommended that services be familiar with the distinct needs, norms, codes of conduct and values of these groups. They also indicate that drug services should include education and training components for community members regarding drug and alcohol-related issues (Sangster *et al.* 2002).
A recent study by Turning Point (2005) in England aimed to explore khat use in Somali, Ethiopian and Yemeni communities, as well as potential treatment and prevention issues. As many members of these communities are refugees (Turning Point 2005) the good practice recommendations of these researchers may be valuable for policy changes around similar issues in Australia. The report provides solutions on two levels: community based solutions and mainstream service solutions.

In terms of community based solutions, like Sangster *et al.* (2002), this report highlights the need for respect and familiarity with each community's norms and values. For instance, Turning Point (2005) advocates for women-only support groups; an important step, given the prevalence of the Islamic religion in refugee communities. The need for provision of factual information about khat was also recognised. Interestingly, it was recommended that information be delivered in cafés popular with khat users, as well as in medical clinics. The latter option may access female Muslim khat users who do not attend cafés.

The report by Turning Point (2005) also indicates that it is important to train and support non-specialist Somali, Ethiopian and Yemeni workers in necessary health information and harm-reduction strategies around khat use. The importance of face-to-face community consultation involving minimal paperwork (to prevent language difficulties) was also emphasised (Turning Point 2005). Furthermore, integration of young people at risk for drug use with other existing sport and recreational programs was suggested. This study found that these communities generally rejected the traditional, individualistic United Kingdome counselling model, and thus suggested the alternative of building relationships with religious leaders and other community elders to promote cooperation with counselling and educational programs. It was also suggested that counselling from treatment services should be based on family support models, which are more appropriate for these communities. Finally, in the same vein as Sangster *et al.* (2002), this report suggests that counsellors should be familiar with and sensitive to the cultural norms of their clients (Turning Point 2005).

At the level of mainstream service solutions, Turning Point (2005) suggests that volunteers from these communities be employed within mainstream drug services and in visible positions. The importance of strengthening the links between mainstream and community services was also espoused. In addition, educating general practitioners and other health professionals about specific health and drug problems associated with each community was advised. Finally, as the problems of refugees and other community members from Africa are multifold, more focused holistic models combining drug services with mental health and social support are recommended.

Practitioners' views

All practitioners suggested that the majority of effort should be focused on education and provision of factual information about drug and alcohol-related issues. For instance, some thought that when some refugees started drinking in Australia, they had very little understanding of what was sensible consumption. This, in turn, could lead to violence, self harm and, in the long term, dependence. In addition, the majority of practitioners highlighted the importance of targeting African communities because the cultural gap is particularly large, when compared with Bosnian refugees, or other refugees.

Moreover, all practitioners thought that there was almost no translated material available for the different emerging communities. However, they recognised the fact that a significant number of newly arrived refugees, especially those from Africa, did not read and write. Potential solutions suggested included audio and visual materials (for example, CDs, DVDs) or pamphlets with pictures and minimal words, and with the appropriate information to be shown at community events or distributed to groups or schools.

The following practitioner suggested another solution:

> As many of them don't read and write anyway … it's vital to get community workers to be able to pass the message around. Although we do flyers and we translate them, I think that word of mouth is the best way and just getting community workers trained and then going to people's homes and spreading the message, that's the best way to get word out.

Another important issue that practitioners commented on was the level of sensitivity of drug and health services to the distinct needs, norms, codes of conduct and values of different refugee groups. Overall, the majority of practitioners thought that, although some organisations were very responsive, most drug and health services did not cater for specific cultural needs of these groups.

Finally, another interesting opinion came from a counsellor who specialised in working with these communities:

> That's difficult to answer, whether drug services are familiar with the distinct needs of these groups, because I don't know what information they have got there. All I know is they haven't produced anything for those communities.

When asked about funding and resources, the majority of practitioners argued that this was not the main issue. The following quote summarised the trend in practitioners' views:

> I think the multicultural health units have a lot more work to do in accessing newly arrived communities, inform[ing] them of the facilities that are available. The easy suggestion is to say, 'well, we need more money and more services,' but I don't know if that's necessarily the only solution. I think there's a lot of people not accessing the services so we're not really seeing services being stretched at the moment.

Consistent with the literature, practitioners emphasised the vital need to integrate members of the communities into mainstream services and in the design and implementation of prevention projects specifically for these communities. Many of them explained that, as the current prevention strategy is targeted towards the mainstream community, there is some ignorance of the problem and issues specifically related to these communities.

An example for such practice came from the following practitioner:

> We do always have community members that help, plan any programs that we're doing or else it won't work. You have to have that community aspect … I mean, they're the ones living in the community, they're the ones that know the issues.

Practitioners' views regarding the importance of building relationships with community leaders were explored. Although some of the practitioners were very supportive of this idea, others had some different views about this topic.

For instance, the following practitioner raised some of the negative issues associated with it:

> Sometimes there are community leaders and they are very newly arrived and they have their own settlement problems. And sometimes they belong to different clans. So the community leader might have the same connections with people in the clan but not with the other people. And there is a breakdown in communication and in the way that you disseminate information. So you have to be careful how you pass messages. It's complicated.

In a similar vein, another practitioner noted:

> … it can be important [to build relationships]. But there's a negative side to community leaders in that they can be gatekeepers to who does and who doesn't participate, and who gets the funding and such like. So we have to be aware that community leaders operate within a context and they're often self-appointed and not necessarily as magnanimous as we'd like them to be. So I think … there's a need to be astute about the political circumstances. You know political parties and affiliations cannot be ignored.

Conclusion

In the past six years, a large number of refugees have been resettled in Australia, the majority of them African. The current report is exploratory in nature and aims to investigate whether newly arrived refugees are at risk for substance use and what types of prevention strategies can be implemented to reduce the likelihood of this. In light of this aim, two methods were employed. First, a literature review was undertaken that targeted issues relating to refugees and substance use. Second, a total of 10 interviews were conducted with health practitioners working with newly arrived refugees. In the following section the findings from the literature review and interviews conducted will be combined and discussed.

To our knowledge, no comprehensive research has been conducted on the prevalence of substance use among these emerging communities in Australia. As many factors can potentially increase the risk of newly arrived refugees using drugs, it seems that there is a vital need to conduct research to document whether there are significant issues of substance misuse within these communities. Furthermore, the existence of factors that may combine to increase vulnerability to substance use, abuse and dependence, highlights the need for implementation of early prevention strategies among the first and second generations of refugees in Australia. Finally, as only 10 interviews were conducted with health practitioners, this report should be regarded as a preliminary inquiry and as a call for further research.

Overall, the existing literature and practitioners pointed out a series of factors that may heighten the risk of newly arrived refugees using drugs and alcohol. While some of them are unique to newly arrived refugees, other risk factors seem to stem from the broader immigrant experience and are relevant to other communities with CLD background.

On the individual level, for instance, previous experience of trauma, the onset of PTSD and other psychological disorders, such as depression, are the mental health factors that appear to be important risk factors for substance misuse and are quite unique to newly arrived refugees. Early detection of these factors and provision of culturally adapted counselling may assist in preventing the onset of comorbidity of psychological illness and substance use. Addition of stress management components to current programs and workshops provided to newly arrived refugees (such as recreational programs) may also equip them with productive mechanisms to cope with cumulative stress. This, in turn, may reduce the likelihood for substance use.

Cultural issues have also been identified as potential risk factors for misuse of drug and alcohol, including unwillingness to access health care services due to shame or stigma. Overall, these issues are similar to those faced by other immigrants. Yet, these are incredibly important, as lack of treatment may lead to further problems such as criminal activity or violence within their families. It seems that, in terms

of prevention, more attention to bridging this cultural gap is required.

Many newly arrived immigrants daily face adjustment-related difficulties such as language barriers and financial difficulties. These, in conjunction with family problems, seem to be of greater significance for emerging communities of refugees. While the link between these issues and drug use among refugees is not entirely clear, future research may examine this relationship. Nevertheless, it is clear that language difficulties and lack of access to, and understanding of, social services can act synergistically as risk factors for drug use, simply because these factors prevent refugees from engaging in any type of preventative medicine or harm-reduction techniques.

From the current report it appears that drug and other health services play some role in decreasing/increasing the risk for substance use among this population. Insensitivity to the cultural values and practices of these unique communities and unavailability of translators or translated material may result in lack of willingness in newly arrived refuges to participate in treatment. This matter highlights the vital need for research on the specific cultural customs and practices of these communities in order to provide them with the opportunity to obtain the best practice available.

It is highly important to research, tailor and implement appropriate prevention strategies for the emerging refugee communities. This is especially crucial given the gap that exists between these communities and mainstream Australian culture. Several creative solutions were mentioned within the present report. The first relates most to the starting point of each prevention strategy; that is, familiarity with your targeted population and awareness of their values, needs and major difficulties experienced. By doing so, practical aspects of prevention would be more effective. For instance, provision of information would be more effective if distributed in the right places, translated and provided in both written and non-written formats so that it will also be useful for people who cannot read. By educating health professionals about the different issues associated with the refugee experience, they can also play a role in early detection of drug-related problems (including mental health) among newly arrived refugees.

Consultation with and employment of people from within refugee communities at multicultural-related health services may also be beneficial. This may especially be helpful in terms of creating a more effective communication channel, exploring difficulties and helping newly arrived refugees to understand that issues such as drug problems can be treated.

Migration continues to shape Australia into a dynamic and diverse multicultural country, one with different ethnic groups and cultures. Much like members of other emerging communities, newly arrived refugees settle in Australia in order to find a better life. In contrast to other immigrants, however, being a refugee usually involves a mixture of additional challenges that increase their potential risk of drug and alcohol abuse. Therefore, careful attention should be given to this specific group in helping its members to adopt healthy lifestyles and to assist them to achieve desirable behavioural changes if necessary.

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Prevention research summaries

Summaries of key research prepared by Mr Netzach Goren, Senior Research Officer, Centre for Youth Drug Studies, Australian Drug Foundation

The first few summaries presented in this report examine substance use issues among different refugee communities. The focus then moves to the link between previous traumatic experience, mental health and substance use. The final summaries examine issues relating to adjustment for newly arrived refugees and their children. Ratings are given only for quantitative studies, and these are based on Peat (2005).

Refugees and substance use

Reid G, Aitken C, Beyer L & Crofts N 2001 "Ethnic communities' vulnerability to involvement with illicit drugs", *Drugs: Education, Prevention & Policy*, *8*:4, pp. 359–74

Key findings This paper reviewed the international literature on culturally and linguistically diverse (CLD) communities and drug intake, and described the socio-economic and cultural factors that increase the risk of people from CLD communities using illicit drugs. The paper investigated whether issues with language proficiency, employment and education applied to CLD communities in Victoria, Australia. Their findings showed that, indeed, lack of English skills, high unemployment rates, intergenerational conflicts and peer pressures are also relevant factors influencing drug use for Victorian CLD communities.

Study quality was not rated Three sources of data were used in this study: a) examination of existing data from the Australian Census about Australian ethnic groups (descriptive statistics); b) interviews with health professionals; and c) focus groups conducted with leaders from different ethnic communities. The use of focus groups and interviews seems to be appropriate when investigating newly emerging communities. However, no details regarding the number of groups conducted, type of questions asked, sampling methodology and analytical strategy were provided.

Yee BW & Nguyen DT 1987 "Correlates of drug use and abuse among Indochinese refugees: Mental health implications", *Journal of Psychoactive Drugs*, *19*:1, pp. 77–83

Key findings This early study examined the prevalence of substance abuse and its relationship to adjustment by Indochinese refugees in the United States. Participants were recruited from lists of refugees from different aid service providers and ethnic organisations. A total of 840 interviews were conducted. Alcohol and cigarette consumption were the most commonly reported forms of drug use among participants. Eight per cent of the participants reported having problems with alcohol drinking or cigarette smoking most of the time. Interestingly, approximately 40 per cent of the participants indicated that they consumed alcohol to alleviate their psychological distress and 12 and 44.2 per cent, respectively, used other drugs or tobacco. Further analyses showed that the greater the intensity of the low mood experienced by refugees, the more alcohol and other drugs were consumed. The authors suggested that adjustment difficulties, mental health issues and lack of social support increase the risk of drug use for refugees.

Study quality was low By providing evidence for high prevalence of drug use among Indochinese refugees, this early study brought to light the substance use difficulties associated with adjustment issues among refugees. This seems to be the main

strength of this study. However, a comparison of the prevalence of drug and alcohol use between this group and the general population could have provided readers with more understanding of how problematic this issue is. Unfortunately, the use of unsophisticated analytical techniques and cross-sectional design mean that the data cannot be interpreted as causative.

Turning Point 2005 *Khat use in Somali, Ethiopian and Yemeni communities in England: Issues and solutions*, viewed online on 31 March 2006, at *www.turning-point.co.uk/NR/rdonlyres/DCE45623-6456-40D4-8FEC-76BBAEC15049/29680/KhatReport_final1.pdf*

Key findings Little is known about patterns of drug use among African immigrants or newly arrived African refugees. The main aim of this study was to examine issues relating to khat use among Somali, Ethiopian and Yemeni communities in England. In light of this, three specific research questions were generated: a) to examine the nature of khat intake among members of these communities; b) to explore the competence of drug service provision to these communities; and c) to identify areas of good practice and gaps in research. Turning Point (2005) identified high prevalence of khat use among their sample (60 per cent), with 26 per cent reporting daily use. Further, khat use was identified by participants as a causative factor for family breakdown and unemployment. Interestingly, although all the drug services examined were found to employ workers from "black and minority ethnic" (a local term) communities, none of the participants had used these services.

Study quality was not rated In addition to 11 focus groups (N = 70–80), 45 interviews were conducted with members of the communities researched. Then, to obtain a broader picture, three discussion groups and two phone interviews were undertaken with drug service workers. The use of qualitative techniques enabled the researchers to gain a valuable insight into a wide range of issues associated with khat use within these emerging communities. However, it is important to bear in mind that none of these measurements was based on random sampling methodology and the sample size was not sufficient to generalise and apply the results to the populations of Somali, Ethiopian and Yemeni communities in England.

Mario-Ring A, Belay D, Nyiransabimana I, Otto J, Bangura J & Robe Z 2005 *Fun and forgetting: Alcohol and other drug use by African young people in Hobart*, Hobart: The Link Youth Health Service

Key findings This recent Tasmanian study attempted to assess prevalence of alcohol and drug use and related issues among an emerging African community in Hobart. Findings showed lower rates of drug and alcohol use among this group, compared to the equivalent Australian-born population. Yet, there was also evidence to suggest that alcohol consumption is increasing among young African communities. The research findings also emphasised the need for provision of more information about the risks associated with drug and alcohol use.

Study quality was not rated The information for this qualitative study was collected through survey, focus groups with young people and interviews with health professionals. The findings of this study could provide drug and other health services with an excellent insight into drug and alcohol-related issues for newly arrived African young people. However, the small sample size employed, the sampling framework used and the socio-demographic characteristics of participants (all were in the labour force or students) restrict these findings to a very specific population.

Exploring links between traumatic experience, mental illness, and substance use in refugee communities

Breslau N, Davis GC & Schultz LR 2003 "Posttraumatic stress disorder and the incidence of nicotine, alcohol, and other drug disorders in persons who have experienced trauma", *Archives of General Psychiatry*, *60*:3, pp. 289–94

Key findings The purpose of this extension of Chilcoat and Breslau's (1998) longitudinal study (described below) was to examine whether previous exposure to trauma among people with or without

post traumatic stress disorder (PTSD) increases individual risk for nicotine dependence or alcohol and other drug abuse or dependence. Using both retrospective and prospective lifetime data (10 years), the authors found that, while PTSD predicted the onset of nicotine dependence and abuse or dependence on drugs, previous trauma without PTSD did not. The authors suggested that comorbidity of PTSD and drug disorders may be more influenced by other underlying factors (for example, genetic) rather than by trauma per se. Implications of this study should be considered when examining the vulnerability of newly arrived refugees for drug use.

Study quality was high By using lifetime data of members of health maintenance organisations as a baseline and a longitudinal design that covered a period of 10 years (N = 899), this excellent design provided interesting evidence that trauma per se does not heighten the risk for potential onset of PTSD. Further, the high response rate of approximately 90 per cent for the completed data attest to the robustness of the results obtained. The main limitation of this study was that the use of lifetime data usually relies on medical files and retrospective reports. As such, it is prone to recall errors. In addition, although the study had a longitudinal design, as observational research it can not establish causality. Generalisation of findings should be restricted to individuals within the age range of 21–39 years.

Thabet AA, Abed Y & Vostanis P 2004 "Comorbidity of PTSD and depression among refugee children during war conflict", *Journal of Child Psychology and Psychiatry*, *45*:3, pp. 533–42

Key findings The aims of this study were twofold: to examine the association between PTSD and depressive symptoms and to investigate the relationship between traumatic events experienced by young refugees during war and PTSD, while controlling for possible depressive symptoms. Low, yet significant correlations were identified between PTSD and the number of traumatic events experienced, and moderate associations were established between measurements of PTSD and depressive symptoms. Interestingly, while depressive symptoms were strongly predicted by the number of traumatic events experienced (while controlling for PTSD), the association between number of traumatic events and PTSD was weaker (while controlling for depressive symptoms).

Study quality was moderate This study has two main strengths. A representative sample of 403 children was employed. Children were selected from four (out of eight) refugee camps in the Gaza Strip. In addition, the measurements employed were previously validated in Arabic populations. However, the study was weakened by two methodological issues. Firstly, the researchers relied solely on surveys (rather than diagnostic interviews) for diagnosis of PTSD and depression among the participants. Secondly, the PTSD measure employed in this study was based on DSM-III criteria, rather than on the current DSM-IV criteria.

Najavits LM, Weiss RD & Shaw RS 1997 "The link between substance abuse and posttraumatic stress disorder in women: A research review", *Journal on Addictions*, *6*, pp. 273–83

Key findings Najavits, Weiss and Shaw (1997) conducted a literature review that aimed to assess the link between PTSD and substance abuse generally, and specifically in women. Based on the literature, the authors identified that both disorders co-occur across different types of trauma and substances. Interestingly, they also present evidence that a family history of substance use problems heightens the risk for experience of traumatic events. In the other direction, high levels of traumatic childhood events (for example, physical or sexual abuse) were identified among women with substance-abuse problems, and comorbidity of PTSD and substance abuse was found to be more prevalent among women than men.

Study quality was low to moderate The main strengths of the findings presented in this narrative review are prevention-related. These findings point to the need to provide early prevention strategies for women who have experienced trauma, such as newly arrived refugee women. Further, important themes associated with PTSD and substance use were discussed, such as the relationship between the two, the link between repeated childhood

abuse and substance use and PTSD, and substance use in women compared to men. However, the authors of this review did not define which typed of search strategies were employed to find the articles presented. Therefore, it is unclear how comprehensive this literature was.

Chilcoat HD & Breslau N 1998 "Posttraumatic stress disorder and drug disorders: Testing causal pathways", *Archives of General Psychiatry*, *55*:10, pp. 913–17

Key findings Three research questions were investigated in this six-year longitudinal design. First, does PTSD increase the risk for substance-use disorders? Second, do pre-existing substance-use disorders heighten the risk for PTSD following a traumatic stressor event? And third, do pre-existing substance-use disorders increase the likelihood of exposure to traumatic events? With regard to the first research question, it was found that PTSD is a risk factor for developing substance use disorders (especially for prescribed drugs). Drug-related disorders were not found to increase the risk for exposure to traumatic events. Nevertheless, it was shown that pre-existing drug abuse or dependence may increase the risk for PTSD for people who are exposed to traumatic events.

Study quality was high A total of 1200 participants were randomly selected for this study from a list of 400 000 members of health maintenance organisations, and three waves of data collection were conducted over six years (N = 1007, suggesting an excellent response rate of approximately 96 per cent). In addition, the use of a sophisticated analytical strategy assisted in determining causality in relationships between the main variables. However, as the age range of the sample was 21–30 years, these findings cannot be generalised to other age groups.

Adjustment issues

Bates L, Baird D, Johnson D & Lee R 2005 "Sudanese refugee youth in foster care: The "lost boys" in America", *Child Welfare*, *84*:5, pp. 631–48

Key findings The authors undertook a thorough examination of the resettlement experience of Sudanese refugee young people placed in foster care through the Unaccompanied Refugee Minor Program in Michigan in the United States. Analyses of both qualitative and quantitative data suggested that overall adjustment to the new environment was impressive, with 91 per cent expecting to obtain a college degree and the majority reporting access to at least one source of social support. Despite these encouraging reports, several challenges were also described by the participants. PTSD symptoms were reported by many of them. The young people described their school experience as a major challenge. They indicated that schools did not properly address the distinct needs and values of different refugee groups. The report also provided findings about the challenges for both young people and foster parents within family life, and identified major characteristics of successful placements. Lessons learned from these projects can be applied in local Australian projects.

Study quality was not rated Data for this study was gathered by qualitative and quantitative methodology. Interviews and focus groups were conducted with young people (N = 33), foster parents (N = 10) and caseworkers (N = 5). In addition, to analyse the qualitative data, African transcribers familiar with the Sudanese participants' cultural norms and accents were employed. Thus, it appears that the methods and the sampling strategy used were appropriate for the aims of the study. However, qualitative analysis is prone to subjective bias, and thus is harder to interpret than quantitative techniques. However, a comparison of the difficulties reported by this sample to a United States-born matched sample could have identified whether these issues are unique to this specific group.

Hyman I, Vu N & Beiser M 2000 "Post-migration stresses among Southeast Asian refugee youth in Canada: A research note", *Journal of Comparative Family Studies*, *31*:2, pp. 281–93

Key findings By using qualitative techniques, this study aimed to identify the variety of prominent stressors in the lives of southeast Asian refugee young people in Canada. Common themes explored were: school adjustment, marginalisation, cultural conflict and stressors relating to parent–child

relationships. More specifically, adjustment to a new school and lack of English fluency, resulting in academic frustration, were found to be major sources of stress. Within families, there was some evidence for intergenerational and cultural strain, as participants perceived their parents to be very strict and not open to different ideas of modern Canadian society. The focus on children of refugees and the recognition of multiple stressors experienced by them is an important line of research that may help to improve sensitivity to their distinct cultural needs in schools and other mainstream services.

Study quality was not rated Data collected for this study were based on individual interviews (N = 16) and three focus groups (with the same participants)—a very small sample size. Nevertheless, as many of the findings obtained in this study are consistent with f,indings obtained in other studies, the results of Hyman and Beiser (2000) could potentially have some important implications for both future research and future policy addressing these issues.

Reading and resource list

This list of selected recent resources does not aim to be comprehensive; rather it is intended to be a starting point in your research. The list is sorted chronologically and by author within each section. These selected resources are all available in the DrugInfo Clearinghouse. For more information please check the library catalogue, or contact us on email *library@adf.org.au*.

Articles

Holleran L, Taylor-Seehafer M, Pomeroy E & Neff J 2005 "Substance abuse prevention for high risk youth", *Alcoholism Treatment Quarterly*, *23*:2/3, pp. 165–84

This pilot study explores issues of culture and alcohol and other drug use in relation to substance abuse prevention with high-risk young people, with a particular interest in Latinos/as and acculturation. Implications for prevention, intervention and future research are discussed. (Haworth)

Lee JP & Kirkpatrick S 2005 "Social meanings of marijuana use for Southeast Asian youth", *Journal of Ethnicity in Substance Abuse*, *4*:3/4, pp. 135–52

Findings from this study suggest that second-generation South East Asian young people locate themselves in opposition to their parents as well as mainstream United States society. Smoking marijuana can be a way of handling the stress of this social situation.

DrugInfo Clearinghouse no vf LEE 05

McCambridge J & Strang J 2005 "Can it really be this black and white? An analysis of the relative importance of ethnic group and other sociodemographic factors to patterns of drug use and related risk among young Londoners", *Drugs: Education, Prevention and Policy*, *12*:2, pp. 149–59

Multiple and logistic regression analyses are undertaken to study the relative significance of potential sociodemographic predictors of drug-related risk. Age, gender and educational attainment are all identified as being associated with some aspects of risk, but found to be much less influential than ethnic group. Young white people are found to be at particularly high risk in relation to levels of consumption of stimulants and other drugs. (Taylor and Francis)

Steel Z, Silove D, Chey T, Bauman A & Phan T 2005 "Mental disorders, disability and health service use amongst Vietnamese refugees and the host Australian population", *Acta Psychiatrica Scandinavica*, *111*:4, pp. 300–309

This study aimed to compare the prevalence of common mental disorders, disability and health service utilisation amongst Vietnamese refugees resettled in Australia for 11 years. The findings suggest that refugee groups resettled for some time in Western countries may show sound mental health adaptation and do not necessarily impose a burden on general or mental health services. (Blackwell)

Amodeo M, Peou S, Grigg-Saito D, Berke H, Pin-Riebe S & Jones LK 2004 "Providing culturally specific substance abuse services in refugee and immigrant communities: Lessons from a Cambodian treatment and demonstration project", *Journal of Social Work Practice in the Addictions*, *4*:3, pp. 23–46

A discussion of Project Sangkhim, in the United States. Recommendations for refugee and immigrant populations include education about addiction as a treatable illness, the siting of treatment programs in non-stigmatising settings, the combination of domestic violence and addiction treatment, non-verbal treatments, and professional training for community members to become independent providers.

DrugInfo Clearinghouse no. vf AMODEO 04

Marsiglia FF, Kulis S, Hecht ML & Sills S 2004 "Ethnicity and ethnic identity as predictors of drug norms and drug use among preadolescents in the US southwest", *Substance Use and Misuse*, *39*:7, pp. 1061–94

This article reports the results of research exploring how ethnicity and ethnic identity may "protect" adolescents against drug use and help them form antidrug use norms. This study was conducted in 1998 and found that positive ethnic identity (that is, strong ethnic affiliation, attachment and pride) was associated with less substance use and stronger antidrug norms in the sample overall. (Taylor and Francis)

Ross AJ, Heim D, Bakshi N, Davies JB, Flatley KJ & Hunter SC 2004 "Drug issues affecting Chinese, Indian and Pakistani people living in Greater Glasgow", *Drugs: Education, Prevention and Policy*, *11*:1, pp. 49–65

This paper describes research on drug issues affecting Chinese, Indian and Pakistani people living in the Greater Glasgow area of the United Kingdom. Predictors of drug use include gender, non-importance of religion and higher consumption among friends from the same ethnic group. Service provision was felt to be insensitive to issues affecting Chinese, Indian and Pakistani groups. Specific issues that need to be addressed by service providers are outlined. A general conclusion is that choices should be available, and stereotypes and general assumptions should be avoided. (Taylor and Francis)

Verdurmen JEE, Smit F, Toet J, Van Driel HF & Van Ameijden EJC 2004 "Under-utilisation of addiction treatment services by heroin users from ethnic minorities: Results from a cohort study over four years", *Addiction Research and Theory*, *12*:3, pp. 285–98

In this study, the hypotheses were tested that retention rates, days spent in methadone treatment and upward mobility to outpatient and inpatient treatment modalities for heroin-dependent people in a methadone program are lower for clients from ethnic minorities as compared with the clients from the ethnic majority. No differences were found between ethnic minorities and the Dutch clients in their use of outpatient treatment. (Taylor and Francis)

Breslau N, Davis GC & Schultz LR 2003 "Posttraumatic stress disorder and the incidence of nicotine alcohol, and other drug disorders in persons who have experienced trauma", *Archives of General Psychiatry*, *60*:3, pp. 289–94

The findings do not support the hypothesis that exposure to traumatic events per se increases the risk for substance use disorders. A modestly elevated risk for nicotine dependence might be an exception. Post traumatic stress disorder (PTSD) might be a causal risk factor for nicotine and drug use disorders or, alternatively, the co-occurrence of PTSD and these disorders might be influenced by shared risk factors other than traumatic exposure. (PubMed)

Brune M, Haasen C, Yagdiran O& Bustos E 2003 "Treatment of drug addiction in traumatised refugees", *European Addiction Research*, *9*:3, pp. 144–6

The comorbidity of PTSD and drug addiction is quite often overlooked in refugees. However, the simultaneous treatment of both disorders is of elemental importance for a positive outcome in addicted and traumatised refugees. Furthermore, mutual misinterpretations of habits, behaviours and reactions through negligence of the distinct sociocultural context of patient and clinician often leads to unfavourable developments. (Karger)

Finch BK, Catalano RC, Novaco RW & Vega WA 2003 "Employment frustration and alcohol abuse/dependence among labor migrants in California", *Journal of Immigrant Health*, *5*:4, Oct., pp. 181–86

The authors test whether or not labour market frustration is associated with clinical alcohol abuse or dependence diagnoses among labour migrants living in California in the United States. The sample consists of 1576 Mexican labour migrants seeking employment. The findings show that frustrating experiences resulting from labour market exclusion and discrimination are significantly related to past-year alcohol abuse and dependence. (Springer)

Kalunta-Crumpton, A 2003 "Problematic drug use among 'invisible' ethnic minorities", *Journal of Substance Use*, *8*:3, pp. 170–5

The concern about white minority ethnic groups draws upon a study of problem drug use and race or ethnicity conducted at a London drug project in 2000–01. While this paper focuses on the Portuguese and Italian clientele of the drug project, it also provides data on a control group of indigenous white (English, Scottish and Welsh) clientele of the drug project for comparison. Findings show points of convergence and divergence in the social needs of clients across the three ethnic groups. (Taylor and Francis)

Tompkins CN, Wright NM, Sheard L & Allgar VL 2003 "Associations between migrancy, health and homelessness: a cross-sectional study", *Health & Social Care in the Community*, *11*:5, Sept., pp. 446–52

This research was conducted at an inner-city health centre for the homeless in the north of England. Place of birth was created as an entry on the computerised registration records. The study identified statistically significant differences for the migration of homeless people, problematic drug use and problematic alcohol use. Understanding the migration patterns of homeless people is important when planning and targeting appropriate health and social services to address their varying health, social and psychological needs. (Blackwell)

Alaniz ML 2002 "Migration, acculturation, displacement: migratory workers and "substance abuse", *Substance Use & Misuse*, *37*:8–10, June–Aug., pp. 1253–57

A diverse group of researchers came together to compare and contrast the substance use and "abuse" practices and patterns of marginalized groups in their region of the world. It was agreed that substance use is not only a process of adaptation but also a coping mechanism in, for the most part, hostile and unwelcoming environments. It is also noted that "abuse" of substances is not common to traditional cultures. Migration to a more modern society was accompanied by initiation and/or increase in substance use. (Taylor and Francis)

Nsubuga-Kyobe A & Dimock L 2002 "Drug and alcohol abuse" in *African communities and settlement services in Victoria. Towards best practice delivery models*, Canberra: Department of Immigrations and Multicultural Affairs, pp. 113–14

Discusses concerns among African Australians about the use of drugs and alcohol, particularly their abuse by young people. There is brief mention of African women and drug abuse and addressing dilemmas faced by community service providers

DrugInfo Clearinghouse no. vf NSUBUGA 02

Reid G, Aitken C, Beyer L & Crofts N 2001 "Ethnic communities' vulnerability to involvement with illicit drugs", *Drugs: Education Prevention and Policy*, *8*:4, pp. 359–74

In this literature review and Victorian research study, socioeconomic and cultural factors that heighten vulnerability to involvement with illicit drugs and disproportionately impact upon ethnic minority communities are described. Several factors that increase vulnerability to illicit drug use were identified in the literature review; our research showed that the same determinants are at work among ethnic minority communities in Victoria. Vulnerability is compounded by poor knowledge of drug treatment services, and difficulties in gaining access to them. (Taylor and Francis)

DrugInfo Clearinghouse no. vf REID 01

Nemoto T, Aoki B, Huang K, Morris A, Nguyen H & Wong W 1999 "Drug use behaviors among Asian drug users in San Francisco", *Addictive Behaviors*, *24*:6, pp. 823–38

This study identified patterns of drug-use behaviours in relation to cultural factors among Asian drug users in San Francisco, in the United States. The study evaluated responses of the participants and, using content analyses, revealed that the patterns of drug use among Asian drug users are unique to their ethnicity, gender, immigrant status and age groups. In addition, Asian drug users share cultural constructs related to drug use such as fear of addiction and injecting drugs, and stigma attached to drug users in the community. (Taylor and Francis)

Chilcoat HD & Breslau N 1998 "Posttraumatic stress disorder and drug disorders. Testing causal pathways", *Archives of General Psychiatry*, *55*:10, pp. 913–17

There was no evidence that preexisting drug abuse or dependence increased the risk of subsequent exposure to traumatic events or the risk of PTSD after traumatic exposure. The results suggest that drug abuse or dependence in persons with PTSD might be the inadvertent result of efforts to medicate symptoms, although the possibility of shared vulnerability to PTSD and drug use disorders cannot be ruled out. (PubMed)

Johnson TP 1997 "Sustance use among homeless, immigrant, and refugee populations: An international perspective. Introduction", *Substance Use and Misuse*, *32*:7–8, pp. 793–803

This article is an introduction to a special issue on an international perspective on substance use among homeless immigrant and refugee populations. Articles include: South East Asians at risk, ethnic differences in substance abuse among first-generation migrants, homeless migrants, vulnerability of migrants and refugees with alcohol problems, and the availability of resources. A comprehensive collection of papers on the subject.

Books and reports

Sowey H 2005 *Are refugees at increased risk of substance misuse?*, Redfern: DAMEC

This report is a snapshot of available evidence of alcohol tobacco and illicit drug use by young people from non-English speaking backgrounds in New South Wales. The author discusses the evidence concerning whether refugees are at increased risk of substance abuse.

www.damec.org.au/Resources/NESBY.pdf

DrugInfo Clearinghouse no. MA6 SOW

Hayes C (ed.) 2003 *Promoting the mental health and wellbeing of new arrival communities, learnings and promising practices*, Carlton South: VicHealth

This is a report on the progress of 11 projects, funded by the VicHealth Mental Health Promotion Plan, focusing on migrants and refugees who have recently arrived in Australia.

DrugInfo Clearinghouse no. MA6 VHPF

Pedersen PB, Draguns JG, Lonner WJ, Trimble JE (eds) 2002 *Counseling across cultures*, Thousand Oaks, CA: Sage

This book looks at counselling a range of cultural groups within the United States community, including refugees. School counselling, spiritual issues, health psychology and conducting research in cross-cultural and multicultural counselling are all covered. Although it is focused on the United States, this book is still relevant to Australian communities.

DrugInfo Clearinghouse no. ADF MA6 PED

Audiovisual

Fremantle Migrant Resource Centre 1997 *Counselling across cultures: Working with people of migrant and refugee backgrounds*, Fremantle: Fremantle Migrant Resource Centre

Cultures influence our behaviour in many ways. We are raised to certain beliefs, customs and traditions, and this in turn reflects in our behaviour. Culture needs to be recognised when working with clients and their families in order to provide a program that will be accepted by all those involved. This video training kit argues that, to ensure the delivery of appropriate and effective services, providers must firstly understand and then practice the principles of cross-cultural counselling.

DrugInfo Clearinghouse no. VID JZ10 COU

Prevention Research Quarterly: current evidence evaluated
ISSN 1832-6013

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DrugInfo Clearinghouse
Australian Drug Foundation
409 King Street, West Melbourne, Victoria 3003 Australia
Tel. 1300 85 85 84 (Victoria only)
Email: **druginfo@adf.org.au**
Web: **www.druginfo.adf.org.au**

Any enquiries or comments on this publication should be directed to the Publishing Manager, DrugInfo Clearinghouse, at the above address.

Centre for Youth Drug Studies

The research presented in this publication represents work done on behalf of DrugInfo Clearinghouse by the Centre for Youth Drug Studies (CYDS) at the Australian Drug Foundation. The work of CYDS on this research is supported by an expert advisory group, the members of which are all highly regarded in their respective fields for their work in drug prevention research, led by Associate Professor John W. Toumbourou of the Centre for Adolescent Health, The University of Melbourne.

DrugInfo Clearinghouse is an initiative of the Australian Drug Foundation and the Victorian Premier's Drug Prevention Council.

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