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Drug and Alcohol Multicultural Education Centre

**Are Refugees at Increased Risk of Substance Misuse?**

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## **Are Refugees at Increased Risk of Substance Misuse?**

This paper investigates various sources of evidence in order to address the question of whether refugees are at increased risk of substance misuse. The existing published literature on substance misuse amongst refugees is reviewed, models which have been developed to account for substance misuse amongst refugees are described, and the few surveys which have been undertaken to assess the aetiology and extent of substance misuse in particular refugee populations are examined.

The stressors experienced by refugees in the areas of trauma, loss, adjustment and disadvantage are examined. These stressors place refugees at an increased risk for mental health problems, which in turn increase risk for substance misuse (Teesson & Proudfoot, 2003). Particular attention is paid to the increased risk of post-traumatic stress disorder (PTSD), the psychological disorder most commonly associated with refugee status (D'Avanzo, 1997). The relationships which have been established between trauma exposure, PTSD and substance misuse are investigated.

Aetiological studies of adolescent substance misuse are also considered, and relationships sought between the risk factors identified in these studies and the vulnerabilities identified amongst refugee youth.

Finally, information gained via recent consultations with African refugees and community workers in Australia is summarised. It is demonstrated that the risk factors described in the refugee literature are indeed present in this community. Further characteristics are identified which are unique to this group and appear to place them at even greater risk of psychological distress and substance misuse.

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### **1. Substance Use Amongst Refugees: Models and Examples**

Any migrant must face the difficulties associated with such a major life change and will struggle to some extent with adapting to life in a new country. Refugees are no exception. They, however, must also confront the additional burden of coming to terms with the circumstances that forced their relocation (Johnson, 1996).

One model of migrant substance use is the Assimilation/Acculturation Model (Johnson, 1996). According to this model, as people become assimilated or acculturated into their new society, they adopt the social norms of the new country with regards to their alcohol and other drug use. The possibility of substance misuse increases if the new host country has a more positive or lenient attitude to alcohol and drug use than the motherland. There is some evidence to support this model (e.g. D'Avanzo, 1997; Johnson, 1996; Vega, 1998).

Evidence has, however, also accumulated in favour of an alternative model, the Acculturative Stress Model (Johnson, 1996). This model is premised on the idea that adjusting to a new country is a stressful life experience. The stress of adjusting, particularly when both internal and external coping resources are scarce, contributes to the development of substance use problems.

This model would appear to be particularly applicable to at-risk populations such as refugees who have to cope not only with the burden of adjustment, but with multiple other stressors as well. Amongst refugees, substance misuse could be related to stressful events experienced in the homeland (e.g. being a victim of torture), in refugee camps (e.g. witnessing violence), or in the new host country (e.g. experiencing culture shock) (Johnson, 1996; Gonsalves, 1992).

Van de Wijngaart (1997) reports that there are hardly any systematic data available about substance use among cultural minorities, and D'Avanzo (1997) notes that refugee groups have rarely been interviewed. It is difficult to ascertain the prevalence of substance use disorders, or the extent to which the various stressors experienced by refugees might contribute to such disorders.

Where refugees have been studied, it seems difficult to generalise across the results (Johnson, 1996; D'Avanzo, 1997). Differences arise in the nature of the crisis the refugees were fleeing, the nature of their flight, how they were received by their new society, and the degree of cultural similarity with their new host country. Cultural differences in the way the refugees interpret and respond to stress also serve to hinder comparison (Gonsalves 1992; Johnson, 1996; Terheggen et al., 2001).

What follows is a more detailed examination of the refugee groups which have been investigated to date. What is known about the prevalence of substance misuse within these groups is presented, along with any aetiological factors which have been identified. Research into these groups has for the most part been undertaken in the United States of America.

#### Indochinese refugees (Yee & Thu, 1987)

In reviewing the literature, Yee & Thu (1987) cite some studies which lend evidence to the Assimilation/Acculturation Model of substance use, demonstrating that after migration the substance use patterns of refugees change to more closely resemble those of mainstream America. However, the weight of evidence appears to fall on the side of the Acculturative Stress Model, with a particular emphasis on the stressors experienced in the new country (as opposed to those experienced in the homeland or during flight). The authors state: "Substance abuse is used as a coping mechanism for dealing with adaptation to a foreign and sometimes hostile social or cultural environment" (Yee & Thu, 1987, p.78).

Yee and Thu (1987) note some variables which help determine an individual's choice of intoxicant. They state that age is of relevance, for instance young refugees are more likely to use drugs (other than alcohol) than older refugees. Culture is also an important variable, for example Taoists are more likely to use opium than alcohol, as losing control over one's behaviour (as may happen when drunk) is incompatible with the Taoist principles of moderation.

In their own survey of 840 refugees (90% Vietnamese), Yee and Thu found that

- 45% had trouble with tobacco or alcohol some of the time
- 8% had trouble all the time
- 14% had trouble with other drugs some of the time.

When they inquired as to whether people used substances to help deal with their sorrows or problems

- 44% reported using tobacco sometimes, 12% a lot
- 40% reported using alcohol sometimes, 6% a lot
- 12% reported using other drugs sometimes, 0.5% a lot.

There was a correlation between using substances as a coping mechanism and having trouble with substance use.

Yee and Thu perceive an increase in alcohol and other drug use to be a symptom of psychological distress, and state that Indochinese refugees may be turning to substances when the stresses and strains of living in the United States become overwhelming. They conclude that, for the population of highly traumatised Indochinese refugees, adjustment and mental health problems, combined with a lack of institutional support, may be among the primary reasons for the use of psychoactive substances.

#### Hmong opium addicts (Westermeyer et al., 1989)

In the early 1980s regular opium use amongst Hmong<sup>1</sup> refugees began to be reported in the US, a country which had not seem opium smoking for several decades. Some Hmong had started to present themselves at treatment clinics.

Westermeyer et al.'s (1989) investigation of 55 refugees revealed that some had been identified as opium-dependent before they entered the US, yet were nonetheless admitted into the country (in breach of US law). Other refugees (mostly younger ones) had not previously smoked opium but had been introduced to it in the United States by older relatives. The study presented further evidence of lax enforcement of United States' laws regarding opium growing and smuggling.

Due to difficulties in accessing health care, the Hmong were turning to folk-healing methods, some of which included opium use. Hmong opium addicts in the United States commonly had low levels of literacy and were likely to be unemployed, with work skills which were irrelevant to the industrialised US society. Westermeyer et al. (1989) declared that "failure in their adjustment to the US – if it occurs – sets the stage for addiction" (p. 787).

In his overview of addiction among immigrants and migrants, Westermeyer (1996) notes that there is often a time-lag of 5 to 10 years before any substance abuse emerges. Similarly, Yee & Thu (1987) comment that refugees' initial adjustment period (of months to several years) is spent simply surviving, and that substance use disorders do not tend to arise until after this time, when basic survival needs have been met and issues of acculturation become overwhelming.

#### Cambodian women (D'Avanzo et al., 1994)

The investigators studied 120 Cambodian refugee women living in Massachusetts and California. Differences were observed between the East and West coasts. In Massachusetts, 45% of women reported they used alcohol for nervousness, stress, headaches, insomnia or pain, and 15% reported that a family member used street

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<sup>1</sup> The Hmong are a highland Laotian tribe.

drugs and was having a dependency problem. In California, on the other hand, alcohol and street drugs were not seen to be problematic, however, 58% of Californian women interviewed reported misusing prescription drugs, most often describing their intention as being to enter into an altered state. In both East and West coast groups, when women reported an alcohol problem in the family, it was most likely to be the husband who was the problem drinker.

D'Avanzo et al. (1994) point out that Cambodian refugees have endured multiple stressors, and offer examples of both pre-migration and post-migration stressors. They conclude that these stressors are likely to increase refugees' risk for substance abuse.

#### Vietnamese refugees in Hong Kong (Reynolds, 1995)

Reynolds quotes estimates that at least 90% of the 738 male Vietnamese refugees aged 17 years and over living in or outside the Pillar Point refugee camp in Hong Kong were using heroin or were heroin dependent. Five percent of the 437 women aged 17 and over were known to be drug users or drug dependent. Reynolds also notes parallels between the situation of these refugees and American soldiers who served in Vietnam, many of whom became heroin-dependent whilst in the highly dysfunctional and unusual environment of combat, but recovered by natural processes once they were removed from this environment.

#### Black Surinamese women in the Netherlands (van de Wijngaart, 1997)

Van de Wijngaart surveyed 12 female Surinamese drug users and 13 workers. He notes that refugees' disadvantaged situation in society often leads to drug problems.

Factors cited as contributing to drug use include adjustment difficulties, and the gradual weakening of the traditional family structure. Drugs which in the country of origin were used in a highly ritualised way were now used to alleviate pain and sorrow, or to induce sleep. Addiction was more likely to develop in this context where social control was lacking.

The author explains that being unable to enter the highly structured Dutch job market, Surinamese people continued the "free-trade" street culture of their home country. In the Netherlands, however, this is a "grey" circuit, well suited for drug-dealing, and for many Surinamese men it became their entrée into the heroin "scene".

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This exploration of the literature reveals that there is much work yet to be done to discover the full extent of substance abuse within refugee populations. Research completed to date demonstrates that substances are indeed used and also misused by refugees. The types of substances and the patterns of use vary, but the contributing stressors are common across most refugee groups (D'Avanzo, 1997; van de Wijngaart, 1991). In the following section, these stressors are examined in greater depth.

## **2. Stressors Experienced by Refugees**

### **Trauma**

People fleeing war-torn countries have usually had multiple experiences of trauma (Tai-Ann Cheng & Chang, 1994). They may personally have been the victims of organised terror, suffering torture, rape or imprisonment, or else they may be the friends or relatives of others who have. Exposure to violence, repression and the experience of extreme powerlessness are themselves psychologically traumatic events (van de Wijngaart, 1997).

The experience of persecution leads refugees to flee or to be forcibly displaced. For most this flight is precipitous, and the resulting disruption and family separation are traumatic (Johnson, 1996; van de Wijngaart, 1997; Yee & Thu, 1987).

Many people fleeing persecution have spent months or years in intermediary refugee camps. Conditions in these camps (which are usually run by international aid organisations) are variable, but are often unclean, unsafe, impoverished and desperate (Johnson, 1996). Recurring memories of recent trauma, uncertainty about the future and the general monotony of existence take their toll.

Refugees also frequently hold grave fears for their friends and relatives still in their homeland, and have great difficulties in communicating with them (Silove et al., 1998). They may also be afflicted with “survivor guilt” (D’Avanzo, 1997).

### **Loss**

Losses for refugees start in their country of origin, when possessions and homes are seized, loved ones are killed, and in some cases the entire country is destroyed (D’Avanzo, 1997; Fazel & Stein, 2003). In flight and even when settled in the new host country, refugees may feel uprooted, homesick and acutely aware of the loss of social networks (Johnson, 1996; van de Wijngaart, 1997). In this situation it is difficult to maintain traditions and rituals from the home culture, and with this comes the loss of traditional social controls (for example, those surrounding the acceptable use of alcohol and other drugs) (van de Wijngaart, 1997). Eisenbruch (1991) writes of a “cultural bereavement” experienced by refugees, acknowledging the existential pain of refugees which “has to do with difficulties in recapturing the lost past and ultimately with the survival of their culture” (p. 677).

### **Adjustment and Acculturation**

In the country of asylum, refugees experience the same difficulties as other migrants in adjusting to life in a different cultural environment. For refugees, however, the difficulties of successful adjustment are compounded by the trauma and loss they have already experienced (Johnson, 1996; Yee & Thu, 1987). Moreover, refugees often come from more “distant” cultural contexts than other migrants, and are often ill-prepared for life in Western culture. They may come from rural backgrounds, yet are usually resettled into urban settings (D’Avanzo, 1994). The greater the difference between old and new cultures, the higher the level of interpersonal stress and culture shock (Tai-Ann Cheng and Chang, 1999).

Crossing the cultural distance to arrive in the host country means giving up valued social roles, identities and occupational positions. These are not easily regained,



especially in the face of language difficulties which make it difficult to find employment. Another barrier is illiteracy in the mother-tongue, (a common occurrence), which hinders acquisition of the new language, and of learning in general (D'Avanzo, 1997; Johnson, 1996; Reid et al., 1992).

Refugees are forced to adjust to the new culture as best they can, in the absence of traditional coping mechanisms (e.g. traditional community structures for problem-solving) (Yee & Thu, 1987). The pressures of adjustment can lead to marital discord, which is often exacerbated by new gender role expectations (even role reversals) in the new country (Gonsalves, 1992). Domestic violence may arise, as the effects of violence experienced in the home country and in flight are played out within the family home (Burnett & Peel, 2001).

There may also be unfamiliar expectations in the new society regarding parent-child relationships. Coupled with the fact that children typically adjust to new environments more quickly than do their parents, this can lead to child-rearing problems, inter-generational conflict, and family breakdown (Ascher, 1984; Reid et al., 1992).

Added into the mix may be anger, grief, social isolation, loneliness and boredom (Tai-Ann Cheng & Chang, 1999; van de Wijngaart, 1997). Refugees often confront these emotional problems alone, unaware of the services which exist to help. Even if they are advised about existing services, they are often unwilling to discuss problems because they are too painful, or because it is not culturally acceptable to raise these issues outside the family (Gonsalves, 1992; Silove et al., 1998).

It is not surprising, then, that refugees sometimes experience "acculturation failure" (Westermeyer, 1996).

### **Disadvantage**

Refugees are a disadvantaged group in society. They may be marginalised or discriminated against on the grounds of their race, ethnicity or religious affiliation (Johnson 1996; Reid et al., 1992; Silove et al., 1998; van de Wijngaart, 1997). This is particularly likely to occur in localities where the influx of large numbers of refugees has changed the ethnic identity and social structure of the area (D'Avanzo, 1997).

If their job skills are not relevant to an industrialised economy, refugees are likely to remain unemployed and therefore economically disadvantaged for some time. Those who arrive with large families are under particular financial pressure, which is intensified if they are committed (by cultural expectation) to send money back home (D'Avanzo, 1997).

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The stressors upon refugees are multifold. Gonsalves (1992) suggests that treatment for decompensating refugees needs to address four factors: failure in personal adaptation, family disintegration, environmental isolation, and existential crisis. He reminds us that refugees who decompensate are not "sick"; rather they

are responding to stressors which have become overwhelming. Nevertheless, refugees do have an increased risk for developing mental health problems.

### **3. Refugees' increased risk for psychological disorder**

Refugee status puts people at an increased risk of developing almost any psychiatric disorder (Haasen et al., 2001; Westermeyer, 1996), and this is associated with an increased risk of alcohol and drug problems, especially for males (Tai-Ann Cheng and Chang, 1994).

Refugee children are particularly at risk (Hodes, 1998). A recent investigation in the UK found significant psychological disturbance in over one quarter of refugee children, three times the rate as amongst controls (Fazel & Stein, 2003). Even years after resettlement, refugees groups have high rates of mental disturbance (Westermeyer, 1988).

Post-traumatic stress disorder (PTSD) is especially common amongst refugees (O'Hare, 1998; Westermeyer 2000). The incidence of PTSD in refugee groups has been estimated at between 10 and 100 times the rate in the general population (where it is less than 1 in 200) (Westermeyer, 1996). Some studies have identified even higher rates of PTSD in particular refugee populations, for example Carlson & Rosser-Hogan (1991) found 86% of Cambodians they interviewed met DSM-III-R<sup>2</sup> criteria for the disorder.

Given that refugees are highly at risk of developing PTSD, it is important to examine what this means for their likelihood of developing substance use disorders.

### **4. Trauma, PTSD and the Development of Substance Use Disorders**

There is evidence to suggest that exposure to trauma, particularly if PTSD develops, can lead to substance use disorders. Certainly a correlational association between PTSD and substance abuse has been established. For instance, Brown et al. (1995) found one quarter of substance abusers in a private detoxification clinic presenting with significant PTSD symptomatology.

Breslau and colleagues have repeatedly demonstrated strong lifetime associations between PTSD and substance use disorders. PTSD has been found to signal an increased risk for alcohol use disorders (hazards ratio 3.0) and for drug abuse/dependence (hazards ratio 4.5) (Breslau et al., 1997; Chilcoat & Breslau, 1998).

Some research has focused on the direction of causality of this correlation. Is it that substance use problems stem from people's attempts to "self-medicate" their pre-existing PTSD symptoms? Or is it that people with pre-existing substance use problems are more likely to be exposed to traumatic events, or to develop PTSD after being exposed to some trauma?

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<sup>2</sup> DSM-III-R refers to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, third edition, revised.



Chilcoat & Breslau's (1998) analysis of longitudinal data attempted to resolve this issue. Whilst they could not rule out the possibility that a third factor leads to both PTSD and drug abuse, the evidence they collected lends support to the "self-medication" hypothesis, rather than the alternative.

Further support comes from a study by Sharkansky et al. (1999). These researchers studied people who were managing their substance use disorders, and found differences between those with and without PTSD in terms of their relapse triggers. Compared with people without PTSD, those with PTSD were more likely to relapse in situations involving unpleasant emotions, conflict with others, or physical discomfort. However no differences were found in the frequency of relapse for other high-risk situations, for example, pleasant emotions or pleasant times with others.

Similarly, Coffey et al. (2002) found that people with comorbid PTSD and substance dependence reported increased craving in response to trauma memories. This increase was particularly noticeable for people with alcohol (as opposed to other drug) dependencies.

Stewart (1996) proposes 4 mechanisms via which alcohol may be used to self-medicate symptoms of PTSD:

- i. Physiological – alcohol dampens physiological reactivity to stressful events
- ii. Behavioural – alcohol is used to reduce behavioural avoidance of triggers
- iii. Affective – alcohol is used to block out emotions
- iv. Cognitive – alcohol is used to avoid thoughts associated with trauma.

Stewart notes that, in the long run, this self-medication is counter-productive, as drinking tends to increase anxiety, thus triggering PTSD symptoms. This can lead to increased alcohol intake and a vicious circle of dependence.

Research interest has been lent to the question of whether an increased risk of substance use disorders is correlated only with PTSD, or also with exposure to trauma in the absence of subsequent PTSD. Evidence on this issue is somewhat mixed. Triffleman et al. (1995) investigated childhood trauma in a sample of male veteran substance abuse inpatients. Even when PTSD was controlled for they found that there was a significant relationship between childhood trauma and substance dependence. Similarly, Breslau et al. (1997) found that women exposed to trauma who did not develop PTSD nevertheless had an increased risk of first-onset alcohol abuse/dependence. However in their analysis of longitudinal data, Breslau et al. (2003) found no indication of increased risk for alcohol or drug misuse (apart from a slightly increased risk for nicotine dependence). Stewart (1996), in an extensive review of the literature on alcohol abuse amongst individuals exposed to trauma, found evidence of associations between substance abuse and both PTSD and trauma exposure, however, she concludes that PTSD may be a stronger predictor of alcohol abuse/dependence than trauma exposure per se.

It is possible that some of the discrepancy observed here stems from definitional problems. Breslau (2002) makes the case that definitional issues with the PTSD construct confound attempts to correlate PTSD with other disorders.

A further issue that warrants attention is the cross-cultural applicability of the PTSD category. Two of the key elements required to be diagnosed with PTSD are having experienced or witnessed a highly traumatic event, and experiencing ongoing distress as a result of this. Yet, as Terheggen et al. (2001) point out, there are cultural differences in what is considered to be a traumatic event, and the way in which emotional distress is communicated. For example, in their study of Tibetan refugees in India, they found that “witnessing the destruction of religious signs” was ranked top in a list of possible traumatic events, and that the most common signs of distress reported were somatic rather than psychological.

Terheggen et al. (2001) assessed the degree of intrusion-avoidance, another concept closely linked to PTSD, in their sample of Tibetan refugees. They found a significant difference in distress levels between those who suffered intrusive-avoidant symptomatology and those who did not. Unfortunately, however, the researchers did not also assess the refugees’ PTSD status, so were unable to determine whether the difference noted between the two groups reflects a Western notion of PTSD.

Eisenbruch (1991) makes the case that many refugees meet DSM criteria for PTSD and are thus diagnosed with the disorder, when in fact what they are experiencing could be construed as “a normal, even constructive, existential response rather than a psychiatric illness” (p. 673). Baker (1992) and Burnett & Peel (2001) concur, suggesting that while psychological distress is common amongst refugees, it could be more accurate to describe this as a behavioural reaction to abnormal experience, rather than as symptomatology of mental illness. Whether refugees experiencing such PTSD reactions have the same increased risk for substance abuse as non-refugees diagnosed with PTSD is a question which at this point remains unanswered.

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It is clear that trauma is a common aspect of the refugee experience, and also that trauma is often associated with substance abuse, particularly in cases where PTSD has developed. For traumatised refugees, substance abuse is not only a problem in its own right, but also “undermines the bereavement process often associated with refugee flight... [and]...overrides the many cognitive, emotional, and behavioural adjustments required in a new culture” (Westermeyer, 1996, p. 342).

## **5. Risk Factors for Adolescent Substance Misuse**

Another body of literature has evolved on the topic of adolescent substance misuse. Researchers have attempted to discern the factors which predispose adolescents to use and misuse substances. This section provides a brief overview of this literature, attempting to draw connections between the experiences of refugee youth and the identified risk factors for adolescent substance misuse.

Ellickson et al. (2001) draw some interesting distinctions between three different types of alcohol misuse during late adolescence. They identify unique predictors for each:

- i. problem-related drinking (e.g. missing school), which is associated with early academic problems and lack of nuclear family
- ii. high risk drinking (e.g. drink driving), which is associated with poor self-efficacy to resist (peer pressure)
- iii. high consumption, which is associated with being male.

The authors cite research conducted by Colder & Chassin (1999), who found that problem drinkers were more likely than moderate drinkers or abstainers to have experienced fundamental family disruptions, stressful life events, emotional distress, and poor behavioural regulation.

Adolescents who use aggressive tactics to handle interpersonal conflicts may also be at high risk for substance abuse, compared with those who have coping strategies to manage interpersonal conflict. Using a self-report measure, Unger et al. (2003) found that adolescents who managed conflict using physical aggression were at increased risk for using cigarettes, alcohol, cannabis and other drugs. Those who reported using aggressive but non-physical tactics (such as yelling or sulking) were at increased risk for using cigarettes and alcohol. Those who reported using non-aggressive tactics (such as discussing the issue calmly) had a reduced risk for smoking cigarettes.

In a large-scale effort to create a compendium of data resources on the aetiology of adolescent drug use, Scheier (2001) reviewed studies in five major domains of risk: personality factors, parental and family socialisation processes, peer social influences, social skills, and drug-related expectancies. It is clear that the refugee experience affects all these facets, with the possible exception of personality factors. Family and peer relationships are often highly disrupted, and social skills and drug-related expectancies are to some extent culture-bound phenomena which must be re-learned following migration.

The following section examines what is known about the African refugee communities in NSW, with particular attention given to any of the above risk factors which have been identified amongst African refugee youth in NSW.

## **6. Issues facing African Refugee Communities in NSW**

The number of African refugees in NSW has increased dramatically in recent years. In 2004, Africans comprised 47% of the total refugee and humanitarian intake for NSW (DIMIA, 2005)<sup>3</sup>. Refugees from Southern Sudan formed the majority of these. Africans in NSW settled predominantly in the Blacktown and Auburn Local Government Areas<sup>4</sup> (although it must be noted that the Area of settlement does not necessarily reflect the current Area of habitation).

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<sup>3</sup> Figures extracted from the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) live database show 1513 African-born out of 3210 Humanitarian arrivals to NSW in 2004.

<sup>4</sup> Figures extracted from the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) live database show that of the 1513 African-born Humanitarian arrivals, 23% settled in the Blacktown LGA and 14% in the Auburn LGA in 1996-2004. These same figures apply to arrivals in 2004 alone.

New South Wales is home for migrants and refugees from approximately 34 different African countries. For an overview of the political, historical, and cultural complexity of these different countries, please see the country profiles in the African Communities' Council (ACC)'s (2000) report entitled *Health and Settlement Needs of Africans in New South Wales – Phase I*. A more detailed description of Sudan and the background of Southern Sudanese arrivals in NSW are provided by Anglicare's (2003) report entitled *The Sudanese Community in NSW*, written by Cheryl Webster.

Little research has been conducted into the African refugee communities of NSW, however the few reports which have recently been released do shed light on the health and settlement needs of these populations. These reports include:

- Southern Sudanese community elder Mayom Tulba Malual's (2004) report entitled *Issues facing young people from Southern Sudan and their community as they settle in Australia*, written under the auspices of Anglicare.
- STARTTS' (2004) report into their large-scale consultations with Southern Sudanese women, compiled by Arna Rathgen.
- The Refugee Council of Australia's (2004) report entitled *How to learn from newly emerging communities from the African continent in order to equip ourselves to work with them in meeting their settlement needs*, compiled by Mark Green.
- Anglicare's (2003) report entitled *The Sudanese Community in NSW*, written by Cheryl Webster.
- African Communities' Council's (2000) report entitled *Health and Settlement Needs of Africans in New South Wales – Phase I and Phase II*.

Another useful reference is the draft report (unpublished) of consultations held in 2004 with the Southern Sudanese community in Brisbane and Logan, Queensland, compiled by Queensland Program of Assistance for Survivors of Torture and Trauma (QPASTT) worker Peter Westoby.

On the basis of anecdotal reports that there were drug or alcohol issues arising in the Southern Sudanese<sup>5</sup> community, the Drug and Alcohol Multicultural Education Centre (DAMEC) conducted a series of 34 informal telephone interviews with Southern Sudanese and other relevant community workers. These preliminary investigations gave some evidence of existing alcohol problems amongst youth and amongst married men, and much support of the notion that the Southern Sudanese refugee community in Sydney is highly at risk (see attached for a summary of the findings of these investigations).

In combination, the reports into African refugee communities in NSW offer evidence of trauma, loss, adjustment difficulties and disadvantage which accords closely with that described in the international refugee literature reviewed above, and which provides further evidence to suggest that African refugees are vulnerable to substance misuse.

It is beyond the scope of this paper to review in detail all the settlement issues identified amongst African refugees in NSW. Instead issues unique to African or

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<sup>5</sup> Sudan has always been characterised by significant differences between the north and the south of the country. The north is arid, and has a long history of Arabic tradition, including adherence to Islam, while the south is tropical, fertile, agricultural, and populated by black Africans. Christianity and animist religions dominate in the south (Williams, 2003).

other small and emerging refugee communities which increase their risk for substance misuse will be highlighted.

### **Trauma**

The torture and trauma issues experienced by African refugees in NSW are highly complex. Amongst others, they include the effects of imprisonment and torture for political reasons, physical and psychological development problems amongst young men who were conscripted as boy soldiers, and pregnancy amongst teenage girls as a result of rape in refugee camps (Green, 2004; Tulba Malual, 2004).

As for many refugees, the trauma African refugees have experienced places them at risk of a range of psychological problems including anxiety, depression and post-traumatic stress disorder (PTSD). Accessing treatment is exceptionally difficult because the concept of counselling is unfamiliar to most Africans, and cultural norms may discourage the disclosure of such problems (ACC, 2000; Green, 2004; STARTTS, 2004). The language of “trauma” in particular, appears to be one which the African people do not relate to.

Participants in the African Communities’ Council consultations (Phase II – 2000) had heard the term PTSD, but had no real understanding of the term or its relevance to the community.

As one Southern Sudanese informant in the Queensland consultations said:

“If you use the word trauma with the Sudanese then you will not reach them. Because they are very proud of the war they are fighting for self-determination. So anything that happens there they know it is happening because of so forth, so it does not disturb them.... We have different understandings of stress to you Westerners. For example, if someone dies it really means nothing – we are so used to it.... The fact that we respond like this is not because of numbness – we simply are used to it – our distress is linked to our experience and history. Death is so common and we understand it through our religion... It does not mean we do not get stressed – we do. But we do not connect our current distress to the past. Even bad dreams are not connected to the past.”

Whilst another said:

“We are getting confused now – some of us, like me, do connect bad dreams to past events and trauma now... My personal experience of torture and detention comes back and causes stress. But I interpret that as a burden I carry as part of my choices to fight in the war”.

And a worker:

“I think the distress in the Sudanese community is about day-to-day life here... Trauma is certainly part of their experience but daily distress is predominant – very here and now.... A lot of it is worry about family back overseas. They often say they know what it is like for people back there and there is a sense of guilt...”

(Westoby, unpublished)



## **Loss**

One of the most significant causes of distress reported by African refugees is family disintegration, and the loss of traditional social supports and conflict resolution mechanisms (STARTTS, 2004; Tulba Malual, 2004; Webster, 2003). Not only is the extended family support system disrupted by partial family migration, but once arrived in Australia, families sometimes break down under the pressure of multiple stressors. Alcoholism and domestic violence issues appear to be often implicated in these breakdowns (ACC, 2000).

Participants in recent consultations spoke of their concern that their adolescent children were “not our children anymore” (STARTTS, 2004). Parents frequently felt their teenagers had lost respect for authority, that they were not obedient, and that they wanted too much independence. Some were concerned that their children were neglecting their studies or becoming involved with police.

Westoby (unpublished) writes that, although family breakdown is by no means the norm amongst Sudanese refugees, people’s *fear* of family disintegration is very strong. He explains that this fear undermines people’s sense of safety and that this is a serious barrier to healing.

## **Adjustment/Acculturation**

Tied in with the loss of family support is the confusion experienced by Africans as they attempt to make sense of the social support systems that do exist in Australia. Australian systems tend to value individual rights over the sanctity of the family unit, and actions which in Sudan would have been considered positive (such as physical disciplining of children) in Australia are considered negative or even criminal (Tulba Malual, 2004).

African refugees commonly experience a great deal of culture shock. They come from a “culturally distant” land, and, despite the multiculturalism of Australian society, African communities are not yet established. These communities are considered to be “small and emerging”, that is, small in membership and generally lacking in community structure and resources (Harding, 2004).

As with all small and emerging communities, lack of accredited interpreters and translators is a serious concern (Tulba Malual, 2004; Webster, 2003). The total number of Africans in NSW is small, and within this total there are multiple different ethnic and tribal groups who speak different languages. It is difficult to maintain anonymity within a group, and there is a perception (whether it is justified or not) that confidentiality will not be maintained by interpreters. This is a particularly relevant concern for people dealing with sensitive or taboo issues such as drug use. Furthermore, there is a social hierarchy in certain cultures which determines who may speak for whom, and whom may be questioned (Green, 2004).

The cultural distance which must be covered is enormous, especially for rural Africans. Upon arrival in Australia they are overwhelmed by a lack of knowledge which for others is taken for granted, for example knowing which foods are healthy, which need to be stored in the fridge, how to clean Western-style homes, use household appliances, or cross the road in high-traffic areas. They often have no



understanding of the concept of an appointment-based health and welfare system, nor banking and credit facilities (Green, 2004; Tulba Malual, 2004; Webster, 2003).

Whilst young people typically adjust more quickly than their parents to a new environment, young African refugees encounter numerous difficulties adjusting to the Australian school system.

Tulba Malual (2004) lists a myriad of issues that young Southern Sudanese refugees must contend with, including poor English proficiency, limited or no prior education (due to many years being spent in refugee camps), lack of literacy in their first language, difficulty using basic equipment such as pens or rulers, difficulty sitting still, difficulty concentrating due to the impact of past trauma, and no previous experience with developing good study habits or doing homework.

African children may struggle with the Australian education system which primarily employs visual and verbal modes of learning, as the African system is typically grounded in the oral and aural transmission of knowledge (Green, 2004; Webster, 2003).

African refugee parents are usually unable to offer their children the type of support which is expected by the Australian school system (e.g. help with homework), and they have difficulty negotiating the education system. Parents are anxious or suspicious about the level of involvement which teachers expect from them (Green, 2004; Tulba Malual, 2004).

A further issue concerns refugees aged 18-24, who have had minimal education due to the disruptions of war and life in refugee camps. These young people have limited opportunities to access the education system, and when they do, they experience difficulties associated with the shame of being older but less educated than their peers (Tulba Malual, 2004).

Southern Sudanese youth at times use aggressive or violent means to resolve conflicts, at school in the playground, and at home when confronted with inter-generational relationship difficulties. Tulba Malual (2004) attributes this violence to isolation, confusion as to the norms of Australian society, and conflict resolution skills learned during very different circumstances to those they now encounter in Australia.

### **Disadvantage**

African refugees in Australia are disadvantaged in multiple ways. Family size is frequently large (8-10 members), and public housing stock can rarely accommodate this number of people. Even in the private rental market, Australian homes are generally too small for such large families. Yet, for lack of alternative, African families often find themselves paying more than they can afford for substandard and overcrowded rental accommodation (STARTTS, 2004; Green, 2004; Webster, 2003). Large rental expenses can lead to insufficient funds remaining to cover basic costs such as healthy food or educational expenses. Overcrowded houses contribute to children's difficulties with homework, and on occasion, young people may be forced to live apart from their families due to lack of space (Tulba Malual, 2004). This can create isolation and insufficient guidance and discipline, risk factors for substance misuse.

Finding employment is a major difficulty. Aside from the obvious barrier of language, African refugees frequently lack the interview skills and work experience necessary for obtaining employment. Awareness of employment agencies and options for training is often limited (Tulba Malual, 2004, Webster, 2003).

Unemployment may impair people's ability to recover from trauma (Westermeyer, 2000), and severely undermines self-esteem, particularly of men. This is exacerbated when multiple child support payments are made to the mother, thereby undermining the man's traditional position as chief bread-winner. There is some evidence that unemployment is a contributing factor to outbreaks of family violence (Green, 2004; DAMEC, attached).

The financial disadvantage experienced by African refugees is exacerbated by the practice of *sanduk* (STARTTS, 2004; Tulba Malual, 2004). Individuals are committed by this cultural practice to send money back home, and to sponsor relatives to enter Australia under the Special Humanitarian Program. Large sums of money are required to cover airfares and other costs (Green, 2004). Once arrived, these sponsored relatives may join their proposers in their already overcrowded accommodation. Commitment to *sanduk* means that African families may not have enough money to cover their basic needs (Webster, 2003).

African refugees may be disadvantaged by their lack of knowledge about the Australian legal system. Being unaware of Australian laws (for example, laws relating to domestic violence or child abuse and neglect) means that African refugees may come into contact with Australian authorities such as Police or the Department of Community Services. Coming from countries where police and other authorities are approached with fear and mistrust, it is natural that they maintain this attitude upon arrival in Australia (Green, 2004; Tulba Malual, 2004).

African refugees often arrive in Australia with poor levels of general health. They may be unvaccinated, carry parasitic infections, or may suffer from malnutrition. They have often been without dental care for extended periods. Children may have delayed development or conditions linked to vitamin deficiency. Women may have complications related to female genital mutilation, or sexually transmitted infections linked to sexual assault in refugee camps (Green, 2004). There are many barriers to accessing healthcare services in Australia including lack of knowledge of available services, difficulties understanding the Medicare and PBS systems, language difficulties, cultural reluctance to discuss issues of a personal nature, and cost (ACC – Phase II, 2000; Tulba Malual, 2004).

African youth may be disadvantaged due to their lack of access to recreation and leisure activities. Whilst this in part stems from poverty, it is exacerbated by their lack of awareness of available youth centres and activities, and parents' reluctance to allow their children to socialise with youth from outside their own community for fear of negative influences (including drugs) (STARTTS, 2004).

Finally, racism and discrimination remain very real issues, particularly in the areas of education, accommodation and employment. Tulba Malual (2004), for example, reports that school-children experience racism from both their teachers and their

peers. In consultations conducted by the African Communities' Council (Phase I, 2000), "one respondent recalled the time he went for an interview in which the employer expressed surprise that he had such high qualifications" (p. 48).

## **7. Mental Health and Drug and Alcohol Issues Identified Amongst African Refugees in NSW**

### **Adults**

Mental health and drug and alcohol issues remain stigmatised, particularly amongst Africans, with the result that they are rarely raised, let alone discussed. In the recent consultations documented above, mentions of mental health or drug and alcohol problems were rare (Green, 2004). Key speakers at the African Communities' Health Seminar (held in June 1999 at the Inner West Migrant Resource Centre in Ashfield) reported that Africans were either unwilling to access mental health services due to fear, or unable to access them because they did not understand what the services were really for, or how best to reach them (ACC, 2000). Speakers also noted that mental health interventions for African communities have, to date, been focused upon treatment rather than prevention. They point out that the communities' risk factors are highly amenable to preventative work, and recommend addressing Africans' lack of knowledge about available services, as well as developing specific programs to help Africans "overcome their sorrows" (p.8, ACC – Phase II, 2000).

High levels of stress were identified amongst African refugees, with unemployment (and underemployment) noted as the main causes. Men, in particular, experienced feelings of inadequacy when unemployed, which was sometimes expressed in acts of domestic violence (ACC – Phase I, 2000; Tulba Manual, 2004).

In the African Communities' Council's (2000) consultations, "key members of the African community identified stress, depression, discrimination and loneliness as problems within the community which affect mental health and wellbeing, and can lead to mild or severe forms of mental illness. Stress was seen as a major cause of anxiety within families, which sometimes led to domestic violence and alcoholism" (Phase I - p. 32).

These findings were echoed by informants in DAMEC's telephone interviews (attached) and STARTTS' community consultations (2004).

### **Young people**

Drug and alcohol issues were mentioned explicitly in the African Communities' Council's Phase II consultations with African children and youth (2000). The young people identified drug and alcohol addiction as the primary issue affecting their health. (Other issues noted were access to sporting and exercise programs, diet, racism, and a lack of understanding of medicines.)

The lack of drug and alcohol awareness programs targeting African youth was also noted at the African Communities' Health Seminar. It was noted that such programs would assist in addressing current health and mental health problems due to unemployment, increased stress, and changed social roles.

In the telephone interviews conducted by DAMEC, respondents described Southern Sudanese youth as having many of the risk factors which were noted above to be associated with increased risk for adolescent substance misuse. These included an aggressive conflict management style (learned in refugee camps), a disrupted family life, poor education and difficulties at school. Tulba Malual (2004) also describes antisocial behaviour by young people in public places, as well as fare evasion, shoplifting, robbery, petty crime, intimidation and harassment. Specifically, he notes that underage drinking and drink driving are problems amongst Southern Sudanese youth.

Several informants in DAMEC's investigation (attached) were concerned that drug and alcohol problems, although not widespread in the Southern Sudanese community, appear to be emerging so soon after resettlement. This observation runs counter to the literature cited above where substance misuse problems amongst refugees emerged only several years after resettlement, and points to the Southern Sudanese community's exceptionally high risk.

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This paper has identified both theoretical and practical reasons why African refugees in NSW are at increased risk of substance misuse. Using published literature from the fields of refugee health, substance misuse and mental health, in combination with recently released reports on consultations conducted in NSW with community members and key informants, it has been argued that adult and young refugees are highly vulnerable to developing problems with alcohol or drug use. Prevention activities, the provision of culturally-appropriate information, and programs to improve access to treatment and rehabilitation services could be of great benefit to this vulnerable population.

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