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*Current  
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**Newly arrived  
refugees and drug  
prevention**

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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; Sowe 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<sup>1</sup> (PTSD) (Agaibi & Wilson 2005; Cohen & Hien 2006; Olf, 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

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<sup>1</sup> 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 Sowe 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<sup>2</sup> 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,

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

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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 Sowe 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.

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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 Kingdom 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

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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 refugees 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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