

**Title:**

Heavy alcohol consumption among marginalised African refugee youth in Melbourne, Australia: motivations for drinking, experiences of alcohol-related problems, and strategies for managing drinking

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**Running head:**

Alcohol use among marginalised African refugee youth in Australia

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## **Abstract**

**Introduction:** Little is known about substance use among resettled refugee populations.

This study aimed to describe motivations for drinking, experiences of alcohol-related problems and strategies for managing drinking among marginalised African refugee youth drinkers in Melbourne, Australia.

**Methods:** Face-to-face interviews were conducted with 16 self-identified African refugee youth recruited from street-based settings in 2012-2013. Interview transcripts were analysed inductively to identify key themes.

**Results:** Participants gathered in public spaces to consume alcohol on a daily or near-daily basis. Three key motivations for heavy alcohol consumption were identified: drinking to cope with trauma, drinking to cope with boredom and frustration, and drinking as a social experience. Participants reported experiencing a range of health and social consequences of their alcohol consumption, including breakdown of family relationships, homelessness, interpersonal violence, contact with the justice system and poor health. Strategies for managing drinking included attending counselling or residential detoxification programs, self-imposed physical isolation and intentionally committing crime in order to be incarcerated.

**Discussion:** These findings highlight the urgent need for targeted harm reduction education for African youth who consume alcohol. Given the importance of social relationships within this community, use of peer-based strategies are likely to be particularly effective. Development and implementation of programs to address the underlying health and social causes of heavy alcohol use and alcohol-related problems are also needed.

**Keywords:** Alcohol, culturally and linguistically diverse communities, refugee health, Africa, youth, qualitative research

## **Introduction**

Forced migration is a growing issue in the 21<sup>st</sup> century. At the end of 2013, 51 million people worldwide had been forcibly displaced from their homes due to conflict or disaster (including 17 million refugees), with applications for asylum at their highest levels in two decades [1, 2]. Each year 60-70,000 refugees are resettled in Western countries, with Australia taking in 5-10,000 refugees per annum, ranking among the top refugee-receiving countries worldwide [3].

Forced migrants are vulnerable to health risks. In particular, pre-displacement traumatic experiences (including limited access to food, water and safe accommodation, loss or disruption of livelihood, and exposure to violence), resettlement challenges (e.g. lack of social support, family separation, poverty and marginalisation), and acculturation challenges associated with adapting to new physical and cultural environments have all been shown to negatively impact psychosocial health and wellbeing [4-8].

Alcohol is a cause of significant morbidity and mortality globally, accounting for roughly 5% of the total burden of disease [9-11]. In particular, alcohol is the leading cause of disease among adolescents and young adults, particularly those living in high-income settings [12]. Alcohol use also contributes to a wide range of social, economic, and legal harms at the individual, family and community levels [13].

Our understanding of the relationship between forced migration and alcohol use remains limited. Although some studies have recorded lower rates of alcohol consumption and alcohol use disorders among some migrant and refugee groups compared with their host population [14-16], contrasting research has found higher rates of alcohol use and related harms among some ethnic and cultural minorities [17, 18]. Migrant and refugee populations may be vulnerable to alcohol use for a number of reasons. First, traumatic or stressful pre- and post-migration experiences may lead to

substance use as a coping or escape mechanism [19]. This is a particular concern among refugee populations, among whom high rates of mental disorders including depression and post-traumatic stress disorder have been documented [4, 20]. Second, migrant and refugee communities commonly experience unemployment and poverty and, as a result, may reside in disadvantaged areas where cheap alcohol is often readily available [21, 22]. Finally, acculturation to mainstream norms and a desire to gain acceptance in their new communities may play a role in increasing substance use [19, 23-25]. Importantly, the negative consequences of substance use may be exacerbated among migrant and refugee communities due to lack of knowledge about substance use and limited access to and uptake of health services [26-29].

Despite the identified vulnerabilities among forced migrants, little research has examined alcohol use and related harms among permanently resettled refugee populations. A systematic review conducted in 2010 examining the influence of forced displacement on harmful alcohol use identified only ten studies, eight of which focused on refugees resettled in high and middle-income countries [30]. Although these studies identified a number of risk factors for harmful alcohol use including male sex, younger age and experiences of trauma, these largely comprised quantitative studies, providing a relatively limited understanding of the ways in which these factors, and other experiences associated with forced migration, may influence harmful alcohol use. There is a need for more in-depth, qualitative work examining harmful alcohol use among forced migrants, in order to improve the evidence base for informing public health interventions for these populations.

In Australia, communities from Sub-Saharan Africa have grown rapidly over the past two decades, with refugees from East Africa and North Africa (predominantly Sudan) comprising the majority of these communities [31]. Studies involving African communities in Australia have documented experiences of unemployment, social

disadvantage, marginalisation and discrimination [32-34]. For African refugee youth, further challenges have been documented in relation to language acquisition and difficulties adapting to the Australian education system and gaining meaningful employment [35-37]. In addition, African young people, particularly those of Sudanese ethnicity, have been further marginalised by characterisation in public discourse as violent, criminal and a 'problem group' [38-40].

In recent years, high levels of alcohol consumption among disengaged and marginalised African refugee youth has been identified by community organisations as an emerging concern [41-43]. The issue has also received attention in the media [e.g. 44, 45]. In the Western region of Melbourne, a major African community hub, studies of public drinking have identified African young people as a key group of concern, with researchers observing groups of young people gathering in public spaces (including spaces in which alcohol use is prohibited) and consuming large amounts of alcohol [46-48]. Youth substance use support agencies operating in this region have also recorded an increase in numbers of clients from African backgrounds [49]. A brief snapshot of these clients found that they experience poor physical and mental health and high levels of disengagement from education and employment [50]. Beyond this, no research has examined alcohol use among African refugee youth in Australia in detail. This study aims to address gaps in knowledge about patterns of alcohol consumption, motivations for drinking, and consequences of drinking among this African refugee youth in Australia, and provide evidence to inform the development of interventions to reduce alcohol use and related problems among resettled refugee youth more broadly.

## **Methods**

### ***Study design and participant recruitment***

In 2012-2013 we conducted a qualitative study examining alcohol and illicit drug use among marginalised African migrant and refugee youth from Melbourne's western suburbs [51]. Eligibility criteria for inclusion in the study were: being born in any part of East Africa or Sudan; age 16 years or older; living, working or studying in the City of Maribyrnong or City of Brimbank (two local government areas in Melbourne's inner west; population ~275,000), and having ever used any illicit drugs. Recruitment largely involved field-based opportunistic sampling in Footscray, the major transport and business hub for the region, and advertisement through local health and welfare service providers with young African clientele. The aim was to recruit a diverse sample in relation to country of birth, age, migration experiences and experiences of substance use, rather than a representative sample.

### ***Data collection***

Data were collected through face-to-face interviews (conducted by DH), which were facilitated by a semi-structured interview guide developed in consultation with community welfare workers of African ethnicity (authors TB and GS). Key areas of discussion included migration to Australia, social integration in Australia, patterns and contexts of alcohol consumption, motivations for alcohol consumption and health and social consequences of alcohol consumption. Interviews took place in a mobile study van or office space located adjacent to the field site, and lasted between 15 and 80 minutes. All participants provided written informed consent. Participants were reimbursed AUD\$30 at the completion of the interview. Ethical approval for the study was obtained from the Monash University Human Research Ethics Committee.

### ***Data analysis***

All interviews were audio-recorded and transcribed verbatim. Pseudonyms were assigned to all participants and any potentially identifying information divulged during

interviews was deleted from the transcripts. Interview transcripts and field notes were managed using Nvivo Version 10 (QSR International, Doncaster, Australia).

Interviews with 16 participants aged below 30 years, who self-identified as refugees were analysed. Analysis employed a thematic approach using inductive coding, with the aim of understanding emic interpretations of individual participant's experiences.

## **Results**

### ***Participants***

The participants were 16 men aged 18-30 years. Twelve participants were born in Sudan (including nine from areas which are now part of the Republic of South Sudan), two in Eritrea, and one each in Kenya and Somalia. Most participants had spent significant amounts of time in refugee camp settings in Africa or in neighboring countries such as Egypt prior to migration to Australia. Participants had resided in Australia for between six and 14 years at the time of interview. Post-migration experiences commonly included family separation (many had arrived in Australia with a member of extended family while immediate family remained in Africa) and disengagement from education and employment.

### ***Patterns of alcohol use***

Young people visited Footscray on most days so they could meet and socialize with friends from different areas of Melbourne. Almost all participants reported consuming alcohol on a daily or near-daily basis. They routinely arrived in Footscray between early and mid-morning, and remained until early evening, consuming alcohol (most commonly cheap cask wine, spirits and high alcohol content pre-mixed drinks) throughout the day. Multiple purchases of alcohol were made on any given day, with participants often pooling money with others to do so.

Participants spoke of the importance of “controlling” their drinking, rather than “letting alcohol drink them”. This was enacted through self-imposed rules, such as drinking only on weekends or when they did not have to work or attend appointments the following day, drinking only until a pre-specified time, and drinking only with friends who were known and trusted. Despite this, as the excerpt below demonstrates, although many participants began this way, such control could be difficult to maintain, for many, evolving into daily use:

Girma: “I started drinking honestly at home... I didn’t, like, drink every day, cos I was still going to high school and all that stuff, and whenever I did drink it’d be like weekends, Saturday, Friday night, cos you go to the city, to a nightclub... We got used to that, like every weekend, then somehow it goes to week days, it’s like...

Interviewer: Yep. You don’t even realise that you’re...

Girma: You’re gone far...”

(Girma, age 26, Eritrean)

Participants linked this notion of control with alcohol dependence or ‘addiction’. For example, despite reporting often drinking 10-20 cans of pre-mixed spirit drinks in a day (1.4 standard drinks each), Jok stated that he could control alcohol and “quit any time I want”, and that he was “not like other people who get addicted to alcohol”. Similarly, Joseph reported that he did not consider himself an addict because even though mentally he felt dependent on alcohol, physically, his body could “handle it”. The term ‘addiction’, and its implication of loss of control and association with injection of illicit drugs, was stigmatised; despite being one of few participants who referred to himself as an ‘addict’, James reported having become violent towards other people who referred to him in this way.



Despite the discourse emphasising control, it was common for participants to report drinking with the intention of becoming extremely intoxicated. Commonly referred to as drinking “to the limit”, these occasions involved drinking until losing consciousness or until other adverse consequences, such as being arrested, were experienced. Not being allowed to drink “over the limit” was identified as one reason for drinking in public spaces, rather than in licensed venues.

### ***Motivations for alcohol use***

Three unique but interconnected themes emerged when participants spoke about their motivations for engaging in these heavy patterns of alcohol consumption and intoxication: drinking to cope with trauma, drinking to cope with boredom and frustration, and drinking as a social experience.

#### *Drinking to cope with trauma*

Study participants commonly described traumatic and stressful experiences in their birth countries such as witnessing the deaths of family members, experiencing violence, and navigating the myriad challenges of growing up in refugee camps. Many participants reported ongoing challenges since arriving in Australia, particularly in relation to a lack of family support and, in some cases, estrangement from family. For example, John arrived in Australia at age 11 with his brother and sister-in-law. He soon began to believe that he was the cause of arguments between his brother and his wife. He eventually chose to move out of their home, living in youth accommodation and experiencing periods of homelessness. Abuk was in a similar situation, forced to leave his aunt’s home not long after arriving in Australia when he refused to leave school to get a job to help support the family.

As a result of these traumatic and stressful experiences, many participants reported ongoing feelings of hopelessness and anger, loss of motivation and difficulty sleeping. For many, alcohol was used as a means of escaping from these “problems in my head”,

as it helped to “forget” and “let everything pass”. As Gabriel explained, “You’re full of information, you don’t know how to get rid of it, and you just want to feel stress free. So you drink.”

#### *Drinking to cope with boredom and frustration*

As mentioned earlier, participants were generally disengaged from both education and employment. With little disposable income, participants had few affordable activities in which to engage, and for many, drinking served as a “distraction” and a way of “killing time”.

Beyond simply drinking to combat boredom however, participants also spoke of drinking to cope with the frustrations of their everyday lives, particularly continued experiences of marginalisation, discrimination and rejection:

“Being white – everything is easy.... It’s just our colour – people judge us with that too much, you know? And it pisses us off, mate. You know, some people even give up... If someone trying [sic] to get a job, trying to get a job, and they keep refusing you, and they look inside himself, ‘I’m fucking black man, no one will accept me.’ Where is he gonna go? He’s gonna come, sit down and drink. ‘Cause fuck man, I tried. No one can see I tried, but I know myself I tried.”

(Gabriel, age 19, South Sudanese)

In this sense, drinking reflected a sense of futility and acceptance of their lives. As James reflected: “Life on the street – that’s the life I choose for me. I’ve been doing this for a long time and that’s what I’m good at... We’ve never had a good life before, never ever.”

#### *Drinking as a social experience*

Alcohol was also seen as a part of social interaction and friendship. Many participants had known each other prior to arrival in Australia, and commonly referred to each other as “my people” or “my brothers”. Sharing alcohol was not only a way to “have fun” and

“kick back” together, but also helped to create a relaxed environment, in which participants could reminisce about Africa, and find support in their shared experiences.

Direct peer pressure was rarely identified as a driver of alcohol consumption; rather, pressure to participate in drinking was more commonly internally-driven and related to social expectations. For example, Girma reported that he often drank because he felt uncomfortable watching others drinking and having fun and not participating. On the day he was interviewed, Jok reported that it was the first time he had drunk alcohol in Footscray. He had only arrived in Melbourne recently and had come into Footscray with one other person he knew, and joined in with the larger group’s drinking as a way to help build new friendships. Cultural norms and expectations also played a role in this, with some participants reporting that declining to share alcohol if it was offered to you was considered disrespectful.

As described in more detail in the following section, although alcohol functioned as a social lubricant, both re-enforcing existing bonds between young people, as well as helping to build new friendships, alcohol also played a role in causing problems between friends.

### ***Experiences of alcohol-related problems***

When asked about the ways in which alcohol had affected their lives, participants identified a range of health and social consequences of their alcohol use. Physical health consequences included dehydration, lack of appetite, poor nutrition and general malaise. Several participants reported that they had previously been active in soccer and basketball teams, but no longer had the motivation or fitness to play sports. Reports of episodes of losing consciousness were common, and as mentioned earlier, were associated with drinking “to the limit”. On several occasions, our research team phoned emergency services to attend to participants who displayed signs of acute intoxication.

During the time our team conducted fieldwork for this study two deaths in which alcohol was a contributing cause occurred among young African people.

Injuries sustained under the influence of alcohol were a common occurrence, and resulted from falls, car accidents, and incidents of violence. Some participants reported that incidents of violence occurred more commonly within the group, rather than with outsiders, and were generally a result of a minor disagreement which escalated as a result of the effects of alcohol:

“You know like when you’re drunk, you’re talking about something that happened last week, or last year or something... they misunderstand each other coz they’re blabbing, they’re not really saying the words right out. And then one of the other guys, he takes it wrong, coz he’s drunk too and he’s not listening properly. It starts with things happening like that and then it just goes off. And once it goes off, the other guy jumps in for the other guy, the other guy jumps in for the other guy, and it gets carried away.”

(Girma, age 26, Eritrean)

Others, however, reported that random, unprovoked, incidents of violence also occurred while under the influence of alcohol. For example, Daniel reported that heavy drinking could make young people easily provoked: “If you’re over the level you’d be fighting for sure. But not one of your friends... I mean, if you go in a train, someone just, I don’t know, say something wrong to you, you might just straight away hit them”. Participants were sensitive about the ways in which African young people were represented in the media, feeling that they were unfairly singled out and that alcohol-related violence is no greater an issue among African youth than other groups of young people.

Participants also identified a number of social consequences of alcohol consumption. The primary concern for most participants was the impact their drinking had on their interpersonal relationships. Gabriel reported that his girlfriend often threatened to

leave him because of his continued drinking; he recalled one incident where he chose to pour out a full bottle of whisky to prove to her that he valued his relationship with her more than alcohol. James reported that his four-year old daughter was currently in her grandmother's custody, and although he was scheduled to visit her once a week, he was often unable to do this because he had been drinking. In turn, this then caused him to drink more, in order to cope with his sadness and frustration at being denied access to his daughter.

Drinking was a major source of intergenerational conflict. Participants reported that alcohol use was highly stigmatised in African communities and contributed to their marginalisation. Reflecting the collectivist nature of African cultures, youth who consumed alcohol risked becoming ostracised not only from their family, but also from the broader community:

“They see you start drinking – your own mum can kick you out! ... Our community, they're not good. They'll go and talk to the parents and say 'Look at your kid!' [They're doing it] to protect themselves, to make their name good.”

(Abuk, age 24, South Sudanese)

“If they see you drinking - no one says to you 'hello'.”

(Hassan, age 29, Somalian)

Drinking also had a significant impact on participants' ability to gain (and maintain) employment, and on their interactions with the criminal justice system. Many participants reported having been stopped and searched by the police in public places and receiving fines in relation to alcohol-related offenses such as public drunkenness.

### ***Managing/reducing alcohol use***

Many participants expressed a desire to better manage or reduce their alcohol consumption, with two key strategies employed to do so. The first was physical isolation

from sites of alcohol consumption. For example, Girma identified that there was a particular friend's house where he often found himself drinking despite his best intentions, so he made a conscious decision to not visit his friend there. For Khaled, being arrested by police prompted a move interstate, in order to isolate himself from his social group who engaged in regular drinking. For many young people however, physical isolation had the unwanted consequence of social isolation, which exacerbated feelings of sadness and frustration, and as such, was not a viable long-term strategy. The second strategy used to reduce alcohol use was committing crime. Despite many participants reporting tense relationships with police, the police cells were sometimes seen as a safe place, where one had a source of food and housing, so, as James explained, "if they wanna take a break from drinking, they do something like crime, to spend a night in the 'hotel'."

Although a small number of participants had utilised professional services such as alcohol counselling (often court-appointed) or residential detoxification programs, participants were generally resistant to engage with these services. This seemed in part to reflect an attitude of stoicism, which again, linked with participants' sense of having given up on life. In addition, as the follow excerpts demonstrate, there was also a sense of stigma and shame in needing help, with participants priding themselves in coping alone:

"Why would I talk about something like that with someone? I just like keeping to myself."

(Daniel, age 20, Sudanese)

"I had a counsellor... It doesn't work for me.... I just rolled with my own flow, you know? I just took it as a man.... I don't need no counsellor [sic]. I don't have to talk to no one to tell them my problem."

(Gabriel, age 19, South Sudanese)

Although participants were not asked specifically about barriers to help-seeking or use of professional support, some barriers which were alluded to by participants included a lack of social support, fear of stigma, limited knowledge about available services and how to access them, and a perceived limited ability of services to meet their needs.

## **Discussion**

African refugee youth in this study reported heavy and harmful patterns of alcohol use and experienced a range of serious health and social consequences of their drinking. Three key motivations for engaging in these patterns of alcohol consumption were identified by participants: drinking to cope with trauma, drinking to cope with boredom and frustration, and drinking as a social experience. In contrast to our expectations, despite ready availability and the normalization of alcohol consumption in Australia, neither exposure to alcohol nor acculturation to Australian norms was identified as a key driver of alcohol use.

The finding that coping with stressful and traumatic pre- and post-migration experiences was an important motivation for harmful alcohol use among this group of refugee-background youth is consistent with findings from quantitative research which has identified exposure to trauma as a risk factor for alcohol-related problems [30]. Although study participants did not specifically refer to their feelings in the context of mental health, or using biomedical terminology, their descriptions of “problems in my head” and how this related to feelings of sadness and hopelessness are possible indicators of unaddressed mental health problems. This fits with previous research which has found that African populations rarely use Western biomedical concepts of mental illness [52, 53].

Although the finding that coping with trauma was a key motivation for heavy alcohol consumption is relatively unsurprising given previous studies have documented a high

prevalence of psychological distress and mental illness among refugee youth [20, 54-56], it is of great concern that young people in this study used alcohol as a coping mechanism, rather than accessing professional mental health services. Although there is a reasonable scarcity of research in this area, studies suggest an unmet need for mental health services, as well as a range of barriers to service access and uptake, including limited knowledge about mental health in general and about mental health services, stigma associated with mental health problems and help-seeking and concerns about cultural competence, trust and confidentiality [57-59]. There is a need for further studies exploring barriers and facilitators of mental health service access and factors which influence service effectiveness for refugee-background youth, particularly those from African backgrounds. Targeted, culturally appropriate programs and interventions can then be introduced to improve mental health literacy, to raise awareness and reduce stigma around mental illness, and to address mental health and substance use problems. The second motivation identified by participants was drinking to combat boredom and frustration. This stems from participants' lack of meaningful education and employment opportunities, and has previously been identified as motivation for alcohol use among other marginalised migrant populations such as asylum seekers [60, 61]. Addressing the structural barriers to education and employment may help to reduce harmful drinking among this population, as these have been shown to be effective in improving health outcomes in a wide range of areas [62]. Socialising with friends was also identified as a key motivation for alcohol use among study participants. Participants in this study considered one another as family, with whom they had a shared history and a sense of belonging. This was particularly important for participants as many were separated from immediate family, and lacked supportive relationships with family in Australia. Friends have shown been to be an important source of support among refugee youth [57, 63], in some ways replacing



these missing family relationships. Further to this, participants felt isolated from, and rejected by, the wider Australian community, so their socialisation within their group created their own sense of community. Addressing underlying factors which contribute to feelings of discrimination and marginalisation, and providing safe spaces in which young refugees can socialise, is essential to reduce both alcohol consumption and alcohol-related harms among this population.

Participants in this study recognised that their alcohol use produced a range of serious consequences, and many expressed a desire to reduce or better control their drinking. Although some participants had accessed professional services, similar to mental health, there was a general resistance to seeking professional support in relation to alcohol use. Participants' desires to manage their issues alone reflected both a fear of stigma and exclusion from their communities, as well a cultural belief that it was inappropriate to discuss their problems with others. Enacting this belief could be interpreted as participants' demonstrating agency, stoicism and inner strength, as has been suggested in other studies [56, 64]. Conversely, this could also reflect participants' acceptance of difficulties in their lives and lack of motivation to seek a better life.

Our study findings indicate several important areas for intervention. Firstly, there is a need for harm reduction education for African youth who consume alcohol. Given the types of harms our study participants reported experiencing, simple messages regarding things such as the importance of nutrition and hydration while drinking and how to recognize and respond to symptoms of acute alcohol intoxication could be effective.

Second, strategies are required to improve inter-generational and community dialogue about alcohol, in order to increase awareness and knowledge and reduce the stigma around alcohol use, and improve parents and communities capacity to respond to alcohol use among youth. Research suggests that communities are receptive to

increased discussion about alcohol use; a recent study involving over 200 newly-arrived migrant and refugee women in Western Australia identified 'support for women whose husband or children are drinking too much alcohol' as among their top priorities [29].

There is clearly an unmet need for professional support in relation to both substance use and mental health, however further research is needed in order to build an evidence base regarding the types of programs and services which will be most appropriate and acceptable for these communities. There is some evidence to suggest that cultural interventions which draw on both traditional and Western approaches to healing may be particularly effective in addressing substance use problems [65]. In addition, avenues should be explored to deliver services through specialist substance use and mental health agencies, youth support services and existing migrant support services.

Our study findings also indicate several important areas for further research.

Quantitative studies are required to measure the prevalence of harmful patterns of alcohol use and to identify risk and protective factors, in order to inform the scope and design of future interventions. It should be noted that female participants were not intentionally excluded from the study but young women were less visible to the researchers, and none of the women encountered consented to participate. Further qualitative studies which employ strategies to identify and include more hidden groups within the community, such as women, are needed.

## **Conclusion**

This study provides an insight into the motivations and consequences of heavy alcohol consumption among a sample of marginalised African refugee youth in Melbourne. Our findings indicate an urgent need for targeted harm reduction education, including the development and implementation of programs to address the underlying health and social causes of heavy alcohol use and alcohol-related problems. Further, interventions

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aimed at increasing community awareness, knowledge and response strategies around alcohol use and alcohol-related problems are also needed.

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