# Substance Use Among Refugees Living in Utah: A Qualitative Analysis

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November 2014

## Introduction

The World Health Organization has indicated that substance use may increase among people who experience conflict and displacement as a way to "self-medicate pain, mental health problems, and the stress of adapting to life in a new environment (WHO, 2008)." Though refugees who are resettled to the United States are screened for serious substance use issues before their arrival and supportive services are offered during the initial resettlement period, substance use may become an ongoing challenge for refugees after the initial resettlement period when supportive services are not as easily available and the stresses of adapting to life in a new place may continue to pose challenges.

Community stakeholders who work with refugees have expressed concern that substance use among refugees resettled in Utah is an ongoing issue. The following report is based on a qualitative analysis of 37 stories collected that document the effects that substance use is having in the lives of some resettled refugees living in Utah. The intent of the analysis was to begin to identify trends in substance use among resettled refugees living in Utah including: common demographic traits; substances being used; the consequences of substance use for the individual, their family and community; and accessibility and appropriateness of community resources.

## Methodology and Limitations

A majority of the stories for this analysis were provided by the Community Resource Specialists (CRS) working for the Refugee Services Office (RSO) at the Department of Workforce Services. At the time the stories were collected, the CRS worked with the Burundi, Bhutanese, Congolese, Karen, Sudanese, and South Sudanese communities living in Utah. In that capacity, each CRS worked closely with individual families, and was able to provide information about individuals in each of the six different communities who had been negatively impacted by

substance use. Additionally, the Refugee and Immigrant Center at the Asian Association of Utah provided a few stories of individuals they encountered in their work who also had been negatively impacted by substance use.

Information received by the Refugee Health Program was written up by CRS at RSO and by staff working at AAU. Though each story provided was about an individual, names and other identifying information was not included to maintain confidentiality. Once all stories were received, each story was read and common themes across all stories were identified. Trends that emerged were tallied by frequency and are included in this report.

The information collected for this report is not without limitation. A uniform guide was not sent out indicating how to collect information, what information each story should include, and how individuals should be selected for inclusion in this analysis. Because of this, results should not be seen as characteristic and/or typical of the six different communities represented in this analysis. The onset of substance use was not addressed in the majority of the stories, which makes it difficult to determine the reasons for substance use and any associated mental health challenges. Many stories also did not directly address whether referrals were made to a community program or resource. These issues would need to be further explored with additional analysis.

**Findings**

From the stories provided, there were a higher frequency of married males who had, on average, 2.07 children, were unemployed, had been in the U.S. an average of 4.43 years, and were mainly drinking alcohol. The majority of the individuals studied no longer had a case manager because of the length of time that had passed since they were resettled in the United States.

Negative consequences of substance use were observed including legal and formal actions, as well as social consequences. Legal and formal actions frequently reported included: arrests, jail sentences, domestic violence charges, driving under the influence charges (DUIs), and the opening of cases with the Division of Child and Family Services. Other formal consequences documented included the termination of a housing lease and a school suspension. Social consequences were also documented, with substance use negatively impacting families being the most frequent issue. Family issues included: distrust between spouses, infidelity, divorce, separation, violence and exploitation of family members, inattention to children, children engaging in substance use, and homelessness.

Chronic unemployment a result of substance use was also a common theme in the stories. Many individuals were fired because of intoxication while working or failure to attend work due to substance use; others quit their jobs because of physical health issues related to the substance use. In the stories of married men included in this analysis, it was commonly reported that the wives of the men had to work to support the family because the men were unable to work because of their substance use.

Most stories did not include information about recovery, however there was one report of an individual who began seeing a therapist for substance abuse treatment and who was then able to maintain a job. Four other stories mentioned that individuals were able to reduce their consumption. More than one-third of all stories mentioned that individuals were reportedly referred to substance abuse counselors or other types of community interventions; it was mentioned in some stories that individuals refused treatment for unknown reasons. Many individuals in the stories admitted they had a problem and expressed a desire to quit, but cost,

availability, and the availability of culturally and linguistically appropriate services were indicated as barriers to receiving adequate care.

| Variables | Burundi | Bhutanese | Karen | Sudanese | AAU Clients | Average/Most Common Theme |
|---|---|---|---|---|---|---|
| Age | Mean: 35.2 | Not enough data | Not enough data | Not enough data | Not enough data | Inconclusive |
| Gender | M: 4 , F: 6 | M: 7, F: 1 | M: 10 | M: 4; F: 1 | M: 2; F: 2 | [redacted] |
| Marital Status | M: 4, S: 6 | M:6, D: 1, S: 1 | M: 6; S: 4 | S: 3; S w/partner: 1; D: 1 | M: 3; S: 1 | [redacted] |
| Employment Status | Unemployed: 5; Unknown: 5 | Employed: 2, Unemployed: 4, Unknown: 2 | Unemployed: 2; Employed: 5; Unknown: 3 | Unemployed: 3; Unknown: 2 | Unemployed: 4 | [redacted] |
| # of Children | Unknown: 3, Mean: 3.33; Range: 0-11 | Mean: 1.63; Range: 0-3 | Mean: 2.125; Range: 0-6; Unknown: 2 | Mean: 1.2; Range: 0-6; None: 4; 6: 1 | Mean: 2; Range: 2; Unknown: 1 | [redacted] |
| English Proficiency | Mostly unknown | Mostly unknown | Unknown | Moderate-Low: 2; Unknown: 3 | Low-Medium: 3; High: 1 | Inconclusive |
| # of Years in Camp | Unknown | Mostly unknown | Mean: 15.25; Range: 10-19; Unknown: 6 | Unknown | Unknown | Inconclusive |
| # of Years in US | Unknown | Mean: 5.6 years; Range: unknown-5 years | Mean: 4.8; Range: 2-6 | Mean: 7.5; Range: 7-11; Unknown: 3 | Mean: 4.5 years; Range: 1-7 | [redacted] |
| Mental Illness | Mostly Unknown | Mostly unknown, 1 Depression | Unknown | Unknown | Yes: 2; Unknown: 2 | Inconclusive |
| Referral | Unknown | Unknown, 2 community interventions | Referred: 6; Unknown: 4 | Unknown: 4; By Friends: 1 | Yes: 3 | [redacted] |
| Case Status | Unknown | Unknown | Unknown | Unknown | Closed: 1; Open: 2 | Inconclusive |
| Substance | Alcohol: 8; Drugs: 2 | Alcohol: 8; Cigarettes: 1 | Alcohol: 10; Drugs: 2; Cigarrettes: 3 | Alcohol: 5; Drugs: 2 | Alcohol: 4 | [redacted] |
| Addiction Gauge | Family: 3; Legal: 2; Self: 2; Community: 1; Unknown: 3 | Family: 8; Legal: 4; Self: 1 | Community: 3; Legal: 4; Family: 2: Self: 2; Medical: 1 | Community: 3; Legal: 1; Unknown: 1 | Case Manager: 3; Medical: 1 | [redacted] |
| Family History | Unknown | Not enough data | Unknown | Yes: 1; Unknown: 4 | Unknown | Inconclusive |
| Age of Onset | Unknown | Not enough data, common to start in camps | Began in Camps: 8 | Mean: 15.75; Range: 13-18; Unknown: 1 | Unknown | Inconclusive, Most recurrent theme is that SA began in camps |
| Legal Action | Arrest: 4, DUI: 3, Jail: 2, School Suspension: 1; Unknown: 5 | DV: 3; DUI: 2; Jail: 2; Unknown: 3 | Jail: 3; DV: 2; Unknown: 6 | DUI: 1; Housing Lease Terminated: 1; Unknown: 2 | DCFS Case: 2; DV: 2, Protective Order: 1 | [redacted] |
| Social Consequence | Family Issues: 6; Community Issues: 2; Drop out of School: 2; Unknown: 2 | Family: 8; Children SA: 2; Drop out of School: 2 | Family: 4; Community: 4; Drop Out: 1; Unknown: 2 | Family: 2; Homeless: 2; Unknown: 2; Drop Out: 1 | Family: 3; Homeless: 1 | [redacted] |
| Recovery? | Unknown | None | Reduce: 4; None: 6 | None: 3; Unknown: 2 | Yes: 1; No: 3 | [redacted] |

**Figure 1, Frequency of Themes Observed in Communities**

**Barriers**

Cultural differences and perceptions about mental health and related substance use issues may be barriers to seeking care when needed. In some cultural traditions, it is a widely held belief that mental health problems are caused by evil spirits or sin. In other cultural traditions, family members as a collective group can be blamed for failing to help an individual family member struggling with their mental health; this may mean families are hesitant to admit and seek help because of fear of being ostracized. These cultural beliefs and traditions accompany refugees as they are resettled, so it may decrease the likelihood of them seeking mental health treatment during their resettlement case management process.

Language may also be a barrier to receiving care because the majority of stories provided were clients who no longer had resettlement case management and did not have access to free interpretive services. Mental health terminology is also not taught in the majority of English Language Learning (ELL) classes, so even if the person was fluent in English, treatment may not be as successful because of communication difficulties. Language and cultural competency are interconnected and are important to provide while assisting a client with substance use counseling.

Cost is also a significant barrier to seeking care. Although there are free or reduced cost substance use counseling clinics in Salt Lake City, they tend to be short term (30 days or less) or are limited in the number of counseling sessions. For many refugees, substance use may stem from larger mental health and trauma related issues, so short term assistance may not be sufficient. Language may even be a cost barrier because of the price of interpretive services. Some clinics offer free interpreters to clients through partner agencies, but it can be a risk for

nonprofit clinics that are providing interpretive services free of charge because they are still required to cover the cost of service even if a client doesn't come to their appointment.

**Recommendations**

Agencies that work with resettled refugees in the Salt Lake area should have referral protocols for those using substances who may also have mental health issues. It is recommended that community leaders and specialists have contact information for free or reduced cost services so they can provide them to clients. The World Health Organization's research on refugee substance misuse indicates that mental trauma is a major determinant of substance misuse and must be addressed in counseling to encourage lasting change (WHO, 2008).

Training should be provided by the Utah Department of Health, nonprofit groups, or other health educators to refugee community specialists and leaders to identify substance use signs, how to address concerns, and where to refer people for treatment. Refugee needs extend beyond resettlement case management, so community forums must be utilized to continue to provide assistance to those who require it. Many counseling centers accept Medicaid for their mental health services, so knowledge of the scope of Medicaid and how to enroll clients is also important for providing treatment. An interpretive service fund for refugees seeking mental health or substance abuse counseling after resettlement would also be helpful for encouraging those within the refugee community to receive help for substance misuse.

**Conclusion**

Substance misuse within refugee communities in Salt Lake City is a very complex issue because of barriers to care and limited resources provided to clients following the resettlement period. After case management is over there must still be resources available that offer affordable, accessible, and culturally and linguistically appropriate care. Through stories

provided, substance use was observed to directly affect the entire family and impact opportunities available to them. In turn, this has the potential to also affect refugee communities and the larger Utah community. It is for this reason that stakeholders should continue to monitor trends in substance use among refugee communities in Salt Lake and advocate for resources to address identified needs on a continuing basis.

**References**

Figure 1: Generated October 2014 based off data provided by stories, analyzed frequency of events

WHO (2008). *Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide.* Retrieved from http://www.who.int/mental_health/emergencies/unhcr_alc_rapid_assessment.pdf?ua=1