Substance use among unaccompanied minor refugees in Vienna

Julian Strizek
GPS meeting, Lisbon, May 2018
Background, objectives, methodology
» **2015 peak** of about 88,000 applications for asylum, mainly from people from Afghanistan (11,800) and Syria (8,800)

» About **10 %** of these applications concern UMR (8,277) with an even higher share of people from Afghanistan (~66 %)

» Since 2016: numbers decline

» In total 171,000 refugees live in Austria (2016, UNHCR) – compared to a population of 8,747 millions (~2 %)
Lack of data on substances use among ethnic minorities/migration

» Increasing numbers of media reports about problematic behavior, including alcohol use and other drug use resp. dealing with drugs, in public

» Increasingly support requested by refugee relief services

» Little and inconsistent monitoring data
  » underrepresented in GPS data
  » Nationality/country of birth used in treatment registries
  » International comparability limited by different definitions
  » Only limited number of studies on asylum seekers and addiction
Objectives, methods and limitation

Target group
» Unaccompanied minor refugees in Vienna

Objectives
» Consumption patterns and motives
» Specific risk factors
» Attitudes and knowledge about substances and health care interventions
» Prevalence estimates

Methods
» “Rapid Assessment and Response”
» Mix of qualitative methods (2 focus groups, 39 interviews with UMR, 10 expert interviews)
» Develop recommendations together with practitioners

Limitations
» No probabilistic sampling
» No female UMR
» No “control group” for comparison
Use of vignettes as „icebreaker“

Results
Consumption patterns and motives

» Nearly everyone is smoking cigarettes, some with somatic problems. Alcohol and cannabis are widespread, only few experiences with opioids. In contrary to other migrant youth, gambling or gaming etc. seems to be no issue.

» “Extreme consumption patterns” prevail
  » early onset (tobacco, cannabis) vs. first experiences in Austria (alcohol)
  » heavy use (e.g. 10–15 joints/1 bottle of whiskey per day) vs. strong opposition against any drug use at all.
  » Almost no moderate use of alcohol reported

» Self medication due to physical (head ache, sleeping problems) and psychological problems (distress, loneliness) and substance use to cope with everyday tasks (smoking cannabis before school)

» Distraction (forget about problems) is more important than pleasure (to get intoxicated).
Problem use is aggravated by environmental “risk factors”

- Lack of **perspectives** for the future and **daily routines**
  - No educational opportunities/job perspectives
  - Affordable leisure time activities

- Novelty of **availability** of substances / freedom in general

- Strong influence of (the absent) family
  - Absence of family causes **grieve**
  - Lack of (traditional, strict) **family control**
  - experiences with substance use in Austria conflict with family expectations causing further **distress**

- Strong influence of **peers**
  - Hard to find friends outside their own “subculture”
  - No “**safe places**” to stay away from substance use

- Improvements of the “setting” will change everything or better
  - Founding/reunion of family
  - Find new and better friends
Knowledge and attitudes on substance use and drug treatment

- Rather **limited knowledge** on health consequences of substance use
- Great importance of **social consequences** of substance use
  - *loss of control*, problems with friends/staff/police/violence.
  - *Financial issues* due to cigarette use.
  - drug legislation in Austria remains rather unclear, strong *fear of legal consequences* on asylum process
- Preference for **abstinence** and **restrictive measures**
- Strong focus on **personal responsibility**: dependency as symptom of a weak personality rather than as a disease.
- **Support strategies**: friends > professionals, pharmacological therapy > psychotherapy
Experts assessment and recommendations

» Problems with substance use ≠ addictive behaviour, but treatment demand may rise

» UMR need specific prevention activities with regard to content and methods (e.g. peer approaches and the additional use of digital media)

» General mental health care services and trauma therapy for young adults need to be expanded to deal with underlying problems (applies not only to UMR!)

» Drug counselling is underused (language barriers, lack of information) or not available. When its available, clients need to be motivated to enter and to stay in treatment (de-stigmatisation of addiction among UMR)

» Addiction care needs to be prepared to care for more and more heterogeneity among their clients (video translation)

» Knowledge transfer between drug treatment facilities and refugee aid needs to be increased and established

» Measures initiatives outside the health sector (employment, education, asylum procedure) may have the greatest impact
Conclusions and questions for discussion
Conclusions and questions for discussion

1. Substance use among UMR is rather characterized by variation than by a homogenous pattern
   » Consumption patterns are shaped by both biographic events and the setting in the host country and show no homogeneous picture
   » Consumption motives vary a lot from boredom to coping mechanism due to severe mental diseases
   » Attitudes on substance use differ from those of other young people reflecting traditional practices, sometimes in conflict with local practices

→ Does it make sense to use migration status as variable?
→ Can results from qualitative research and quantitative data from routine monitoring be synthesized?
## Conclusions and questions

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<tr>
<th>Country of Birth</th>
<th>Police reports</th>
<th>Population</th>
<th>% of Police reports</th>
<th>Police reports per 1,000 Persons</th>
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<td><strong>2,268,545</strong></td>
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## Conclusions and questions

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</table>
Conclusions and questions for discussion

1. Substance use among UMR is rather characterized by variation than by a homogenous pattern
   » Consumption patterns are shaped by both biographic events and the setting in the host country and show no homogeneous picture
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2. Substance use among UMR is more a social than a health problem and demands a HiAP-approach and an overall political will to support integration
   » Who should pay for support measures?
   » Stressing substance use/treatment demand may raise awareness on the issue or may increase further stigmatisation
   » Partisan positions and changes in legislation make planning very difficult
Conclusions and questions for discussion

2019?
Thank you your attention!

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