Substance use among unaccompanied minor aged and young refugees in Vienna

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Background, objectives, methodology
Asylanträge (gesamt) | Asylanträge UMF

- In total 171,000 refugees live in Austria (2016, UNHCR) – compared to a population of 8,747 millions (~2%)
- **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
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

- Few publications cover migration and addiction (rather on **attitudes** than consumption patterns)
Objectives

» Consumption patterns and motives
» Specific risk factors
» Knowledge on substances, social consequences and possible support (health literacy)
» Use experts opinions on support opportunities for recommendations
» 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 female UMR
» No “control group” for comparison
Results
Consumption patterns and motives are shaped by biographic events

» **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 school)

» 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

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

» Lack of **perspectives** for the future and **daily routines** (educational opportunities/leisure time activities)

» Lack of (traditional, strict) **family control**: experiences with substance use in Austria conflict with family expectations.

» Novelty of **availability** of substances / freedom in general (western consumerism)

» Strong influence of **peers** (positive and negative)
  » Hard to find friends outside their own “subculture”
  » No “**safe places**“ to stay away from substance use

» Change of **“social surrounding”** will change everything or better
  » Founding/reunion of family
  » Find new and better friends
Negative effects of substance and attitudes on substance use differ from those of other young people

- 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** are much more urgent, especially due to cigarette use. **Legal consequences are more severe** (asylum process), legal situation remains unclear
- Rather black/white pictures on substance use, preference for **abstinence** and **restrictive measures**
- Strong focus on **personal responsibility**: dependency as symptom of a weak personality rather than as a disease. Religion might be helpful.
- **Support strategies**: friends > professionals, pharmacological therapie > psychotherapy
Experts assessment: not the biggest problem, but it might get one

» Problems with substance use ≠ addictive behaviour, but need for support measures **might rise** in the future

» **Improvement of environmental** risk factors is crucial (duration of asylum process, Housing, Education and daily routines)

» The heterogeneity of experiences and knowledge of UMR asks for **specific prevention activities** with regard to content and methods (e.g. peer approaches)

» Drug counselling is often not available. When its available, clients **need to be motivated** to enter and to stay in treatment.

» **General mental health** care services need to be expanded to deal with underlying problem
Recommendation by experts

» **Risk competence** and safer use practices should be increased, existing prevention measures should be expanded (at the moment mostly general prevention measures by police)

» Expansion of **general mental health** and **trauma therapy** services is needed, resources to get people into treatment (mentoring) are needed to prevent treatment abortion

» More information on **treatment and support measures** sector is needed but also **de-stigmatisation of addiction treatment** among UMR

» Addiction care needs to be prepared with more heterogeneity among their clients

» **Knowledge transfer** between addiction aid and refugee aid should be increased and needs to be established in a institutional way

» **Peer projects** and the additional use of **digital media** could lower the threshold to seek help

» Measures **outside the health sector** (employment, education, asylum procedure, “safe places”) may have the greatest impact
Thank you your attention!

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