Introduction

The global refugee crisis is an issue of urgent national and international importance. Currently, the number of people displaced worldwide by war or persecution (henceforth referred to as refugees) is higher than it has ever been since World War II (The UN Refugee Agency, 2015). Individuals displaced by conflict often seek refuge in refugee camps administered by the United Nations, where a few pursue resettlement to countries such as the United States (US), Canada, Australia, and some Western European nations. Resettlement of refugees in the US is governed by the Refugee Act of 1980, which draws upon the UN definition of a refugee as someone who has fled their home country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (US Department of State, n.d.). While the vast majority of refugees are resettled in the US from overseas refugee camps, the US also accepts asylum seekers who claim refugee status after arrival at a port of entry within the US. If granted asylum, these individuals have access to similar benefits and supports as resettled refugees.

The US accepts more refugees for resettlement than any other industrialized nation. Each year, between 50,000 and 80,000 refugees are resettled in the US, based on annual consultations between the President, Congress and appropriate agencies (Office of Refugee Resettlement, 2011). These refugees account for 10% of annual immigration flows to the US (Singer & Wilson, 2006). Approximately three million refugees have been resettled in the US since 1975 (US Department of State, n.d.). Refugees from Bhutan and Iraq constitute two of the largest groups of refugees resettled in recent years (Martin & Yankay, 2014).

Refugee populations have a higher than average incidence of mental health conditions, such as posttraumatic stress disorder and depression (Cardozo et al., 2004; Keller et al., 2006; Miller et al., 2002; Porter & Haslam, 2005; Savin, Seymour, Littleford, Bettridge, & Giese,
These serious mental health problems have been largely attributed to psychological distress from exposure to violence and trauma prior to and while fleeing their country of origin (Miller et al., 2002), though post-migration stressors also play an important role (Birman & Tran, 2008; Porter & Haslam, 2005). The increased risk and incidence of mental health conditions prevail among refugee populations, even whilst living in transit refugee camps owing to harsh camp conditions (Porter & Haslam, 2005), and after resettlement in industrialized countries owing to structural barriers that limit refugees' access to stable housing, employment, and social services (Kirmayer et al., 2011; Porter & Haslam, 2005; Savin et al., 2005).

A growing body of research suggests that the combination of pre-migration trauma, comorbid psychological conditions, and post-migration stress places refugees at high risk for substance use problems (Mills, 2012; Sowey, 2005). Prevalence of substance use problems among refugees resettled in the US remains largely unknown. However, rates of substance use have been found to be as high as 11.8% in long-settled refugee communities in Europe (Bogic et al., 2012). Types of substances used, attitudes about use, and prevalence of use vary widely between refugee communities (Ezard, 2012; Sowey, 2005). Despite these variations, a common factor for most refugee communities is limited utilization of resources and supports in their countries of resettlement. Several barriers are believed to hinder refugees' utilization of available services. These barriers include limited knowledge about resources, lack of linguistically accessible care, incongruence between Western-centric care and indigenous health beliefs, fear of deportation, social stigma, and structural barriers to public health services (Mills, 2012; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). In the US, under the federal government’s humanitarian resettlement program, refugees are entitled to a brief period of supportive services, including public health insurance. However, they still face structural barriers to mental health
care such as gaps in health insurance coverage and limited availability of linguistically-accessible services (Morris et al., 2009; Mirza et al., 2014).

In order to address these service barriers, it is important to first understand how different refugee communities define and experience substance use problems (Gagnon & Lonsdale, 2006). The US Substance Abuse and Mental Health Service Administration describes substance use disorders as recurrent use of drugs or alcohol that impairs daily function and/or health (SAMHSA, 2015), however definitions of problematic substance use may vary widely in refugee communities. To date limited systematic research exists on substance use in refugee communities, and research that explores social and cultural perspectives related to substance use is particularly lacking (Ezard, 2012; Sowey, 2005). In response to this critical gap in the literature, we used a community-engaged approach (McCloskey et al., 2011) to explore factors that trigger, sustain and/or prevent substance use in Iraqi and Bhutanese refugee communities resettled in the US.

Methods

Research design

This research represents the first phase of a sequential mixed-methods study on cross-cultural and cross-language mental health services for refugee communities in a large Midwestern city in the US. The larger parent study built upon a prior community-based participatory research project (Mirza et al., 2014) in which a Community Advisory Board (CAB) was assembled to identify unmet health needs and research priorities for refugee communities. Over a series of meetings spanning 18 months, the CAB consistently identified mental health as one of the highest health priorities affecting refugee communities across ethnicity and nationality of origin. Among the various mental health issues affecting refugee communities, substance use
was identified as an emerging and under-recognized area of concern. Members of the CAB, which included refugee service providers and community members, also identified specific substance use concerns in two of the largest local refugee communities: alcohol use in the Bhutanese community and prescription pain medication use in the Iraqi community. In the broader literature, hazardous alcohol use has been noted as a concern for Bhutanese refugees in transit refugee camps in Nepal (Luitel, Jordans, Murphy, Roberts, & McCambridge, 2013) and in the US (Centers for Disease Control, 2014). Similarly, misuse of prescription drugs is believed to have increased in Iraq since the US invasion in 2003 (Levin, 2006; Webster, 2011).

Therefore, in response to community-identified needs, we conducted exploratory focus groups (Krueger & Casey, 2000) to capture perspectives and experiences related to substance use among the local Bhutanese and Iraqi refugee communities.

**Participants and Recruitment**

We chose to focus on the Iraqi and Bhutanese communities at the recommendation of our community informants and because these two communities represent the largest proportion of refugees resettled in the research setting over the previous decade. (Illinois Department of Human Services, 2014). Community informants also cautioned us about the high prevalence of stigma and general reluctance to discuss issues related to mental health among refugee communities. Therefore, eligibility criteria were defined broadly so as not to focus only on individuals with a clinical problem. Individuals were eligible to participate if they were male, 18-65 years old, identified by self or community leaders as having a known or suspected problem with substance use, or being considered at-risk for developing substance use. Flyers describing the study and the above eligibility criteria were disseminated through community liaisons affiliated with organizations that serve refugee communities in the city and surrounding suburbs.
Interested individuals were invited to attend a focus group and complete a brief demographic survey. Written informed consent was obtained from all participants and they were compensated $30 for their participation. Using this convenience sampling strategy, a total of 50 participants were recruited, of whom 28 were Bhutanese and 22 were Iraqi.

**Language and Translation**

All study materials were translated into Nepali (native language of Bhutanese refugees) and Arabic (native language of Iraqi refugees). We used a combination of the back-translation and committee approach (Beck, Bernal & Froman, 2003; Brislin, 1970) to ensure accurate translation of documents. Study materials were developed in English after seeking input from our community informants. Materials were translated to the target languages by independent translators hired through a reputed translation company. Translated forms and questionnaires were then back-translated to English by a second pair of independent translators who were unfamiliar with the research aims of our study. Back-translation is important to accurate translations of measures in that it allows the researcher to compare the two English versions of the document and check for discrepancies in translation (Beck et al., 2003). Discrepancies in translation were discussed in a committee meeting comprising bilingual community members, back-translators, and members of the research team. Disagreements were resolved by consensus. Specific dimensions discussed during committee meetings included conceptual equivalence of content and use of respectful terminology. We refrained from using judgmental or incriminatory language in the flyers and all other study materials by avoiding phrases such as substance abuse, misuse, and addiction. We have retained the use of non-judgmental language recommended by our community informants throughout this manuscript as well.

**Data Collection**
Separate focus groups were conducted with Bhutanese and Iraqi refugee participants. Focus groups provide an ideal forum for communities to share collective opinions (Kamberelis & Dimitriadis, 2005). Four focus groups (one Iraqi and three Bhutanese) took place at community agencies, and one (Iraqi) took place at a public library. Number of participants at these focus groups ranged from six to 14. Two additional focus groups (Iraqi) were organized but only one participant arrived to participate in each group, so researchers instead conducted individual interviews with those participants. One individual interview took place at a community agency, while the other was held at the university.

Focus groups were facilitated by a doctoral clinical psychology student trained in group facilitation using a semi-structured interview guide. The interview guide was developed to reflect the research aims and concerns reported by community informants. Questions in the guide addressed the following topics: examples of someone (themselves or someone else) consuming excessive amounts of a recreational substance, reasons for excessive consumption, consequences of excessive consumption, and strategies for support. During focus groups, the facilitator introduced each topic with a broad, open-ended question and encouraged the participants to respond either to the question or to one another’s comments. If the conversation did not transition naturally to the next topic, the facilitator would formally introduce the topic with a question. Participants were frequently encouraged to disagree with one another and share divergent perspectives.

Each focus group lasted approximately two hours. An in-person interpreter provided real-time interpretation. Debriefing meetings were held between interpreters and other members of the research team after each data collection episode. Focus groups were audio-recorded and portions of the conversation translated to English were transcribed by an external transcription.
agency. A second interpreter reviewed the audio recordings and transcripts to assess accuracy of the real-time interpretation. Detailed field notes were also written to capture the dynamics of each focus group. A second phase of this research, not discussed here, included individual interviews with participants to allow an opportunity to privately discuss the sensitive topic of substance use.

Data analysis

Data were analyzed using a conventional content analysis approach. This approach is recommended for exploratory studies of phenomena with little pre-existing theory or research literature (Hsieh & Shannon, 2005). Atlas.ti Qualitative Data Analysis Software was used to facilitate the analytic process (Muhr & Friese, 2004). The first and second authors independently reviewed all transcripts and field notes and recorded their initial thoughts and impressions. Transcripts were then re-reviewed word-for-word to derive codes that captured emerging insights (Miles & Huberman, 1994). Separate coding schemes with labels and definitions for emerging codes were developed for the full set of Bhutanese and Iraqi transcripts. Codes were applied independently by the two coders and the coding scheme was iteratively revised as data analysis proceeded from descriptive to conceptual analysis. Disagreements with application of codes to textual data were discussed between the two coders and resolved by consensus. During conceptual analysis, related codes were organized into meaningful clusters or categories. Finally, in a team meeting involving the first three authors, emergent categories were compared between the Bhutanese and Iraqi transcripts to identify overarching themes.

Subsequent to completion of data analysis, researchers engaged in member-checking by sharing preliminary themes with our community informants. Our preliminary findings were also shared at a national conference on refugee and immigrant issues. Conference attendees, including
former refugees, interpreters and refugee service providers corroborated our findings through personal or professional experience.

**Results**

Study participants were mostly young and middle-aged with an average age of 35 years for the Bhutanese participants and 34 years for the Iraqi participants. The Bhutanese refugees had been expelled from Bhutan following years of persecution and discrimination, which culminated after changes in Bhutan’s nationality laws that denied them citizenship rights. All Bhutanese participants in our study had lived in transit refugee camps in Nepal prior to resettlement in the US. Most of the Iraqi refugees had fled sectarian violence that emerged in Iraq after the 2003 US-led invasion and occupation. Many of them had sought refuge in neighboring countries in the Middle East before being resettled in the US.

Overall, Iraqi participants were more recent arrivals in the US. Median time in the US was 18 months for Iraqi participants and 30 months for the Bhutanese participants. Fifty-five percent of the Bhutanese participants were employed, 30% had a high school or technical degree, 28% had a primary school education, and 30% had no formal education, 55% rated their English as not good. Approximately 30% of the Iraqi participants were employed, 35% had an associate’s or bachelor’s degree, 40% had a high school or technical degree, and 60% rated their English proficiency as good or very good.

Analysis of the focus group data revealed four salient themes that were compared and contrasted across both groups of refugees: (1) perceptions of excessive substance use, (2) triggers and evolution of excessive substance use, (3) post-migration changes in substance use, and (4)
effective ways to help and intervene. Each of these themes is described below with illustrative verbatim quotes from participants.

**Perceptions of excessive substance use**

Overall, the Bhutanese participants perceived excessive consumption of alcohol as a problem affecting many young and middle-aged men in their community. While only two participants discussed their own past experiences with excessive alcohol use, several described the experiences of friends, relatives, and acquaintances. Talking about others’ experiences seemed to provide them with a safe opportunity to discuss behaviors indicative of excessive alcohol use based on our observation that they more readily disclosed information about others than about themselves. Some participants defined excessive drinking in contrast with occasional drinking for enjoyment, while others defined it in terms of frequency of drinking and amount consumed:

“People need happiness. If [one] is happy, he would not drink or if he does, drinks a little. Now, drinking…once in a month, or twice a month, it is not a drinking habit. That’s enjoyment. We need to be happy…and happy [people] cannot drink too much. That is enjoyment, not excessive drink[ing]” (Bhutanese Focus Group 2)

“Excessive use doesn’t mean only being very drunk. It also means, drinking many times, anytime, during breakfast time, during lunchtime, during dinnertime, anytime, if one uses alcohol then, we say that is excessive use.” (Bhutanese Focus Group 1)

There was also some misperception and confusion about the ‘cutoff’ or threshold when someone crosses over from acceptable to excessive drinking. Some participants

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1 Some quotes have been edited for grammar. These quotes were translated to English from participants’ native languages. Some of these quotes, in their original translated form, appeared to be in ‘broken’ English. This is likely a reflection of challenges associated with real-time translation between languages. However, we believe it is unfair to present these quotes in ‘broken’ English, when our own unfamiliarity with the relevant languages constitutes the problem. Therefore we have chosen to edit quotes for grammar. Edits are indicated by ellipses (...) and box brackets [ ].
said they needed external information to make this determination, others believed that an individual could drink alcohol as much as their body could tolerate:

“In my opinion, excessive means drinking above the body’s capacity. If someone drinks and his body can tolerate, that’s okay but if not and he falls down on the sides of street then that is excessive” (Bhutanese Focus Group 1)

“Actually we don’t know what excessive means. We need to learn from you. How much is excessive?” (Bhutanese Focus Group 3)

The Iraqi participants expressed similar uncertainty when discussing signs of excessive use of prescription pain medication. Many participants were able to define excessive use, in principle, as taking “medication more than the amount prescribed by the doctor”.

However, in practice, the distinction between appropriate and excessive use was less clear-cut for many of them. This ambiguity appeared to stem from the general approach to prescribing and using pain medications in their country of origin. Several participants explained that in Iraq and other countries in the Middle East where they had lived it was far easier to procure pain medication, including opioid pain medications, even without a doctor’s prescription. Participants reported that practices such as self-prescribing, borrowing a friend or family member’s medication, and getting medication directly from a pharmacy or nurse were not only common, but also acceptable:

“The patient when he goes to the doctor, he will not let the doctor prescribe for him the medicine that [doctor] recommends. The patient himself will ask the doctor to write medicine for him which he wants.” (Iraqi Focus Group 1)

“I prescribed every medicine for [myself]. Whatever I feel, I will prescribe for [myself] and I will take it by myself. Even the IV [intravenous] injection.” (Iraqi Focus Group 1)

“In the Middle East, once you have a problem from your experience, you know the treatment, you will go for it and take it. From the pharmacy. And you can buy it easily without prescription.” (Iraqi Interview 1)
Since the above behaviors were not seen as aberrant or deviant in any way, participants had a hard time discerning excessive use of prescription pain medication in accordance with US standards. As stated by one participant, “Iraqi people, they don't have this thought of, this concept of excessive consuming of medicine.” (Iraqi Focus Group 1). Usage was deemed as aberrant when it became “like addiction to alcohol”. Like the Bhutanese participants, the Iraqi participants also reported instances where friends and family members had become addicted to opioid pain medication, however these instances were seen as sporadic occurrences and not as a community-wide problem.

**Triggers and evolution of excessive substance use**

Participants in both groups discussed various psychosocial factors that could possibly trigger excessive substance use. Stress related to their migration history was a common factor identified by Iraqi and Bhutanese participants, although reasons for being stressed differed between the two groups. Some Bhutanese participants reported lingering worries about family members they had to leave behind in transit refugee camps in Nepal. On the other hand, many Iraqi participants discussed chronic stress from having lived under precarious conditions of war and insecurity:

“Some of us have family members left out in Nepal and miss them. So that gives [us] tension and...because of too much tension, somebody can drink an excessive amount.” (Bhutanese Focus Group 2)

“If you are living in a situation which is all killing, war, the only way, the only way to be relaxed and calm is taking these [opioid pain] medications.” (Iraqi Interview 1)

Both groups of participants also reported work-related stress as a possible trigger for excessive substance use. Being out of work as well as being overworked were cited as reasons for being drawn to excessive substance use:
“If somebody works too much, he will be too much tired. So he could not prepare food at home. And drinks to get rid of his sadness.” (Bhutanese Focus Group 2)

“Excessive drinking is mainly because of no job/work. If there is work, people drink once in a week; just for enjoyment but no work means more stress and more drinking.” (Bhutanese Focus Group 2)

“I think the people who they don't have work, they have a lot of time, they will take such medicine and in Iraq, especially, because they don't have jobs. They don't have work. They will take these pills which make hallucination.” (Iraqi Focus Group 1)

Bhutanese participants also talked about an individual’s social milieu, including one’s family environment and circle of friends, as a possible trigger for excessive drinking. For example, some participants reported that drinking alcohol was permissible in certain families starting at a very young age. They shared examples of village elders who allowed children to drink alcohol causing them to become alcoholic later. Several others stressed that being with friends who drank excessively can influence an individual to do the same.

“Well, some people drink because of friend relationships. For example, if my friend is like drunk, if I am involved with him, he or she might force me to drink. And you know, I might try [drinking alcohol myself].” (Bhutanese Focus Group 2)

Participants also discussed how excessive substance use was a behavior that does not emerge overnight, but rather one that evolves gradually over time:

“It is happening gradually. They take one tablet and then two, until they reach this addiction stage. And then he cannot stop” (Iraqi Focus Group 2)

“Everybody started from very little and then they used to consume more and more. One example is…the heating iron, [the iron] isn’t that hot but when we… continue heating that iron then it becomes hot everywhere. Like that, alcohol affects every part of body.” (Bhutanese Focus Group 1)

Post-migration changes in substance use

Participants in both groups believed that substance use behaviors, their own and those of others they knew, had changed after immigrating to the US. Changes in behavior were largely attributed to changes in access. For example, the Bhutanese participants, who had lived in transit
refugee camps in Nepal before coming to the US, described how alcohol was more easily available in Nepal and in the US than in their native Bhutan.

“When we were in Bhutan, it was too strict and we could not buy alcohol or drink. When we came to Nepal at that time, the local alcohol, they sell anywhere on the street. And we can buy [alcohol] anywhere. So we used to have habit of drinking …when we were in Nepal…[In the US it’s] more organized than in Nepal. Here we can buy in particular store and we can go into particular restaurant and drink or we can buy and drink at home…” (Bhutanese Focus Group 3)

Along with easy access to alcohol, life in refugee camps also offered plenty of unoccupied time and few opportunities for recreation or legal paid employment, a factor that further contributed to excessive drinking. On the other hand, excessive drinking in the US was described as being prevented by work-related responsibilities and living expenses. Thus some participants reported they had cut down on their drinking after coming to the US, and others were hopeful that future generations of their community would not struggle with the drinking behaviors that some older community members had developed when living in refugee camps.

“When we were in camp, we had lots of free time. We cannot go out and use that time in good way. But [in the US] we need to work always so we only have two days off. For two days we need to think for our life, so we cannot go out and drink too much. We cannot use time. Maybe from next generation, we will not have such type of drinking habits [in our community].” (Bhutanese Focus Group 2)

“I did a lot of drinks while I was in Nepal…But not here. I don’t drink. I did in Nepal. Here, I don't have money and that's why I stopped here.” (Bhutanese Focus Group 3)

The Iraqi participants similarly discussed how attitudes and behaviors related to use of prescription pain medications were changing in their community after migrating to the US. Again, these changes were attributed to variations in access to prescription medications in the US compared with their native Iraq:

“I don't know what is the health system here when I came first to the U.S. I took medicine from my friend and I showed it to my doctor. He refused to let me take this medicine because he said I didn't prescribe it for you. Because we used to take one medicine from one prescribed to each other in Iraq...”(Iraqi Focus Group 1)
“We have to change our cultural beliefs and our thoughts about the medication and how we take it. In Iraq it is a different thing and here it is different.” (Iraqi Focus Group 1)

A few Iraqi participants also emphasized that law enforcement and surveillance were more stringent in the US than in Iraq. Members of the Iraqi refugee community were aware of this and would therefore refrain from inappropriate use of prescription pain medication for fear of breaking the law and jeopardizing their prospects of permanent residency in the US:

“I think for Iraqis -- say if there is an Iraqi that used [opioid pain medication without prescription] back in Iraq, I don't think he will do it here. I'm pretty sure he won't. Because here there is a lot of watching here. If you do one bad thing, it is on.” (Iraqi Interview 2)

**Effective ways to help and intervene**

Participants suggested specific strategies and approaches that professionals, refugee service providers, and refugee community leaders could implement to help those struggling with excessive substance use. Several Bhutanese and Iraqi participants discussed the high risk of stigma and social isolation for members of their respective communities who were struggling with these issues. Therefore using an approach that preserves the respect and dignity of affected individuals was strongly emphasized:

“Society should respect the person addicted to the alcohol. One should talk with him or her very politely. And one should know the root of the cause, why he drinks alcohol too much. Then only we can go in a positive way.” (Bhutanese Focus Group 1)

“Some sort of nice way of treating -- dealing with other people's mistakes. I mean, we are not angels, we are not prophets, we all do mistakes. We are human beings. Not being like because he is taking pain medications excessively, that he's a loser. That you are worthless. You should not live. I don't think that's the way. That just makes them feel worse and makes them wish they killed themselves.” (Iraqi Interview 2)

Education and awareness was another important intervention strategy identified by both groups. For example, the Bhutanese participants suggested group workshops to inform members of their community about adverse effects of excessive drinking. Since many of them had limited
literacy in English, they also highlighted the need for training in basic skills such as reading the labels on alcoholic beverages to help people make more informed choices regarding alcohol consumption:

[Some] knowingly drink excessive [alcohol] and some unknowingly. They do not know the alcohol capacity, how much is written over the bottle…The concentration of alcohol is more in some bottles and less in some bottles. People do not know the concentration of that bottle so they can drink. (Bhutanese Focus Group 2)

Similar to the Bhutanese participants, the Iraqi participants also suggested community-wide awareness about norms related to use of prescription medication in the US, as well as alternatives for pain management:

“It is a matter of awareness and finding alternatives of what is the [appropriate] use of these medications.” (Iraqi Focus Group 1)

Both groups of participants expressed openness to clinical interventions offered by professionals. However, peer counseling from a close associate or confidante also emerged as an important theme, especially from the Bhutanese participants. Many of them expressed concerns that someone struggling with excessive use of alcohol would be resistant to professional intervention and more receptive to informal counseling from a trusted member of their own community.

“If somebody is close to him or her, they can express their feelings. It is easier to share feelings with friends compared to strangers.” (Bhutanese Focus Group 2)

Another common area for intervention identified by both groups was employment. Participants believed that young men in their respective communities would steer clear of excessive substance use if they had stable jobs to keep them busy and mitigate financial worries. For example, one Iraqi participant cited the example of a friend who curbed his addiction to prescription pain medication after finding employment:
“Because he had more doors open for him, more opportunities. So he just started making money, buying a car and things like that and then he stopped doing that thing [using pain medication]” (Iraqi Interview 2)

Finally, intervention strategies were brought up that were unique to each community. For example, Iraqi participants frequently brought up placebo-based interventions. Many of them offered examples of family members or friends whose dependence on prescription medication had been discouraged by replacing their medicine with sugar pills. On the other hand, Bhutanese participants stressed the importance of addressing peer group influence for young men in their community who were struggling with excessive use of alcohol:

“We need to change [the alcoholic individual’s] company as bad company makes him drunkard. And we need to change the environment. We need to respect him every day. We need to talk with him politely, make him happy so that he can change that habit. It is possible to change him like that. Several people have changed. It can be done.” (Bhutanese Focus Group 1)

Discussion

While a great deal of research has focused on refugee mental health issues, a much smaller literature has considered that refugees displaced by war and conflict also experience many of the risk factors associated with substance use problems (Ezard, 2012; Sowey, 2005). In order to develop culturally acceptable supports for refugee communities in their country of resettlement, it is important to first understand how these communities recognize and experience excessive or hazardous use of recreational substances (Gagnon & Lonsdale, 2006). To this end, our research revealed critical insights into excessive use of alcohol and opioid pain medications from the perspectives of Bhutanese and Iraqi refugees, respectively.

Prior work on substance use in immigrant communities suggests two explanatory models for development of substance use problems. The first of these, the Acculturative Stress Model (Johnson, 1996), implicates the stress of adjusting to life in a new country as the main
contributor for development of substance use problems. The second is the Assimilation/Acculturation Model (Johnson, 1996), which suggests that social and legal norms of the new country strongly drive substance use behaviors of new immigrants.

Our findings lend some credence to the theory of post-migration stress as a risk factor for substance use problems. Participants in both groups cited stress experienced after resettlement in the US, from being unemployed, from finding and holding on to a job to cover living expenses, and from missing family left behind, as an important trigger for excessive substance use. Similar stressors related to employment and partial family migration have been identified in prior research studies with different refugee groups in the UK (Patel et al., 2004) and Australia (Sowey, 2005). Prior research (Sowey, 2005; Porter & Haslam, 2005) has also highlighted the role of pre-migration stressors, such as exposure to violence and difficult refugee camp conditions, as precursors to substance use problems. Similar pre-migration stressors were also identified by participants in our study.

In addition to pre- and post-migration stressors, we also found evidence that social and legal norms in the US exerted an important cultural influence on substance use behaviors among newly resettled refugees from the two groups included in this study. The Bhutanese participants found that access to alcohol was easier, albeit more expensive, in the US compared with their native Bhutan. At the same time they also felt encumbered to be employed and self-sufficient in the US, unlike the chronic lack of occupational activity, paid or otherwise, in refugee camps in Nepal. These two factors seemed to have a push and pull influence on their alcohol use behaviors. Similarly, use of prescription medication in the Iraqi community was also reportedly changing as community members became familiar with the different social and legal norms that govern prescription and use of opioid pain medication in the US.
Therefore, taken together, our findings suggest that there exists an interplay between pre-migration experiences, post-migration stressors, and acculturation to new legal and social norms. This interplay exerts different risk and protective factors throughout a displaced refugee’s migration history to influence development, resurgence, or attenuation of substance use problems. This is an important finding which is divergent from previously held notions on substance use in immigrant and refugee communities. Some previous scholars (Westermeyer, 1996; Yee & Thu, 1987) postulate that substance use problems surface in immigrant communities after a lag period of a few years post-immigration, after basic survival needs have been met. On the contrary, our findings suggest that substance use problems might emerge sooner post-immigration or not at all, depending on the interplay of triggers and protective factors in the individual’s risk environment at that point in time. Indeed, the few participants in our study who self-identified a problem were all recently resettled in the US. For these participants, the extent of their problems did not become apparent until follow-up interviews were conducted for the subsequent phase of our study (not reported here). It is also likely that other participants were not ready to self-report problems in the context of a research study, but nonetheless were in need of support and information. This may be one reason that prior studies of refugees found low prevalence of substance abuse relative to mental health problems (Betancourt et al., 2012). Our research team was often asked if we would be hosting more groups and were occasionally urged to organize more groups and open the groups to minors (as suggested by Bhutanese participants) and to women (as suggested by Iraqi participants).

The above findings support the importance of early intervention, risk assessment, and preventive support before problems become apparent or are self-reported. Participants in our study emphasized the need for education, awareness, and counseling. Community organizations
that serve refugee newcomers in the US can play an important role in this regard. These organizations are charged with the task of orienting newly arrived refugees to life in the US. Standard orientation activities could be expanded to include preventive substance use counseling that is tailored to the needs of specific refugee communities. For example, preventive workshops for the Bhutanese community may include information on how a standard drink is defined in the US, the difference between moderate and excessive drinking, and how to read alcohol content of beverages. Similarly, workshops for the Iraqi community may include strategies for managing somatic pain and information on safe and appropriate use of prescription medication for pain management. These messages can be couched within a larger dialogue on healthy behaviors and habits to avoid stigma commonly associated with substance use problems.

Training and capacity-building around substance use is also critical within refugee-serving organizations and among refugee community leaders (Patel et al., 2004). Musser-Granski and Carrillo (1997) recommend bilingual and bicultural paraprofessionals to bridge gaps between community organizations and professional mental health services. Thus, bilingual members of refugee communities could be trained to lead educational workshops, offer peer counseling, conduct risk assessments, and make referrals to professionals where needed. As individuals who share the cultural heritage of the communities they serve, paraprofessionals can also conduct community outreach to address stigma and attitudinal barriers toward substance use intervention. They can also play an important role in educating professional service providers about sociocultural norms around use of specific substances in their respective communities (Musser-Granski & Carrillo, 1997). The use of bilingual and bicultural paraprofessionals has been successfully implemented by the Asian American Substance Abuse Intervention Initiative (AASAI). Funded by the Illinois Department of Human Services, AASAI strives to build
capacity within Asian American community organizations by training paraprofessionals to provide culturally and linguistically appropriate education and outreach, screening, early substance abuse intervention, and referral to treatment (Asian Health Coalition, n.d.). This type of model might be worth replicating in refugee-serving organizations to proactively address the risk of substance use problems in refugee communities.

Limitations

Our study carries a few limitations. First, we used a convenience sample of participants who met our study’s eligibility criteria. Therefore, it is likely that our study participants and the perspectives they shared are not representative of the broader Bhutanese and Iraqi refugee communities in the US. We tried to address this limitation as best as we could by recruiting participants through multiple community organizations within the city and in surrounding suburbs. Second, we only used focus groups to gather data. As such, use of multiple methods, such as focus groups and in-depth interviews, and triangulation between methods would have strengthened our findings. Finally, members of the research team were fluent in neither Arabic nor Nepali, thereby necessitating our reliance on interpreters and translators. Despite our use of rigorous translation processes during data collection and analysis, the possibility that certain linguistic and cultural nuances might have been missed cannot be ruled out.

Conclusions

Our study provides some initial insights into the ways in which substance use issues are defined and experienced by Iraqi and Bhutanese refugees resettled in the US. We also identified risk and protective factors for substance use problems in these communities and promising strategies for support and intervention. This information can aid in development of preventive and remedial interventions that are culturally appropriate and accepted by refugee newcomers.
References


