

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

Danielle Horyniak ^{1,2*}	danielle@burnet.edu.au	+61 3 9282 2176
Peter Higgs ^{1,2,3}	peter.higgs@curtin.edu.au	+61 3 9079 2202
Shelley Cogger ¹	shelley@burnet.edu.au	+61 3 8506 2394
Paul Dietze ^{1,2}	pauld@burnet.edu.au	+61 3 9282 2134
Tapuwa Bofu ⁴	tapuwab@ceh.org.au	+61 3 9418 9929

¹Centre for Population Health, Burnet Institute, 85 Commercial Rd, Melbourne, VIC, 3004, Australia

²School of Public Health and Preventive Medicine, Monash University, 99 Commercial Rd, Melbourne, VIC, 3004, Australia

³National Drug Research Institute (Melbourne Office), Curtin University, Suite 6, 19-35 Gertrude Street, Fitzroy, VIC, 3065, Australia

⁴Centre for Culture, Ethnicity and Health, 23 Lennox St, Richmond, VIC, 3121, Australia

*Corresponding author

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Abstract

Objective: 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 young people in Melbourne, Australia.

Design: Face-to-face interviews were conducted with 16 self-identified African refugees 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.

Conclusion: These findings highlight the urgent need for targeted harm reduction education for African young people 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 that address the

underlying health and psychosocial causes and consequences of heavy alcohol use are also needed.

Keywords: Alcohol, culturally and linguistically diverse communities, refugee health, Africa, young people, qualitative research

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1. Introduction

Forced migration is a growing issue in the 21st 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 (United Nations High Commissioner for Refugees 2013, 2014). Each year 60-70,000 refugees are resettled in Western countries, with Australia taking in roughly 14,000 refugees per annum, ranking among the top refugee-receiving countries worldwide (United Nations High Commissioner for Refugees 2012, Australian Government Department of Immigration and Border Protection 2014).

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 (Steel et al. 2009, Porter and Haslam 2005, Schweitzer et al. 2006, Savic et al. 2013, Kirmayer et al. 2011).

Alcohol is a cause of significant morbidity and mortality globally, accounting for roughly 5% of the total burden of disease (Begg et al. 2007, Lim et al. 2012, Rehm et al. 2009). In particular, alcohol is the leading cause of disease among adolescents and young adults, particularly those living in high-income settings (Gore et al. 2011). Alcohol use also

contributes to a wide range of social, economic, and legal harms at the individual, family and community levels (Laslett et al. 2011).

Our understanding of the relationship between forced migration and alcohol use remains limited. Although several studies have recorded lower rates of alcohol consumption and alcohol use disorders among some migrant and refugee groups compared with their host populations (Salas-Wright and Vaughn 2014, Donath et al. 2011, Donato-Hunt, Munot, and Copeland 2012), contrasting research has found higher rates of alcohol use and related harms among some ethnic and cultural minorities (Unger 2012, Keyes, Liu, and Cerda 2012). 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 (Durrant and Thakker 2003). 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 (Steel et al. 2009, Fazel, Wheeler, and Danesh 2005). 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 (Carter and Osborne 2009, Livingston 2012). Finally, acculturation to mainstream norms and a desire to gain acceptance in their new communities may play a role in increasing substance use (Reid et al. 2001, Durrant and Thakker 2003, De La Rosa 2002, Fosados et al. 2007). 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 (Browne and Renzaho 2010, Morris et al. 2009, Neale et al. 2007, Lee, Sulaiman-Hill, and Thompson 2013).

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 10 studies, eight of which focused on refugees resettled in high and middle-income countries (Weaver and Roberts 2010). 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 (Hugo 2009). Studies involving African communities in Australia have documented experiences of unemployment, social disadvantage, marginalisation and discrimination (Colic-Peisker and Tilbury 2007, Polonsky, Brijnath, and Renzaho 2011, Wille 2011). For African refugee young people, further challenges have been documented in relation to language acquisition and difficulties adapting to the Australian education system and gaining meaningful employment (Poppitt and Frey 2007, Brown, Miller, and Mitchell 2006, Nunn et al. 2014). 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' (Nunn 2010, Windle 2008, Australian Human Rights Commission 2010).

In recent years, high levels of alcohol consumption among disengaged and marginalised African refugee young people has been identified by community organisations as an emerging concern (Khawar and Rowe 2013, Ahmed 2006, Ethnic Communities Council of Victoria 2007). The issue has also received attention in the media (e.g. Oakes 2012, Petrie 2012). 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 consumption is prohibited) and consuming large amounts of alcohol in a session (Papanastasiou, Higgs, and Dietze 2012, Manton, Pennay, and Savic 2013, Dwyer et al. 2007). Youth substance use support agencies operating in this region have also recorded an increase in numbers of clients from African backgrounds (Youth Support and Advocacy Service 2012). A brief snapshot of these clients found that they experience poor physical and mental health and high levels of disengagement from education and employment (Youth Support and Advocacy Service 2013). Beyond this, no research has examined alcohol use among African refugee young people in Australia in detail. Our study aims to address gaps in knowledge about patterns of alcohol consumption, motivations for drinking, and consequences of drinking among this group, and provide evidence to inform the development of interventions to reduce alcohol use and related problems among resettled refugee youth more broadly.

2. Methods

2.1 Study design and participant recruitment

In 2012-2013 we conducted a qualitative study examining alcohol and illicit drug use among marginalised African migrants and refugees from Melbourne's western suburbs (Horyniak et al. 2014). 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. Authors DH, PH, and SC (the primary research team for the study) spent several months in the field, conversing and engaging with young people of interest in the spaces which they frequented. Key young people with whom we developed strong relationships acted as 'brokers', introducing us to other members of their social group. Young people who expressed an interest in the study and were available to complete the study interview on the day or who were willing to schedule an interview, were invited to participate. 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. Further information regarding participant engagement and recruitment methods has been previously published (Horyniak et al. 2014).

2.2 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 background. Key areas of discussion included migration to Australia, social integration in Australia, patterns, contexts of and motivations for alcohol consumption, and health and social consequences of alcohol consumption. Questions such as 'Can you tell me a bit about when, where and why you drink alcohol?' encouraged participants to describe personal experiences of alcohol use, and it is from these narratives that 'motivations' for alcohol consumption are drawn. 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.

2.3 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 when describing their migration experiences were analysed. Analysis employed a thematic approach using inductive coding, with the aim of understanding emic interpretations of individual participant's experiences. All coding was conducted by DH. DH, PH and SC communicated frequently during the participant engagement, data collection, and data analysis processes, reflecting on the content of participant interviews and the coding of key themes. This process allowed for discussion of different interpretations of the data from diverse perspectives (one younger female epidemiologist who has travelled extensively in Africa, one male qualitative researcher with a background in social work and harm reduction with Vietnamese communities, and one female social scientist with extensive experience in conducting field-based research with people who use illicit drugs), limiting the potential impacts of assumptions and prejudices that any individual researcher may have had during any phase of the study. A return visit to the field site was also conducted in September 2013, during which preliminary findings were discussed with a small number of participants to ensure that our interpretations accurately reflected participants' understandings of their own behavior.

3. Results

3.1 Participants

The participants were 16 men aged 18-30 years (median: 24 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 (median: 10.5 years). Post-migration experiences commonly included family separation (many had arrived in Australia with a member of their extended family while immediate family remained in Africa) and disengagement from education and employment.

3.2 Patterns of alcohol use

Young people visited Footscray on most days so they could meet and socialise 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 being controlled by drinking, or 'letting alcohol drink them' as it was described. This was initially 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 weekdays, 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 the use (and in particular 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.

3.3 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 the couple and 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 because he refused to leave school to get a job to help support the family.

As a result of these traumatic and stressful experiences, 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, frustration and marginalisation

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 resignation; 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.

3.4 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 who frequented the study site.

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 was no greater an issue among Africans 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 often did not attend because he had been drinking. In turn, this caused him to drink more, 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 that their consumption of alcohol contributed to their marginalisation. Reflecting the collectivist nature of African cultures, young people who consume alcohol risk 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, searched, and having their drinks poured out by the police in public places and receiving fines in relation to alcohol-related offenses such as public drunkenness.

3.5 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, 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 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.

4. Discussion

African refugee young people 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 normalisation of alcohol consumption in Australia, neither exposure to alcohol nor acculturation to Australian norms was identified as a key driver of alcohol use. This is not to suggest that these factors are unimportant; further research is required to measure exposure to alcohol use and to

collect validated acculturation measures, which may shed more light on the role these factors may play in alcohol consumption.

The finding that coping with stressful and traumatic pre- and post-migration experiences was an important motivation for harmful alcohol use among the young people in this study is consistent with findings from quantitative research which has identified exposure to trauma as a risk factor for alcohol-related problems (Weaver and Roberts 2010). Although participants did not specifically refer to their emotions in the context of mental health, or using biomedical terminology, their descriptions of experiencing '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 (Tilbury 2007, Bailes and Minas 2013).

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 disorders among refugee youth (Fazel, Wheeler, and Danesh 2005, Ziaian et al. 2012, Hansson et al. 2012, Ellis et al. 2010), 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 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 and mental health services, stigma associated with mental health problems and help-seeking and concerns about cultural competence, trust and confidentiality (de Anstiss and Ziaian 2010, Colucci, Minas, et al. 2012, Colucci, Szwarc, et al. 2012). 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 (Finch et al. 2003, Dupont et al. 2005). 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 (Blankenship et al. 2006).

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 been shown to be an important source of support among refugee youth (Halcón et al. 2004, de Anstiss and Ziaian 2010), in some ways replacing these missing family relationships. Further, 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 refugee young people 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 for alcohol use.

Participants' desires to manage their issues alone reflected a fear of stigma and exclusion from their communities. Although not identified by participants, religious beliefs, particularly for those of Muslim heritage, may play a potential role in underlying the stigma and shame associated with consuming alcohol. Participants also identified with cultural beliefs that discussing their problems with others was inappropriate. Enacting this belief could be interpreted as participants' demonstrating agency, stoicism and inner strength, as has been suggested in other studies (Ellis et al. 2010, Khawaja et al. 2008). Conversely, this could also reflect participants' resignation to experiencing difficulties in their lives and lack of motivation and support 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 young people 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. Community-led interventions are likely to be particularly effective in this regard. We are excited by the potential of the recently funded 'Be a brother' project, targeting African men aged 16-25 years in Melbourne's Western suburbs. This project will involve collaboration between a local health service and African young men who have successfully controlled their drinking or whose lives have been adversely affected by alcohol, to produce a peer-led social media campaign (Cohealth 2015, Millar 2015).

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. Recent research has found that 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 (Lee, Sulaiman-Hill, and Thompson 2013). In response, support programs aimed at improving parents' (and communities') capacity to respond to alcohol use among young people are needed.

There is clearly an unmet need for professional support in relation to both alcohol use and mental health. People who experience comorbid mental health and substance use issues have significant difficulty accessing services, and this may be exacerbated even more for people of refugee background (Posselt et al. 2013). Further research is needed in order to build an evidence base regarding the types of programs and services (including dual diagnosis services) which will be most appropriate and acceptable for people of refugee background. Community-based interventions are again likely to be promising in this regard. There is some evidence to suggest that peer-led programs and cultural interventions which draw on both traditional and Western approaches to healing may be particularly effective in addressing substance use problems (Rowan et al. 2014). 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, and through both outreach and fixed-site models.

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 we encountered consented to participate. This is a major limitation of the study; further qualitative studies which employ strategies to identify and include more hidden groups within the community, such as women, are needed. A second key limitation which should be addressed in future studies is that the inclusion of participants from a range of African countries and distinct tribal/cultural affiliations limits the ability to explore how cultural and religious beliefs may impact alcohol use and treatment seeking behaviours. Third, although we placed significant emphasis on building strong relationships with participants, it is possible that participants' responses may have been influenced by social desirability and discourses

regarding alcohol use in the wider community. We are however encouraged by the fact that the findings reported by participants in our study are consistent with emerging public discourse (e.g. Millar 2015, Johnstone 2012). Finally, this study focused exclusively on young people of African refugee background who were engaged in harmful patterns of alcohol consumption. Future studies should consider including young people who are not engaged in such patterns of use, in order to explore factors which promote resilience and prevent uptake of harmful patterns of alcohol use.

5. Conclusion

This study provides an insight into the motivations and consequences of heavy alcohol consumption among a sample of marginalised African refugee young people 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 aimed at increasing community awareness, knowledge and response strategies around alcohol use and alcohol-related problems are also needed.

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