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HOLDSTOCK-PIACHAUD STUDENT ESSAY PRIZE

Treating substance abuse as a consequence of conflict and displacement: a call for a more inclusive global mental health

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In settings of conflict and displacement, the provision of appropriate mental health services is essential. While most mental health research has focused on identifying rates of post-traumatic stress and other common disorders in post-conflict settings, there has been little recognition of substance abuse as both a cause and consequence of mental health problems. Problems that arise when people begin to abuse substances to cope with the severe stress of emergency situations include the depletion of finite family and community resources, violence, exploitation, neglect of children and other protection threats. As a case in point, refugee camps on the Thai–Burma border have become a fertile breeding ground for drug and alcohol addiction. A more inclusive view of global mental health—one that addresses the problems of substance use in post-conflict and displacement contexts—will better enable health professionals to make meaningful contributions to conflict resolution and longer term peace-building processes.

Keywords: alcohol; substance abuse; mental health; conflict; displacement; refugees

Introduction

Psychological suffering is the most enduring consequence of war and disaster. The psychological consequences of war can profoundly impact an individual's ability to pursue a meaningful, productive life, and alter an entire society's capacity to recover, rebuild and re-establish peace. The provision of appropriate mental health services in post-conflict settings is thus indispensable to the recuperation of peaceable, humane societies around the globe (Patel et al. 2011).

Mental health researchers in humanitarian settings have most frequently focused on identifying rates of post-traumatic stress and other common mental disorders (Tol et al. 2011), but there has been little acknowledgement of substance abuse as both a cause and consequence of mental health problems. This is in spite of the fact that both the United Nations High Commissioner for Refugees (UNHCR) and the World Health Organisation (WHO) have affirmed that

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a rise in alcohol and drug use problems poses a significant and largely unaddressed challenge to public health (UNHCR and WHO 2008). As a case in point, refugee camps on the Thai–Burma border have become a fertile breeding ground for drug and alcohol addiction in one manifestation of people’s efforts to cope, however dysfunctionally, with the extreme stress of conflict-related displacement.

Drug and alcohol addiction amongst Burmese refugees

For the past six decades, armed conflict in Burma between minority groups’ armies and the central government’s military has forced hundreds of thousands of people to flee to refugee camps across the border in Thailand (UNHCR 2013). Near the heart of this conflict is Burma’s role as one of the largest producers of opium in the world. According to the 2012 report by the United Nations Office on Drugs and Crime (UNODC), Burma is second only to Afghanistan for the size of its opium production, which is refined into heroin and trafficked globally (UNODC 2012). Political economist Catherine Brown has argued that ‘The expansion of the drugs trade can be seen as both a cause and a consequence of the wider economic and social dislocation of Burmese society after decades of military rule and civil war’. The material profits of the drugs trade go a long way to accounting for the persistence of conflict and complex emergencies in this region (Brown 1999).

Violence follows the spread of opium cultivation in a vicious cycle of impoverishment, human rights violations and population displacement, in which large numbers of the area’s ethnic minorities have been forced to flee as refugees (Brown 1999). For these refugees, upheaval from their homes and the process of adaptation to new cultural and physical environments can be extremely stressful. The UNHCR and WHO note that substance use problems can develop at any stage of displacement: in the country of origin, in transit, in temporary refuge, or in resettlement (UNHCR and WHO 2008). Previous research has shown that forcibly displaced persons commonly experience a high number of traumatic events related to the armed conflict and persecution that they have fled (Porter and Haslam 2005). Often they have lost their family, friends, possessions and employment – and with that their livelihoods, roles, income, cultural and social supports, and self-esteem (Carballo and Nerukar 2001; Miller and Rasco 2004). A systematic review of the evidence of harmful alcohol use following from forced displacement indicates high rates of psychiatric disorders such as depression, anxiety and generalized psychological distress in post-displacement conditions (Weaver and Roberts 2010).

In the Thai–Burma refugee camps, population surveys have confirmed that alcohol use is viewed as an important security concern (Ezard et al. 2012). In-camp service provider data listed alcohol as an important cofactor in recorded incidents of gender-based violence, physical assault and suicide (UNHCR 2007). Interviews with camp residents revealed the dominant belief that the

pressures of displacement and life in a refugee camp contribute to problem alcohol use. Some men said that they resort to substance abuse because they feel deprived of their typical means of livelihood: ‘We have only alcohol. It’s like being in a farm [...] surrounded by a fence’ (Ezard et al. 2011).

Restricted movement, education and employment opportunities were seen to drive a sense of hopelessness and idleness. Disenfranchised young men felt they had no other avenues to express their frustration: ‘There is only alcohol to get release’ (Ezard et al. 2011). This, coupled with the ready availability and cultural acceptability of male drinking, was believed to result in the disproportionately high levels of alcohol use among men. Female residents, in turn, described the added stress and pressure on their families as a result of male drinking, including gender-based violence, crime, the serious neglect of children, and the financial burden of alcohol and substance use on families’ limited resources. One camp resident put it this way: ‘The majority of addicts are men. Because of this, women are mentally ill’ (DARE Network 2000).

What is currently being done?

One effective drug and alcohol rehabilitation programme being carried out in the Thai–Burma camps is by the Drug and Alcohol Recovery and Education (DARE) Network. They are a small, community-based organization that has had remarkable success in the treatment of addicts on both an in-patient and outpatient basis (DARE Network 2011). Rather than regarding addiction as purely a medical problem, DARE Network also tries to address the social, political and economic dimensions of addiction in order to achieve long-term recovery. Their treatment paradigm recognizes that widespread addiction to drugs takes away people’s ability to think, plan and resist a military regime that is bent on their destruction. Their overarching belief is that ‘A free mind cannot be destroyed’. DARE Network thus envisions the ethnic people of Burma using the power of recovery from addiction as a form of non-violent resistance and conflict resolution. Recovery from drug and alcohol addiction returns people to their communities, which makes communities more resilient to deal with political and economic upheavals: ‘Even though everything else has been taken from them, as long as they keep their minds they are free people’ (DARE Network 2011).

The role of academic research and teaching

Despite the prevalence of substance-related problems amongst refugees, the research literature and availability of practical resources on the subject are sparse (Ezard 2012). Vast gaps in the global delivery of mental health services reflect, in part, substantial deficits in scientific knowledge about virtually all aspects of the delivery of such care in resource-poor settings (Becker and Kleinman 2013). And yet, it is crucial for doctors committed to improving the

health of people affected by war, social violence and human rights abuses to recognize these elevated risks for substance-related harms. Complex humanitarian interventions should include access to comprehensive treatment services for mental health problems as both a cause and consequence of substance use. As set forth in *The Lancet's* 2011 series on Global Mental Health, the pragmatic and moral imperatives are self-evident: without comprehensive mental health care, there is no justice (Raviola, Becker, and Farmer 2011).

Health professionals are needed to conduct targeted research that will generate an evidence base (and debunk myths) to guide strategic planning for the prevention, treatment and minimization of substance-related harms. Academic research and teaching will be able to justify the right interventions and motivate the broad-based support necessary for mental health policy, research, training and infrastructure to become explicit priorities at the national, regional and multinational levels (Becker and Kleinman 2013).

Even though there exists considerable evidence about what does and does not work to reduce the hazardous use of alcohol and drugs, this knowledge is based primarily on trials conducted in and driven by the needs of the richest countries (Room, Babor, and Rehm 2005; Royal Australasian College of Physicians, Royal Australian and New Zealand College of Psychiatrists, and GROW (Australia) 2004). Only a tiny fraction of published clinical trials have been conducted in low-income countries, so the effectiveness of treatments across culturally diverse, low-income settings is largely unknown (Becker and Kleinman 2013). In order to appropriately translate research findings into clinical and public health practices, it is critical to accelerate implementation research to evaluate interventions beyond the controlled conditions of research settings, and in the types of populations that suffer the largest proportion of the global burden of morbidity and mortality (Dua et al. 2011).

For example, classic models of high-risk drinking such as the social stress model, whereby social stressors may promote individual substance use, and the 'self-medication' hypothesis, whereby substances are thought to be used to relieve individual suffering, applied to patterns of drinking in the Thai–Burma camps fail to explain why levels of high-risk drinking are *less* than would be predicted by these models (Ezard et al. 2012). Investigation into the underlying protective mechanisms at work in the Thai–Burma camps would bear valuable insights toward future efforts to prevent transitions to harmful substance use in other conflict-affected populations.

One promising line of investigation could explore the role of community resilience, by which problem substance use is kept under control by the social stability of communities and tight social networks. In the Thai–Burma camps, the social and cultural unacceptability of drinking by women, drinking to intoxication, drinking by young people and drinking in solitude may all be acting to limit the spread of alcohol use problems (Ezard et al. 2012). In addition, people in the camps may be benefiting from a sense of hopefulness provided by access to free education and the possibility of resettlement to a third country afforded

by their United Nations-sanctioned refugee status. That the level of risky alcohol use among displaced Burmese populations may be lower than those of other displaced populations with alcohol-drinking cultures highlights the complexity and context-specificity of the relationship between alcohol and displacement (Ezard et al. 2011).

At the top of the research agenda should be the refinement of diagnostic tools and protocols in community and primary care settings, the identification of mediators and modifiers of risk and resilience, and the measurement of the effectiveness of conventional and novel treatment-delivery strategies in a variety of health systems (Becker and Kleinman 2013). The present dearth of rigorous empirical evaluations of humanitarian interventions means that people around the world are receiving untried, untested and unmonitored mental health treatments in the aftermath of wars and disasters (Abramowitz and Kleinman 2008). Given the very real nature of mental health problems and the suffering that they cause, our present use of scarce resources on irrational and inappropriate treatments can no longer be tolerated (Patel et al. 2011).

What more can be done?

Many compelling arguments have been made for the inclusion of mental health on the global health agenda (Raviola, Becker, and Farmer 2011). Important advances have been made in the requisite scientific knowledge base and political will to scale up mental health care services in low-income and middle-income countries, where the treatment gaps are the largest and where some of the most serious human rights abuses against people with mental health problems are perpetrated (Becker and Kleinman 2013). This paper argues, however, that the global mental health mandate must be extended to recognize substance abuse as a mental health problem of particular exigency in post-conflict and displacement settings. Although mental health has been recognized as a human right in several international documents, this recognition has thus far failed to extend itself to humanitarian contexts (Abramowitz and Kleinman 2008). Mental health has not been recognized as a priority in the restoration of governance and mental health care is not well understood within the structural and cultural contexts of violence, transition and transitional governance in which they occur. Present uncertainties around the status of mental healthcare as a human right result in appalling instabilities in the provision of care (Abramowitz and Kleinman 2008).

Conflict and natural disasters create situations in which people, in an attempt to cope with the stress of emergency situations, may experience severe problems related to substance use. The Inter-Agency Standing Committee (IASC) urges humanitarian emergency response programmes to realize that communities will have difficulties recovering from the effects of emergencies when substance use inhibits individuals and communities from addressing problems; finite family and community resources are spent on alcohol and

other substance use; and substance use promotes violence, exploitation, neglect of children and other protection threats (IASC 2007).

Substance use should not be treated as an issue separate from mental health. Addiction is not a character flaw; it is both a cause and consequence of mental health problems. Substance use interventions should be incorporated as essential components of general health services, mental health and psychosocial support, HIV and sexually transmitted infections interventions, and gender-based violence prevention (Ezard et al. 2011). Mental health assessments should include information on substance use. As far as possible, substance use prevention, treatment, care and support should be integrated into primary health and community-based services.

Conclusion

A more inclusive view of global mental health – one that addresses the problems of substance use in post-conflict and displacement contexts – will better enable health professionals to make meaningful contributions to conflict resolution and long-term peace-building processes. At the individual level, addiction is directly related to feelings of powerlessness. But, at least in the case of Burma, there is also the growing realization of addiction's role in the bigger story of refugees: persecution, armed conflict, instability, a profitable drugs trade and undemocratic rule. Providing support to those who are trying to break free from the cycles of addiction will enable a more full and inclusive participation in the long process of rebuilding society after war. Such a paradigm of care has broad implications for our collective healing.

Notes on contributor

Lucinda Lai is a first-year student at Harvard Medical School. From 2011 to 2012, she lived on the Thai–Burma border and worked for a non-profit organization that provides mental health services to Burmese refugees in Thailand.

References

- Abramowitz, S., and A. Kleinman. 2008. "Humanitarian Intervention and Cultural Translation: A Review of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings." *Intervention* 6 (3): 219–227.
- Becker, A. E., and A. Kleinman. 2013. "Mental Health and the Global Agenda." *New England Journal of Medicine* 369 (1): 66–73. doi:10.1056/NEJMr1110827.
- Brown, C. 1999. "Burma: The Political Economy of Violence." *Disasters* 23 (3): 234–256.
- Carballo, M., and A. Nerukar. 2001. "Migration, Refugees, and Health Risks." *Emerging Infectious Diseases* 7 (3 Suppl): 556–560.
- DARE Network. 2000. *Health Messenger 11, Special Issue: Alcoholism*. <http://www.ibiblio.org/obl/docs3/PdF%20FINAL%20ISSUES/ISSUE%2011.pdf>.

- DARE Network. 2011. *Annual Report*. http://www.darenetwork.com/images/documents/2011dare_annual_report.pdf.
- Dua, T., C. Barbui, N. Clark, A. Fleischmann, V. Poznyak, M. van Ommeren, M. Yasamy, et al. 2011. "Evidence-based Guidelines for Mental, Neurological, and Substance Use Disorders in Low- and Middle-income Countries: Summary of WHO Recommendations." *PLoS Medicine* 8 (11): e1001122. doi:[10.1371/journal.pmed.1001122](https://doi.org/10.1371/journal.pmed.1001122).
- Ezard, N. 2012. "Substance Use among Populations Displaced by Conflict: A Literature Review." *Disasters* 36 (3): 533–557. doi:[10.1111/j.1467-7717.2011.01261.x](https://doi.org/10.1111/j.1467-7717.2011.01261.x).
- Ezard, N., E. Oppenheimer, A. Burton, M. Schilperoord, D. Macdonald, M. Adelekan, A. Sakarati, and M. van Ommeren. 2011. "Six Rapid Assessments of Alcohol and Other Substance Use in Populations Displaced by Conflict." *Conflict and Health* 5 (1): 1–15. doi:[10.1186/1752-1505-5-1](https://doi.org/10.1186/1752-1505-5-1).
- Ezard, N., S. Thiptharakun, F. Nosten, T. Rhodes, and R. McGready. 2012. "Risky Alcohol Use among Reproductive-age Men, Not Women, in Mae La Refugee Camp, Thailand, 2009." *Conflict and Health* 6 (1): 7. <http://www.ncbi.nlm.nih.gov/pubmed/22963719?dopt=Abstract&holding=f1000,f1000m,isrctn>.
- IASC (Inter-Agency Standing Committee). 2007. "Action Sheet 6.5: Minimise Harm Related to Alcohol and Other Substance Use." In *Interagency Guidelines on Mental Health and Psychosocial Support in Emergencies (IASC Guidelines)*, 142–147. Geneva: IASC.
- Miller, K. E., and L. M. Rasco. 2004. "An Ecological Framework for Addressing the Mental Health Needs of Refugee Communities." In *The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation*, edited by K. E. Miller and L. M. Rasco, 1–66. Mahwah, NJ: Lawrence Erlbaum Associates.
- Patel, V., N. Boyce, P. Y. Collins, S. Saxena, and R. Horton. 2011. "A Renewed Agenda for Global Mental Health." *The Lancet* 378 (9801): 1441–1442. doi:[10.1016/S0140-6736\(11\)61385-8](https://doi.org/10.1016/S0140-6736(11)61385-8).
- Porter, M., and N. Haslam. 2005. Predisplacement and Postdisplacement Factors Associated with Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis. *JAMA: The Journal of the American Medical Association* 294 (5): 602–612. doi:[10.1001/jama.294.5.602](https://doi.org/10.1001/jama.294.5.602).
- Raviola, G., A. E. Becker, and P. Farmer. 2011. "A Global Scope for Global Health—including Mental Health." *Lancet* 378 (9803): 1613–1615. doi:[10.1016/S0140-6736\(11\)60941-0](https://doi.org/10.1016/S0140-6736(11)60941-0).
- Room, R., T. Babor, and J. Rehm. 2005. "Alcohol and Public Health." *The Lancet* 365 (9458): 519–530. doi:[10.1016/S0140-6736\(05\)17870-2](https://doi.org/10.1016/S0140-6736(05)17870-2).
- Royal Australasian College of Physicians, Royal Australian and New Zealand College of Psychiatrists, and GROW (Australia). 2004. *Illicit Drugs Policy: Using Evidence to Get Better Outcomes*. Sydney: RACP.
- Tol, W. A., C. Barbui, A. Galappatti, D. Silove, T. S. Betancourt, R. Souza, A. Golaz, and M. van Ommeren. 2011. "Mental Health and Psychosocial Support in Humanitarian Settings: Linking Practice and Research." *The Lancet* 378 (9802): 1581–1591. doi:[10.1016/S0140-6736\(11\)61094-5](https://doi.org/10.1016/S0140-6736(11)61094-5).
- UNHCR, and WHO. 2008. *Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide*. Geneva: Author. http://www.who.int/mental_health/publications/field_guide_alcohol_substance_use/en/index.html.
- UNHCR (United Nations High Commissioner for Refugees). 2007. *Protection Incidents in Refugee Camps on the Thai/Myanmar Border: Trends and Analysis 2003–2006*. Geneva: Author.

- UNHCR (United Nations High Commissioner for Refugees). 2013. *2013 UNHCR Country Operations Profile – Myanmar*. <http://unhcr.org/cgi-bin/texis/vtx/page?page=49e4877d6&submit=GO>.
- UNODC (United Nations Office on Drugs and Crime). 2012. *Patterns and Trends of Amphetamine-type Stimulants and Other Drugs: Asia and Pacific*. Vienna: United Nations Office on Drugs and Crime. http://www.unodc.org/documents/scientific/Patterns_and_Trends_of_Amphetaime-Type_Stimulants_and_Other_Drugs_-_Asia_and_the_Pacific_-_2012.pdf.
- Weaver, H., and B. Roberts. 2010. “Drinking and Displacement: A Systematic Review of the Influence of Forced Displacement on Harmful Alcohol Use.” *Substance Use & Misuse* 45 (13): 2340–2355. doi:10.3109/10826081003793920.