

The hunting of the snark: detecting and managing abusers of alcohol and other drugs in refugee camps – a commentary on Ezard et al. and Streel & Schilperoord

Colin Brewer

The abuse of alcohol and other drugs (AOD) is evidently a significant, but often neglected, problem in refugee camps. There are some differences compared with AOD problems in developed countries (notably fewer affected women), but also many similarities. Alcohol is the major problem in terms of behaviour and is often manufactured and traded by refugees themselves. Not all AOD users are AOD abusers, but identifying abusers may be worth the effort if it can be shown to reduce, rather than increase, the healthcare workload. If staff can be engaged, there are several techniques for engaging and managing abusers. The nonspecific effects of interventions may be considerable.

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Even addiction specialists who have worked in low income countries have little idea of some of the problems that are common in a refugee setting. Merely by describing them, the authors do a useful service, yet despite the specific problems of refugees and within the camps in which their problems often need to be managed, there are many similarities with conventional practice.

First, as both papers note, it is increasingly accepted that in developed countries alcoholism treatment services have concentrated

excessively on drinkers with classic physical dependence at the more severe end of the spectrum. Like most conditions, alcoholism and other varieties of substance abuse come in all degrees of severity. For many people with less extreme problems, even if some will graduate to severity, different public health and individual management approaches may be needed.

Nevertheless, as Ezard, et al. observe, it is difficult to see how price control, one of the most effective public health interventions for alcohol, could easily be implemented in a camp setting. This is especially true if the manufacture of alcohol becomes an important and widespread industry among the poor, as it did in Britain during the great gin epidemic of the 18th century. Attempts at enforcing prohibition are even less likely to succeed in largely unpoliced refugee camps than in countries like the USA, where the ‘war on drugs’ is increasingly regarded as a costly, vicious and counter productive failure (Brewer, 2008). War zones are often notoriously porous to drug trafficking, while conflict increases the already considerable potential for corrupting officials.

Streel & Schilperoord recognise that problems with alcohol and other drugs (AOD) are often as much youth problems, as drug

problems. That is also true of countries and communities living in relative peace, where the fact that most adolescent AOD abusers spontaneously *'mature out'* in their late 20s accounts for quite a lot of the apparent *'treatment success'*. However, providing an adequate level of hope for uprooted and under employed refugee youth must be a real challenge, especially when making or trading in intoxicants provides one of the few job opportunities.

Given the reluctance of many health professionals to address AOD patients and problems, even in well endowed services, I think both papers are right to emphasise the need to collect objective outcome data, especially on the results of any planned interventions. Even quite modest *'brief interventions'* may be cost effective, but already overworked staff might need persuasive evidence that these will not be a waste of their time, and indeed make their lives easier. However, given the overwhelmingly male nature of alcohol abuse apparently typical of camp life, it does no harm to remember that many wives and mothers have little difficulty in recognising problem drinking in their families, especially if asked. Involving family members in the management of identified problem abusers is often helpful to both parties, and makes feedback about progress, or lack of it, much easier. Where a tribal or wider social structure remains reasonably intact, recruiting community leaders to spread an educational message and/or to identify problem users and support their families would be less difficult and more useful in this context, than in individualistic Western societies.

There is strong evidence (Edwards et al., 1977) that once alcohol abusers accept that they have a problem and decide (or are persuaded) to do something about it, many of them improve for useful periods, regardless

of whether or not they have formal treatment. Encouraging some sort of self-help group is therefore an obvious and economical intervention to consider. Alcoholics Anonymous (AA) is the best known, but not the only variety. Its *'12-step'* philosophy gives it a tendency to ideological rigidity, making it strongly opposed, for example, to harm reduction approaches aimed at reducing drinking and drink-related harm, as opposed to lifelong abstinence. A recent systematic review (Ferri et al., 2006) failed to find evidence of any specific effectiveness of the AA programme. However, as Edwards et al. found, the nonspecific effects of treatment are often considerable and should not be dismissed simply because they are essentially a manifestation of the placebo effect. For cultures (or indeed professionals) uncomfortable with the AA philosophy, there are alternative groups. Of these, SMART (self-management and recovery training), which uses cognitive-behavioural therapy (CBT) techniques and involves some professional guidance (Brooks & Penn, 2003) is perhaps the best known. For involving concerned family members and persuading problem AOD users to accept help, community reinforcement and family training (CRAFT) also uses a CBT approach and proved considerably more effective than traditional 12-step approaches. (Roozen et al., 2010). How appropriate and effective such interventions are within refugee camps in Africa or South Asia remains to be seen.

Anti-alcohol medications, especially the more expensive ones such as acamprosate or naltrexone, are unlikely to feature prominently (or at all) in most refugee formularies.¹ There may be a small, but useful, place in managing the more troubling and troublesome abusers for disulfiram, which deters drinking by the threat (and

sometimes, the experience) of an unpleasant reaction if alcohol is consumed. It is much cheaper, as well as significantly more effective, than either acamprosate or naltrexone. Moreover, it has been shown to be equally superior in low income countries, such as India (de Sousa & de Sousa, 2004; de Sousa & de Sousa, 2005). It is also, in some respects, a 'natural' treatment, since in essence, it reversibly converts the physiology of alcohol abusers into one similar to that of the 10% of the Japanese population who find that drinking has such unpleasant effects that alcoholism is virtually unknown among them (Brewer, 2005). However, it will only be effective if healthcare, family or social structures make possible its supervised administration at least twice weekly, which is the key to success.

Unfortunately, effective medical interventions for most drug problems, other than alcohol, either do not yet exist or are too expensive, too complex or too heavily regulated to be of much use in this setting. Methadone maintenance is a 'gold standard' intervention for heroin abuse, but currently requires legal and administrative frameworks (and budgets) that are unlikely to exist in either refugee camps, or many of the countries that host them. Opiate antagonists, which block the action of heroin, are relatively expensive and require highly trained staff. For *khat*, cannabis or the benzodiazepine sedatives, there are no effective nor easily prescribed medical techniques to make life a little easier for would-be helpers in a camp setting.

In practice then, the management of AOD problems in refugee settings will largely involve much the same types and principles of individual, social, psychological and – in some cases – legal intervention that (with the exception of methadone or buprenorphine maintenance) still characterise the

typical treatment models in most developed countries.

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¹ The aforementioned medications for use in alcohol use disorders (acamprosate, naltrexone and disulfiram) are not included in the *WHO List of Essential Medicines*, but they are mentioned in the *WHO Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings*.

Colin Brewer is a retired British psychiatrist with over 40 years of clinical and academic interest in alcoholism and other drug abuses. His publications include studies and reviews of alcoholic brain damage, the use of heroin-blocking drugs and other medications as adjuncts to addiction treatment programmes, placebo effects and the ineffectiveness of prohibition. email: cbrewer@doctors.net.uk