A Healthcare Provider's Guide to Understanding and Addressing Substance Misuse in Refugees and Asylees with an Islamic Migration Background

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Abstract: Substance use disorders (SUDs) include the use of alcohol, pharmaceuticals, or street drugs at a clinically significant level resulting in development of tolerance, withdrawal, craving, and impairment in key functions required for human life and survival.[1] Increasingly prevalent worldwide and a significant cause of morbidity and mortality globally, SUDs develop within a complex context and have significant implications for individuals, families, and communities. Refugees and forced migrants may be particularly vulnerable to substance misuse given their more frequent exposure to trauma, co-morbid mental health disorders, acculturation challenges, and socioeconomic inequality within migration and post-migration settings.[2,3] Furthermore, these individuals may be more hesitant to report substance (mis)use given deeply rooted stigma around such activities within their systems of religion and the fear of being marginalized within their communities.[4] In the last 10 years, 36% of refugees entering the United States have identified as Muslim.[5] Within Islam, the use of substances, broadly referred to as *khamr*, is expressly forbidden, or *haram.*[6,7] However, religious belief alone does not constitute immunity against the development of substance (mis)use and the path to resettlement increases both substance access and exposes individuals to various challenges that may precipitate the use of substances as a means of coping or self-medication.[2] Given the increasing number of displaced people worldwide and the unique factors predisposing such populations to SUDs, it is critical to examine substance use within this population and to provide healthcare providers with recommendations and resources to more effectively screen for and support refugees and asylees with SUDs. This paper intends to illuminate and contextualize barriers to adequate substance use screening in Muslim refugees as well as to underscore the critical need for tailored screening, prevention, and recovery support resources for persons with an Islamic migration background resettled in non-Islamic majority countries.

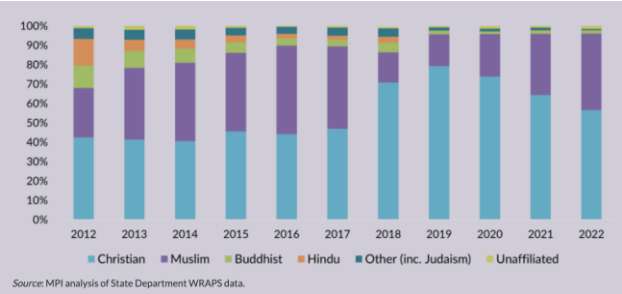
Introduction

Exploring Dominant Religious Backgrounds of Forcibly Displaced Populations

Historically, the United States has been one of the leading refugee resettlement countries in the world, admitting more than 60,000 refugees and asylees during 2023 alone and over 3 million since 1975.[8,9] Forcibly displaced from their countries of origin due to war, violence, or persecution, refugees and asylees comprise a rapidly growing portion of those seeking care within the US health system. In addition to recognizing the unique healthcare needs of this population,

providers should be aware of the cultural and religious backgrounds of those they serve to better understand shared patient attitudes and practices and facilitate quality care. The International Family Medicine Clinic (IFMC) at the University of Virginia serves refugees and special immigrants in the Charlottesville area, many of whom are from predominantly Islamic countries in Africa and the Middle East, including Somalia, Syria, Afghanistan, and Iraq among others.

Figure 1. Religions of Refugees Admitted to the United States, Fiscal Year 2012-2022



Migration Policy Institute. (2023). *Refugees and asylees in the United States.* Retrieved from https://www.migrationpolicy.org/article/refugees-and-asylees-united-states.

According to the Migration Policy Institute, 46% of all those resettled in the United States in 2016 were Muslim (Figure 1).[5] Indeed, Islam is the fastest growing religion within the United States, with over three million Americans identifying as Muslim today.[10]

Islamic Perspectives on Substance Use

While research on rates of alcohol and drug use within Muslim communities remains scarce, it has been documented that Islamic-majority countries have some of the lowest rates of substance use per capita in the world. However, many posit that such results are distorted due to stigma and taboo-related underreporting considering prevailing attitudes towards substance use within Islamic communities.[11] Underreporting may be further perpetuated within groups sharing an Islamic migration background, including forcibly displaced individuals, given what De Kock in her research refers to as 'triple stigma,' indicating that these individuals not only face stigma around problem substance use in broader society and their own religious and ethnic communities, but also migration-related stigma.[6,12]

To provide culturally competent healthcare to forcefully displaced patient populations identifying as Muslim, it is critical to understand the relevant Islamic teachings concerning substance use. Central to the teachings of Islam are the preservation of individuals' dignity as well as the emphasis on protecting mankind from harm and destruction.[13] The foundation of Islamic laws, ethics, and theology, the Qur'an prohibits alcohol use for recreational reasons, referring to alcohol as the "Handiwork of Satan."[7] While the Qur'an does not specifically address other substances, the consumption of alcohol in addition to other intoxicating substances has been broadly prohibited within Islamic societies since around 600 A.D. In a recent qualitative study examining imams' (leaders of mosques) perspectives on substance use, one imam remarked upon the shame and stigma associated with substance use in the broader Muslim community:

"It could be that they do whatever is not good to their bodies … Not only is it [i.e.,

substance use] not good for them, it is not good for the society. That is why they hide. They hide themselves. They don't want people to know that they are smoking and they are drinking because they know that is a bad habit. It is forbidden in Islam. It is haram."[14]

One's religious affiliation may have a multi-dimensional impact on their path to reporting and recovering from substance misuse. Indeed, in their qualitative analysis of recovery capital among migrants and ethnic minorities in recovery from problem substance use, Pouille et al. note that Muslim communities may have both a helping and hindering influence on recovery processes, stating that while one's religious social network has the potential to offer spirituality, faith, and a supportive community environment, the moral load of substance use problems within the Islamic context may prevent individuals from disclosing substance use problems or seeking treatment, leading to isolation and loss of social ties.[6] Thus, while certain aspects of Islamic teachings may serve as protective factors, prevailing attitudes towards substance use within the community may lead to its stigmatization, creating a fundamental barrier to treatment for those struggling with misuse.

Beyond Stigma: Further Barriers to Treatment and Recovery

Undoubtedly, the heightened stigma associated with substance use within Islamic communities represents a significant social and psychological barrier towards effective reporting and treatment of SUDs by and among forcibly displaced individuals identifying as Muslim. Beyond the stigma and social isolation that these individuals may feel within their religious communities is the broader societal stigma that they may face as misusers of substance(s) in society. Hertner et al. write: "In addition, it must be acknowledged that refugees that (mis)use substances face barriers when aiming for equal participation in society on two levels, being a refugee and being a substance (mis)user." [4] While it is important to keep this idea of compounded stigma in mind, it is by no means the only barrier that refugees face when seeking clinical help for substance misuse. Within humanitarian settings, the availability and accessibility of mental health and substance use treatment services remain low.[15] Indeed, in such places there is a gross lack of infrastructure for providing such services and the provision of food and shelter is typically prioritized. In the post-migration context, authors Saleh et al. identify organizational and cultural barriers within the host country as well as lack of mental health and substance use awareness among refugees to be significant barriers to connecting individuals with appropriate resources.[1]

Particularly in Western countries, there is a lack of culturally diverse substance recovery models and interventions. In fact, in the US, many substance use intervention programs are Christian faith-based, including the widely implemented twelve-step programs.[14] Broadly, recovery capital refers to both the internal and external resources that help facilitate and sustain one's recovery from

substance misuse. Among the pillars of recovery capital is cultural recovery capital, which can be further understood as those resources which intend to maximize the opportunity for a culturally sensitive recovery. In a qualitative content analysis using recovery capital theory, it was shown that the importance of cultural recovery capital was most evident in the narratives of participants who self-identified with a culture closely tied to religion, such as Islam. While religious values and codes of conduct could have a negative impact on individuals' recovery processes (e.g., secrecy and isolation due to taboo and stigma), they dually had a profoundly positive impact on most individuals during their recovery, including one 31-year-old Muslim participant, Hamid, who said: "Belief, culture, maintaining my values and norms, that is an important anchor in my recovery."[16] As discussed in a co-creative case-study focused on tailoring the continuum of care for substance use problems to persons with an Islamic migration background, a dearth of religiously and culturally tailored prevention and treatment interventions for this population may actually lead to a greater misunderstanding and taboo surrounding addiction within Muslim communities.[16] In this study, Arafat, a Muslim man with a history of problem substance use, comments on the lack of tailored prevention initiatives in Ghent, Belgium and how the more westernized commentary concerning addiction may not be well received by individuals in the Muslim community: "Tell my brothers: 'addiction is a disease', and they shoot me. 'No, that is your own responsibility!' But that's just because we're [persons with an Islamic background] behind in all that, regarding what addiction is (…). There just wasn't that much prevention going on in the community." [6] Apart from the lack of culturally sensitive prevention and treatment interventions for substance use in host countries is the problem of misconception and limited awareness of mental health and substance use terminology among refugees. Indeed, in a study assessing the perceptions and awareness of refugees regarding substances of abuse and their treatment in the US, Bhutanese and Iraqi refugees were unable to distinguish between the excessive use of alcohol, prescription drug abuse, and self-medication.[17] In the aforementioned co-creative case study, Arafat discusses his own experience with heroin addiction, describing how his lack of education on the dangers of heroin use propelled his ignorance into an addiction. He therefore emphasizes the importance of sufficiently informing persons with an Islamic background about addiction, recovery, and evidence-based interventions in a linguistically, religiously and culturally appropriate language.[6] The same is true for mental health terminology; Muslim immigrants may lack understanding of Western healthcare systems' description and framing of mental health symptoms and diagnoses.[18] Furthermore, there may not be clear translations of such terminology and ideas when using language interpreters. Thus, beyond the stigma surrounding substance use among those with an Islamic background, other barriers to the adequate prevention and treatment of SUDs in this population include lack of culturally

relevant prevention and intervention resources in the host country as well a general misunderstanding of substance use and its harms among refugees with an Islamic migration background.

At Risk: The Migration and Post-migration Contexts

Substance use, including the misuse or excessive use of alcohol or illicit drugs to the point of causing personal or social problems, is an important cause of morbidity and mortality, accounting for 6.5% of total disability-adjusted life-years and 5 million deaths worldwide in 2010.[19] It is well-documented that a wide variety of substance misuse problems exist across refugee and humanitarian settings.[2] Indeed, while numerous environmental and sociocultural factors are known to contribute to the development of SUDs, refugees are considered to be particularly vulnerable to substance use as a self-medication behavior given the following elevated risks associated with the process of migration and resettlement: 1) increased access to substances in both migration and post-migration settings, 2) exposure to trauma and other stressors associated with mental health disorders, 3) acculturation challenges, and 4) socioeconomic discrimination in countries of resettlement.[2,3]

1. Increased access to substances in both migration and post-migration settings

It has been well-documented that within places of temporary residence, including refugee camps and similar humanitarian settings, access to illicit substances may increase.[15] Fewer drug enforcement policies and limited security in such settings allows for increased local drug supply and subsequently drug trafficking.[2] Conducted over a period of six months, a cross-sectional study from 2015 demonstrated that lifetime substance use was higher among Palestinians born in Lebanon who were residing in refugee camps in that country than among Palestinian and Syrian adults (aged 18 and older) who had been more recently displaced from the Syrian Arab Republic and were now living in refugee camps in Lebanon, indicating that more prolonged exposure to the camp setting contributed to increased rates of drug use among those residing there.[15, 20] A second study from 2018 examined rates of substance use among refugees from South Sudan and Somalia living in camps in Uganda. It showed that while substance use among refugees predated their displacement, more frequent patterns of use among those displaced reflected substance use patterns more common in the host country.[21] Indeed, differing social norms within host countries may result in intensification of pre-displacement patterns of drug use among refugees, more closely reflecting baseline substance use patterns within host communities. Beyond increased access to substances and exacerbation of pre-existing drug use patterns within the migration context (i.e. settings of temporary displacement such as more transient stays within refugee camps), is the reality of more permanent exposure and access to alcohol and illicit substances within the post-migration setting. Forcibly displaced

populations are often provided residence through various local and national resettlement programs and agencies, however the neighborhoods in which refugees find themselves more permanently resettled are often socioeconomically disadvantaged, increasing local exposure to alcohol and drugs given the effects of area-level socioeconomic status on availability of illicit substances.[22, 23] This concept will be further explored when discussing impacts of socioeconomic discrimination on substance use and SUD development among refugees below. It is critical to examine the existing evidence pointing to increased substance access in such settings as well as to understand the post-migration landscape which may predispose refugees to substance use in order to better assess the risks in populations with a history of forced migration.

2. Exposure to trauma and other stressors associated with mental health disorders

The burden of mental health disorders among forcibly displaced populations is extraordinarily high. From a pre-migration standpoint, refugees and asylees have often witnessed conflict and violence within their own countries which may contribute to the development of mental health disorders or exacerbate preexisting mental health conditions. Published in 2019, a systematic review of 129 studies looking at 39 different countries concluded that nearly one in five people exposed to settings of conflict were estimated to be suffering from depression, anxiety, PTSD, and other mental health conditions.[15, 24] In that same year, it was estimated that one in eight people globally were living with a mental health disorder, illustrating the increased prevalence of mental health disorders among those exposed to areas of unrest.[15, 25] Other forms of trauma in the pre-migration or "pre-flight" setting include physical injury, sexual violence, and neglect, all of which are known to increase individual risk of developing post-traumatic stress disorder (PTSD). PTSD has further been established as a strong lifetime indicator of increased risk for alcohol use disorders and drug abuse or dependence which may result from efforts to self-medicate or cope with relived experiences of trauma.[26]

When examining mental health issues among those forcibly displaced, researchers Miller and Rasmussen emphasize shifting the focus away from pre-migration experiences of trauma to the post-migration social ecology of refugees.[27] A common form of trauma among refugees in the post-migration context is separation from one's family members. Many families are often unable to leave their country of origin or exit as an intact unit. The emotional distress of being separated from one's spouse, children, siblings, or parents is further compounded by the governmental barriers in place which limit institutional family reunifications once some members are resettled. Beyond the positive impact of family reunification on mental health is the protective nature that an intact, supportive family has on preventing or "buffering" individuals from developing problematic patterns of substance use.[4] There is an abundance of literature to support the comorbidity between mental

health and substance use disorders, however, only recently has this link been studied more closely within forced migrant populations.[3] Considering the often traumatic circumstances under which individuals and families are displaced and further stressors greeting them upon resettlement, refugees and asylees are particularly vulnerable to problem substance use.

3. Acculturation challenges

The term 'acculturation' refers to the process of cultural and psychological change that follows contact with a culture other than one's own.[28] Younger migrants specifically may be motivated to adhere to mainstream social norms to gain acceptance into their new communities following resettlement. Particularly in Western countries where the use of alcohol and drugs is more normalized and such substances are more widely available, this propensity to assimilate may lead to higher rates of substance use among young refugees.[3] Based on a review published in 2014, rates of opiate use increased among Afghan youth and women following their displacement to refugee camps in the Islamic Republic of Iran and Pakistan. Moreover, there was a transition to the use of a concentrated form of heroin known as "kerak" as well as the injection use of heroin.[29] This intensification of pre-displacement patterns of drug use more closely reflected baseline rates of drug use within the host countries (i.e. Iran and Pakistan) as well as mimicked more popular forms of drug use and drug administration in these countries. Apart from attempting to gain acceptance into the community by partaking in alcohol and drug use, young refugees may have the separate experiences of peer-pressure and boredom that may further predispose them to substance (mis)use.[2, 3] Consider the following vignette based on a patient encounter at the IFMC:

A 22-year-old male from Iraq arrives for a follow-up visit to discuss tobacco cessation and weight loss. He reports that since his last appointment, he has not been able to cut back on the number of cigarettes he is smoking despite implementing strategies discussed between him and his physician to help him do so. When asked how ready he is to completely quit, he replies "70%. The thing is, I know myself. I know that if I have a job, I will stop. It's just that I have nothing else to do during the day and then I crave a cigarette. I have been interviewing for so many jobs and have not heard back yet." After a brief pause, he adds: "I want you to know because I feel like you should know. I went to the store to get cigarettes yesterday and the young man working there said I should try a new kind of cigarette that makes you relaxed. He said I'd really like it. I tried it but I didn't like the way it made me feel."

This patient encounter effectively illustrates how young refugees in particular may be vulnerable to developing problematic patterns of substance use. Not only does the patient report stress about finding a job and boredom at home as factors contributing to his continued tobacco use, but he experiences peer-pressure resulting in him trying an unknown substance for the first time. Undoubtedly, the individual marketing the drug to the patient leveraged the existing

language barrier as a profitable tactic in ensuring a sale.

4. Socioeconomic discrimination

Loss of resources, including social and financial capital, has been shown to precipitate patterns of substance misuse as well as amplify pre-existing risk factors for developing an SUD.[2] Indeed, following resettlement, forced migrants often experience social and economic inequality and discrimination within their host communities. Such factors are considered important determinants of health, shaping both individuals' health status and outcomes.[3] Once arrived in a host country, refugees are offered affordable housing through resettlement agencies, like the International Rescue Committee (IRC) in Charlottesville, VA. According to the United Nations Refugee Agency (UNHCR), the provision of secure and affordable permanent housing is one of the most challenging problems facing countries of resettlement today.[22] In the US, housing refugees is particularly difficult given that there is minimal public or subsidized housing across the country. This is in contrast to countries like Denmark, Sweden, Finland, and the Netherlands which allocate specific municipalities according to a quota system and are able to house refugees immediately upon their arrival. Regardless, it is almost universally recognized that refugees face significant disadvantage in the housing market and often are resettled in low-income neighborhoods within their host countries.[22] In a multilevel analysis of neighborhood socioeconomic context and health outcomes, researchers Pickett and Pearl found that of the five studies that examined the effects of neighborhood social factors on smoking behavior, four reported increased relative risks (RR) of smoking between 1.2-1.7 in low socioeconomic status (SES) neighborhoods.[30] The concept of area-level disadvantage and its association with increased substance use is not a new one. Social exclusion and relative deprivation theories posit that lower SES neighborhoods are afflicted by differential development of social structures, including those that maintain social order (policing, schools) and physical resources (housing, employment opportunities).[23] Additionally, increased targeted marketing of alcohol and increased drug availability in lower SES neighborhoods may further contribute to observed patterns of heightened substance use within these neighborhoods. Discussed above, increased access to substances is one of the driving factors contributing to elevated risk of developing SUDs among refugees in the post-migration landscape.

Current Pitfalls: Screening for SUDs in Clinical Practice

At the IFMC, a 28-year-old male from Afghanistan recently resettled in Charlottesville presents for his intake visit accompanied by his 24-year-old wife. During the social history portion of the interview, when asked briefly about alcohol, tobacco, and recreational drug use, the couple bashfully laughs and shakes their heads. "We are Muslim," his wife replies softly, indicating that such consumption is not permitted within his belief system.

Scenarios like this are not uncommon at the IFMC, where much of the patient population identifies as Muslim. Providers may be reluctant to further question or clarify when presented with such answers for fear of offending their patients or appearing culturally insensitive or untrusting. Time constraints imposed by working with language interpreters may further discourage physicians from lengthening the conversation on this point. Thus, screening for substance use often ends here, prompting the question: do primary care providers adequately screen for substance use in Muslim refugees and asylees?

Current guidelines

In the primary care setting, initial and frequent follow-up screening for substance use is encouraged by federal agencies and professional medical associations, however many factors prevent physicians from adequately doing so, including lack of time, low or no reimbursement, and few referral resources among others.[31] Such challenges may be further compounded by physicians' own knowledge gaps and fear of offending patients when specifically screening for substance use in refugee and asylee populations identifying as Muslim. Although screening is highly encouraged, few professional guidelines offer concrete screening advice. For example, the United States Preventive Services Task Force (USPSTF) recommends screening for alcohol, tobacco, and other drug use in adults 18 years or older, including pregnant women, by asking questions about unhealthy use.[32] While many PCPs may perform brief screening by asking simple yes/no questions at wellness visits, the existing guidelines do not remark specifically upon how frequently screening should be performed and thus there may be more reluctance among providers to perform screening and brief intervention (SBI) at subsequent visits, particularly if patients have identified themselves as Muslim and denied any substance use previously.

For those who screen positive for alcohol or drug use with any number of validated brief questionnaires, including the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C), Cut down, Annoyed, Guilty, Eye-Opener (CAGE), or Drug Abuse Screening Test (DAST-10), there is evidence suggesting that behavioral counseling interventions, defined as one to four in-person or web-based sessions that are typically short in duration and provide education on and strategies to reduce substance use, lead to less alcohol and other drug use.[33] Unfortunately, literature broadly reveals that PCPs generally feel they lack adequate training to perform such interventions. Compounding this is the dearth of behavioral health specialists available to provide patient consultation. Competing demands on providers' time further prevent them from asking screening questions during patient visits and providing adequate behavioral counseling follow-up.[31] Particularly when working with populations requiring language interpreters during visits, providers may feel stretched for time in appointments. In a single visit, it may be difficult to fully address the patient's chief

complaint(s) and screen for substance use given that conversation takes twice as long. Further potentiating gaps in substance use screening of patients with a language barrier, including many refugees, asylees, and migrants, is the fact that numerous validated screening tools, including the aforementioned AUDIT-C, CAGE, and DAST-10 which are optimally self-administered by patients and thus designed to be time-saving, are not available in languages such as Dari, Pashto, Somali, and other languages common among those who have been forcibly displaced. Thus, populations who primarily speak these languages, including most refugees from Afghanistan and Somalia, are unable to self-administer these widely implemented resources.

For school-aged children and adolescents under 18 years of age, the USPSTF recommends primary care interventions to prevent tobacco use, including e-cigarettes, nicotine gels, hookah, vapes, and other nicotine delivery systems in children with no history of tobacco use.[34] Such interventions include brief education on the harms of use. Apart from the aforementioned barriers preventing PCPs from adequately screening for substance use in the general population and more specifically among those with a language barrier and identifying as Muslim is the fact that many providers may feel that providing such education to their young Muslim patients is not a good use of time. Indeed, within a typical one hour well child appointment at the IFMC, providers and staff are tasked with addressing medical concerns as well as responding to and facilitating the coordination of social, transportation, and other needs. Thus, if providers have met a family before and are aware that the family identifies as Muslim, they may feel it is less essential to provide education to their pediatric patients about the harms of tobacco as they don't want to sound redundant or come across as untrusting. However, a study by Arfken, Owens, and Said published in 2012 found that Muslim parents are uncomfortable talking to their children about the harms of substance use, further underscoring the importance of communication and education about substance (mis)use in the primary care setting.[35]

Conclusions: Guidance for the Primary Care Provider

Having examined the unique pre- and post-migration factors predisposing forced migrants to SUDs as well as the existing barriers preventing Muslim refugees from accessing prevention and treatment resources, the reader may be daunted by the seemingly insurmountable structural inequities and organizational obstacles perpetuating the increased prevalence of substance use among this population and by the inadequate screening practices and treatment options currently employed or available in clinical settings. The suggestions provided here by no means represent an exhaustive list of critical interventions, but rather enumerate practical considerations for the primary care provider when proceeding with the prevention and treatment of substance use disorders in forcibly displaced individuals with an

Tips for assessing SUD risk and screening	*Considerations when facilitating treatment*
● Inquire about any time spent in refugee camps or similar humanitarian settings ● Ask patients if they have been separated from any members of their family ○ Are their legal obstacles preventing family reunification? Consider involving IRC case manager ● Screen for and provide brief education on substance use at all annual visits ● When screening for substance use in children <18, request that other family leave the room to ensure confidentiality ● Consider employing DSM-5 Cultural Formulation Interview to enhance clinical understanding and decision-making	● Consider involving individual's family in discussions around treatment and recovery ● Use an interdisciplinary health care team to provide education and employment resources to recovering individuals ● Consider referral to Family Stress Clinic for behavioral health intervention ● Consider participating in community based outreach to provide substance use education and intervention ○ Incorporate into current community partnership/health education programs like Cville Tulips

Islamic background. First, it is critical to ask new patients with a known history of displacement about any time spent in refugee camps as well as to inquire about any pre- or post-migration family disunification. These questions should be asked objectively with the goal of better understanding one's individual circumstances and risk factors for pre-existing or developing mental health and/or substance use disorders. Given that family disunification is known to negatively impact refugees' mental health and concordantly that an intact family may buffer an individual member from developing problematic patterns of substance use, care providers should inquire about any legal obstacles preventing family reunification to better understand the circumstances around patients' elevated risks and to coordinate patients' care with available social or case workers.[4] Following initial visits, PCPs should screen individuals for substance use during all subsequent yearly wellness visits, if not more frequently, to both provide brief education on substance misuse as well as to monitor for its development. This is especially important when caring for refugees and asylees, who face resettlement challenges which are known to increase SUD susceptibility and exacerbate pre-existing patterns of drug use. When screening for substance use in children under 18 with an Islamic migration background, providers should not hesitate to ask their parents/guardians to step out of the room so that they may speak to patients alone given that heightened parental disapproval and religiously rooted stigma may make younger patients reticent to report any degree of substance use in front of family members. While there are few substance use screening tools validated for administration through a third-party interpreter, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Cultural Formulation Interview (CFI) is an innovative, evidence-based tool that

clinicians may use to obtain information about the impact of culture on key aspects of an individual's clinical presentation and care during a mental health assessment. This 16-question tool enables the physician to collect collateral information from family members or caregivers and has specific modules tailored to populations with specific mental health needs, including immigrants and refugees.[36]

As in the general population, forcibly displaced individuals along with their families and broader cultural and/or religious communities are negatively impacted by substance misuse. Harmful consequences of substance use include loss of social ties, including the breakdown of family relationships, as well as social and employment repercussions for the affected individual. In light of this, further considerations for providers when initiating and facilitating culturally relevant treatment of SUDs in general practice include the incorporation of family and other social networks into discussions around recovery as well as the provision of employment and education resources through the use of an interdisciplinary healthcare team. Given that Muslim communities are generally family-centered, approaches to treatment that are family-oriented may be more successful than those that are only focused on the individual.[6] Beyond incorporating one's family into substance use treatment models, providers should consider an individual's employment and educational opportunities as significant factors in their recovery. Indeed, in the US, Bhutanese and Iraqi refugees with histories of substance misuse believe that treatment approaches should offer resources and support in these domains.[17] At the IFMC, this entails gathering a multidisciplinary care team consisting of a social worker, behavioral health specialist, IRC case manager, and clinical coordinator, among others, to facilitate an individual's durable recovery. Outside of the clinical setting, there may be opportunities for members of health teams to engage in outreach aimed at raising awareness about substance use, addiction, and treatment options in the greater refugee community. Through a recent partnership with a local organization called Cville Tulips, a group of resident physicians and medical students at the University of Virginia has begun volunteering time to provide female refugees in the Charlottesville area with relevant lessons on women's and children's health. A similar model could be adapted for substance use education and prevention in the community.

Among displaced peoples, the baseline risk for substance misuse may be increased due to a number of factors, including greater access to and availability of substances in both refugee camps and post-migration settings, as well as exposure to conflict and resettlement stressors which may precipitate substance use as a means of self-medication or as a means of adopting cultural norms to be more quickly accepted into host communities. It is important that the primary care provider be aware of these existing vulnerabilities when preparing to discuss substance use with refugees and additionally recognize that individuals with an Islamic migration background may be less willing to

report and seek treatment for substance misuse. The purpose of this commentary is to draw attention to the current pitfalls in the prevention and management of SUDs in Muslim refugees and to propose practical, culturally-sensitive tips for preventing, screening for, and treating problematic substance use in this community.

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