May 29, 2019

Special Commission of Inquiry into the Drug ‘Ice’
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RE: AOD use including ‘ICE’ and treatment amongst CALD communities

It is very difficult to identify rates of alcohol and other drug use in CALD communities. Australian national surveys tend to be administered in English and there are limitations in the way data is collected, which undermines understanding the differences in substance use, prevalence and harms within CALD populations and comparatively between groups (Rowe et al, 2018).

Recent analysis of data from the National Drug Strategy Household Survey suggests that while overall AOD rates amongst CALD respondents are lower than non CALD communities, virtually no data is available relating to the prevalence of ‘ICE’ amongst CALD population groups (Rowe et al, 2018, p. 2). However current figures (between May 2018-2019) from the Drug and Alcohol Multicultural Education Centre (DAMEC) suggests that ‘ICE’ is the highest ranking illicit primary substance of concern for their CALD clients seeking treatment.

Some evidence suggests that CALD people who inject drugs may be at greater risk of blood borne infections (Maher, Li, Jalaludin, Chant & Kaldor, 2007; Rowe et al., 2017). While these findings do not explicitly include the substance ‘ICE’, their relevance lies in the need for more public health campaigns directed towards safer injecting practices for CALD communities. Other research has noted that CALD communities have similar or even more supportive attitudes towards harm reduction measures such as NSPs and regulated injecting rooms compared to non-CALD respondents (Rowe et al, 2018).

While it is difficult to determine levels of ‘ICE’ and other AOD consumption of CALD communities, a variety of risk factors related to migration, resettlement and acculturation have been identified (Posselt, Galletly, de Crespigny, & Procter, 2013) while AOD consumption patterns may change as a result of the former forces (see Horyniak et al, 2014) including intergenerational changes (Renzaho, Dhiriga, & Georgeou, 2017; Horyniak, Cogger, Higgs), length of time and age of arrival in Australia (Agic et al. 2016; Bayley & Hurcombe,2011).

Pre-migration experiences of forced displacement, torture and trauma (VAADA, 2016) can increase AOD consumption while other risk factors include the loss of economic, family or social identity, disruption to traditional parenting relationships which can impact on the ability to discipline young people, and adaptation to Australian settings where certain substances may be more widely available and use is tied to social practices (Ethnic Communities Council of Queensland, 2012; Anile, 2018). Experiences of alienation (Schwartz, Unger, Zamboanga, & Szapocznik, 2010), and structural racism (Smith & Reside, 2010; Coffey et al., 2004) have also been found to shape AOD use amongst CALD communities. Other potential burdens of harms for AOD use include the disproportionate high levels of preventable health issues and criminal justice figures for CALD groups. (Maher, Jalaludin, Chant, & Kaldor, 2007; Coffey et al., 2004).

Under-representation of CALD communities in Australian AOD treatment is continuing with little improvement in recent years (AIHW, 2018). There is some evidence that shame in some CALD
communities is particularly acute, leading to greater reluctance to seek assistance from Australian mainstream treatment services. Previous research has also highlighted concerns about a lack of access to supports for early intervention and CALD persons with AOD issues “bypassing treatment services”; with the first contact with treatment often arising after involvement in the criminal justice system (VAADA, 2016).

When people from CALD backgrounds do access AOD services they often receive less than adequate care. Structural concerns about cultural relevance and responsivity of AOD services has been acknowledged amongst a national cohort of AOD workers (see Rowe & Santos, 2016) and importantly as an issues amongst CALD communities who have sought AOD treatment and those who support them (Flaherty & Donato-Hunt 2012; Jaworski et al, 2019; Rowe 2014; VAADA, 2016).

Yet to date there is no existing state-wide or national cultural assessment framework within the AOD sector that considers the specific needs of CALD communities. The Drug and Alcohol Multicultural Education Centre (DAMEC) remains the only service in NSW that is specifically dedicated to clinical interventions, community development and research in reducing AOD related harms within CALD communities. With the expansion of its services into Western Sydney in 2017, DAMEC was commissioned by WentWest PHN to undertake a study on some of the most prominent CALD communities’ understanding of AOD harms and harm reduction strategies within this highly diverse region.

The findings of this study are attached with recent and relevant DAMEC publications which may be useful to this inquiry.

To summarise DAMEC recommends the following for this Commission:

1. Further research that highlights ‘ICE’ related harms and harm reduction strategies among CALD communities will be of broad benefit.
2. Expand AOD health literacy educational opportunities for CALD communities and those supporting them including harm reduction strategies. Specific attention should be paid to identifying ‘ICE’ use as a health issue and addressing concerns around shame and stigma that may inhibit help seeking.
3. Encourage opportunities for expanding family involvement in AOD support, education and treatment programs.
4. Build peer education and leadership capacities with CALD communities
5. Enhance the capacity of the sector to provide flexible, long term support
6. Adequately resource the AOD workforce to address CALD individual, family and community needs in a sensitive and culturally responsive manner including the expansion of CALD specific AOD services.

Prepared by:

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References:


Executive Summary

Previous research has indicated that it is very difficult to identify rates of alcohol and other drug (AOD) use in Culturally and Linguistically Diverse (CALD) communities in Australia due to national surveys being administered only in English (Rowe, Ansara, Jaworski, Higgs, & Clare, 2018). Additionally, limitations in the way data is collected also undermines determining substance use prevalence and harms within CALD populations and comparatively between groups (Rowe et al, 2018). Yet the Australian National Drug Strategy 2017-2026 has identified CALD communities as a priority population who may be more vulnerable to risk of harmful use of AOD for a variety reasons related to forced and voluntary migration, acculturation, intergenerational issues, trauma and loss (Victorian Alcohol and Drug Association (VAADA), 2016) and the changing nature of AOD access and consumption in the resettlement context (Anile, 2018; Ethnic Communities Council of Queensland, 2012; Horyniak et al, 2014).

Scholarship has highlighted that for AOD treatment intervention to be effective, services need to be capable of responding to diverse communities where there are unique risks or resilience factors, or different explanatory models of health and health behaviours (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000; Castro, Barrera & Holleran Steiker, 2010). To date, there is no existing state-wide or national cultural assessment framework within the drug and alcohol sector that considers the specific needs of CALD communities while the small amount of Australian research on culturally responsive AOD clinical practice has tended to focus on single treatment types or streams (Rowe, 2014; VAADA, 2016). Under-representation of CALD communities in AOD treatment is continuing with little improvement in recent years (AIHW, 2018). Previous research has also highlighted concerns about a lack of access to supports for early intervention and CALD persons with AOD issues “bypassing treatment services”; with the first contact with treatment often arising after involvement in the criminal justice system (VAADA, 2016).

From its inception, the Drug and Alcohol Multicultural Education Centre (DAMEC) has undertaken several studies which have identified a range of issues related to AOD usage, risk and protective factors amongst CALD communities and analysis and evaluation relating to culturally responsive service provision and structural constraints relevant to the Australian AOD sector (see Donato-Hunt, Munot & Copeland, 2012, Flaherty & Donato-Hunt 2012; Rowe 2014; Rowe & Santos, 2016; Rowe, Berger, Yaseen, & Copeland, 2017; Rowe et al, 2018).
With the expansion of its services in Western Sydney including a new outpatient clinic established in 2017 at Blacktown, DAMEC is committed to sharing its expertise in culturally responsive practice in reducing AOD related harms with the highly diverse and complex population of CALD communities and related services within this region. Western Sydney houses a total of 43% residents who were born overseas and 45% of its population speak a language other than English at home (Western Sydney Local Health District Strategic Plan, 2013). Some of the more sizeable communities relevant to this study include people of Arabic speaking backgrounds, Pacific Islander communities and members from the Sub-Saharan African diaspora.

In response to the former demographics and lack of research, DAMEC was commissioned by Wentwest Primary Health Care Network (PHN) to undertake a study entitled **Boosting understanding, Enhancing Communication and Supporting Change (BES project): Alcohol and other drug treatment needs among Western Sydney’s CALD communities.** Like its title suggests, the BES study aims are:

1. **To BOOST** understanding of the specific needs and experiences of people from Arabic speaking, Pacific Islander and African backgrounds in the Western Sydney catchment area relating to AOD usage, harms and harm reduction behaviours

2. **To ENHANCE** communication through grounded research between CALD communities, AOD treatment providers and other relevant service providers within Western Sydney to improve understanding of related issues and needs.

3. **To SUPPORT** change that emphasises culturally responsive policy and practices for CALD communities within Western Sydney in the following areas:
   i. Early Intervention and Prevention including harm reduction strategies
   ii. Safety and Quality of AOD treatment and other health related services
   iii. Workforce Development in the former sectors
   iv. Client, family and community participation

To achieve these aims, DAMEC undertook an initial consultation process with various academic and local health institutions and individuals in Western Sydney to inform the research design before establishing an advisory committee of relevant stakeholders in the former region to support and advise on the process. The study design encompassed a mixed methods approach amongst the three specific CALD communities mentioned. Limits and strengths of the former methodology were also considered. Ethics clearance was obtained from Nepean Local Area Health District Human Ethics Committee (HREC) and Western Sydney Local Health District HREC.

Participants comprised of a purposive sample of 148 adult women, men and young people (18-26 years) based on the following criteria:

- Are from an Arabic-speaking, Pacific Islander or African Community
- 18 years old or over
- Currently or have recently lived in Western Sydney
- If they, a family member or friend has tried to get help for alcohol or other drugs
Recruitment was conducted through DAMEC’s existing networks, social media outlets and posters advertised in targeted locations. A variety of culturally responsive and risk mitigation strategies were employed to ensure safety and inclusive participation for these focus groups and interviews.

18 Key experts were also recruited through the former networks utilising semi structured questions and interviews related to AOD related usage, harms, barriers and service needs for CALD communities in the Western Sydney catchment area. Participants included relevant CALD community leaders and workers from the AOD, health and multicultural services sectors in Western Sydney.

Interviews and focus groups were undertaken at a variety of venues including DAMEC’s office in Blacktown, relevant service locations, community centres and other locations amicable to participants and researchers’ safety including Occupational, Health and Safety obligations and human ethical requirements.

Analysis included using a range of tools including SPSS version 25 software to categorise the quantitative data while qualitative material was initially analysed through an inductive grounded approach with data cleaned and a total of 65 major and minor codes assigned. Data was coded separately between Authors 1 & 2 and cross referenced. A deductive stage was then incorporated into the analysis for further refinement of themes given the breadth and size of data collection. This included the researchers’ adaptation of the Mental Health in Multicultural Australia’s Framework for Mental Health in Multicultural Australia: Towards Inclusive Service Delivery (2014) to include considerations related to the AOD context. The appropriation of this framework was needed given the absence of a state wide or national framework for the AOD sector on culturally responsive workforce practices.

Key findings of this study include:

**AOD usage**

- Across all communities; licit drugs (alcohol and smoking tobacco) were consistently rated as of the highest concern including the widespread use and acceptability of these substances in their communities. This was a view that aligned with many of the key experts interviewed.

- However, awareness and knowledge of AOD related harms were varied with some participants having comprehensive knowledge and others far less. This is particularly concerning for those newly arrived participants who may be relying on media reports where a disproportionate and sensationalised focus on the ‘dangers’ of illicit substances (Bright, 2008) disrupts evidence of the extent of harms from alcohol and tobacco use within Australia (Commonwealth of Australia, 2017).

- There was some ambivalence which requires further research related to the benefit versus harms of culturally and communally sanctioned AOD consumption patterns including the use of kava amongst some Pacific Islander participants and shisha amongst Arabic speaking populations.

- AOD consumption was largely attributed to young people and individual behaviours governed by choice and control including use viewed as a ‘performance’, sustaining relationships, cultural connections or gender norms.

- The challenges of 2nd generation young people ‘fitting into’ mainstream society were also cited as push factors towards AOD usage. Such factors were often juxtaposed against parental and familial expectations therefore raising the importance of addressing intergenerational and acculturation issues to further enhance strengths of collectivist ties and reduce harms.
In some cases, community participants felt that AOD use reflected individual faults or deficiencies, which were sometimes emphasised as more important than economic or social exclusion contributing to health disparities.

**Prevention, Early intervention and Harm reduction strategies**

- Overall prevention and early intervention were highly valued.
- The need for greater regulation and supply control were cited by some participants.
- Participants described feeling frustrated or helpless to assist if a person did not want to stop using AOD. Very little mention was made of what could be done to support a person who continued to use AOD.
- Abstinence was often cited as the preferred harm reduction strategy particularly by parents and older participants. However, concerns about the limitations of this approach were raised by various community members.
- While the role of the religious leaders, particularly in African and Pacific Islander communities was cited as an important first point of contact for assistance, specific concerns were raised about the promotion of abstinence by traditional communal supports and collectivist parental norms.
- Several participants also raised that fears about confidentiality of information discussed would act as a barrier to disclosing AOD issues in the former settings.
- Particularly in the African and Pacific Islander groups, advice and assistance for these issues was sought from friends and peers. This view was concurred by several professionals spoken to.
- The value of these personal connections was also extended to services by some participants in terms of encouraging access
- Strong cultural, identity, familial, collectivist and historic traditions and ties were cited as important arenas to reduce AOD harms and strengthen culturally responsive harm reduction strategies.
- Specialists and their respective knowledge were particularly valued amongst Arabic speaking participants with both participants and professionals commenting that GPs are highly valued and trusted amongst this cohort.
- Providing training and support opportunities for families, community leaders and organisations with an emphasis on intercultural exchange and information relating to harm reduction which is sensitive to familial and community attitudes and structure is highly valued.

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5 Intercultural learning is an area of research and application of knowledge about cultures with the intention of negotiating between people and cultures to account for difference. The intention is to learn the encoded logics of cultural differences to formulate mutual understanding and shared outcomes which combine and include different worldviews. (see Bennett et a 1999; Hofstede, 2001)
Safety and Quality of AOD treatment and other health related services

- In support of former findings, safety and quality of AOD treatment and other health services was largely measured by interpersonal and relational qualities. These include the importance of:
  - Rapport building
  - Deeper interpersonal engagement
  - Client centred approaches
- Both community members and key experts spoke of the importance of time and flexibility in establishing the former qualities of service provision.
- Integration of service delivery and continuity of care was felt to be important due to the complex bio-psycho-social influences on AOD use amongst CALD communities. This would include supported referral pathways through pre-established connections.
- Cultural responsiveness of services is a KEY marker of quality service provision. This included adaptation and integration of service models to meet the relational and collectivist orientation of CALD Clients.

Workforce Development in the former sectors

- Participants highlighted that the quality of the workforce was variable and required further regard for the importance of trust, rapport, time and interpersonal culturally responsive engagement.
- Many participants highlighted the importance of diversity within the workforce including Bicultural and non-Bicultural workers, with the recognition that there are preferences for CALD communities to engage to workers outside of their own cultural groups due to fears related to confidentiality and stigma.
- Bicultural workers need to have complex combination of cultural knowledge, strong engagement/interpersonal skills and be adequately supported for such an approach to be truly effective given that there are multiple differences and complexities within communities. Furthermore, to avoid essentialism of CALD groups as a single entity, bicultural workers should not be expected to represent entire communities.
- Several professionals interviewed raised that they had experienced difficulties accessing interpreter services when required.

Client, family and community participation

- Encouraging client, family and community participation was felt to be underpinned by two elements: strong bonds of trust and being able to demonstrate real advantages from involvement.
- In line with the above findings, trust was fostered by rapport building and cultural sensitivity towards issues of privacy and confidentiality.
- Personal connection including word of mouth, bicultural workers and community members acting as a conduit for service access were also important to client willingness and trust in services.
The value of ‘lived experiences’ as a tool to aid a person’s individual treatment such as sharing one’s story or life lessons to assist people experiencing similar issues was also valuable in fostering trust.

Given the findings highlighted the levels of distress of families and disconnection from support networks being a risk factor for AOD use amongst CALD communities, family involvement in terms of education, family inclusive practices and utilising the strengths of collectivist orientation whereby the problem is owned by the family while gaining the trust and cooperation of family members is also important.

Taking a long-term community development approach including building links with community-based organisation and leaders and utilising credible bicultural staff to do so was cited by both community members and key experts to encourage participation.

Key recommendations (for further details please see page 79):

1. **Expand AOD health literacy educational opportunities for CALD communities and those supporting them including harm reduction strategies.**

   Greater education in harm reduction programs including safer consumption patterns and responding to addiction should be provided in ways that utilise existing help seeking strategies within CALD communities. This would include offering educational opportunities in partnership with religious institutions, migrant resource centres, ethnic associations and community leaders. Specific attention should be paid to identifying AOD use as a health issue and addressing concerns around shame and stigma that may inhibit help seeking.

2. **Encourage opportunities for expanding family involvement in support, education and treatment programs.**

   As well as fostering AOD health literacy, interventions to enhance intergenerational communication, parenting skills and bonds of trust within the family unit would address underlying risk factors identified by a range of participants in this study. This would likely involve building up service capacity to deliver family inclusive interventions and fostering opportunities to partner with other family support services.

3. **Build peer education and leadership capacities with CALD communities**

   This recommendation relates to the strong evidence from the study that peers and friends were a trusted source of advice and support, including in terms of group help seeking behaviours. Useful gains could be made by enhancing the capacity of experienced organisations already working in this space to outreach and offer targeted programs to increase capacity within these communities to equip peers to encourage pathways to treatment as well as to act as support persons within existing treatment programs to enhance the quality of treatment experiences.

4. **Enhance the capacity of the sector to provide flexible, long term support**

   The elements discussed that were felt to enhance CALD client, family and community engagement and outcomes in the AOD treatment system, namely: being flexible to outreach into communities, rapport building, and walking with a person through all aspects of the system are clearly time and labour intensive. It is important that services are supported to be able to have staff capacity and
treatment systems in place to offer this degree of assistance. Addressing siloing issues and promoting intercultural learning for example through joint service networking meetings between AOD and CALD services should be considered.

5. Adequately resource the AOD workforce to address CALD individual, family and community needs in a sensitive and culturally responsive manner.

There is need for additional workforce development programs to enable current staff to meet CALD communities’ needs. However, given the systemic issues identified in the study, it is unlikely that short-term training on its own would solely address the sector’s capacity to respond in a culturally appropriate way to community needs. A level of choice also needs to be offered in terms of the workforce available i.e. bicultural and non-bicultural staff. Increasing diversity within the AOD workforce will need to be accompanied by an appropriately trained and resourced interpreter service.

References:


Boosting understanding, Enhancing communication, and Supporting change (BES Project)
Alcohol and other drug treatment needs among Western Sydney’s CALD communities

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² Senior Research Officer, DAMEC. Responsible for part of collection of data, co-analysis and co-writing of this report
³ Social planner; Campbelltown City Council, Responsible for co-research design, recruitment and part data collection
⁴ PhD Candidate, School of Public Health and Community Medicine, University of New South Wales. Responsible for research proposal, co-research design, co-author for ethics application and feedback for this report.
Acknowledgements

1. All participants who shared their time and knowledge


3. Study partners: Western Sydney Local Health District, Community Migrant Resource Centre (CMRC) and SydWest Multicultural Services (SydWest)

4. Project Advisory committee: John Abdel-Ahad (Corrective Services NSW), Abulla Agwa (formerly SydWest Multicultural Services), Margie Drake (Went West Primary Health Network), Dr Kate Kennett (Western Sydney Local Health District), Dora Onesemo (Western Sydney Local Health District), Dr Mieke Snijder (University of Sydney), Hamed Turay (NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors).

5. Persons providing input into study design and analysis: Dr Kate Kennett (Western Sydney Local Health District), Dr Briony Larance (University of Wollongong); Meryem Jeffries (Western Sydney Local Health District), Jennifer Luksza (Western Sydney Local Health District)

6. DAMEC Clinical Team

This study was funded by WentWest Primary Health Network.

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5 DAMEC would particularly like to thank Dr Kate Kennett for her suggestions for the framework used in the deductive analysis of the data.
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Executive Summary

Previous research has indicated that it is very difficult to identify rates of alcohol and other drug (AOD) use in Culturally and Linguistically Diverse (CALD) communities in Australia due to national surveys being administered only in English (Rowe, Ansara, Jaworski, Higgs, & Clare, 2018). Additionally, limitations in the way data is collected also undermines determining substance use prevalence and harms within CALD populations and comparatively between groups (Rowe et al, 2018). Yet the Australian National Drug Strategy 2017-2026 has identified CALD communities as a priority population who may be more vulnerable to risk of harmful use of AOD for a variety reasons related to forced and voluntary migration, acculturation, intergenerational issues, trauma and loss (Victorian Alcohol and Drug Association (VAADA), 2016) and the changing nature of AOD access and consumption in the resettlement context (Anile, 2018; Ethnic Communities Council of Queensland, 2012; Horyniak et al, 2014).

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Key findings of this study include:

**AOD usage**

- Across all communities; licit drugs (alcohol and smoking tobacco) were consistently rated as of the highest concern including the widespread use and acceptability of these substances in their communities. This was a view that aligned with many of the key experts interviewed.

- However, awareness and knowledge of AOD related harms were varied with some participants having comprehensive knowledge and others far less. This is particularly concerning for those newly arrived participants who may be relying on media reports where a disproportionate and sensationalised focus on the ‘dangers’ of illicit substances (Bright, 2008) disrupts evidence of the extent of harms from alcohol and tobacco use within Australia (Commonwealth of Australia, 2017).

- There was some ambivalence which requires further research related to the benefit versus harms of culturally and communally sanctioned AOD consumption patterns including the use of kava amongst some Pacific Islander participants and shisha amongst Arabic speaking populations.

- AOD consumption was largely attributed to young people and individual behaviours governed by choice and control including use viewed as a ‘performance’, sustaining relationships, cultural connections or gender norms.

- The challenges of 2nd generation young people ‘fitting into’ mainstream society were also cited as push factors towards AOD usage. Such factors were often juxtaposed against parental and familial expectations therefore raising the importance of addressing intergenerational and acculturation issues to further enhance strengths of collectivist ties and reduce harms.

- In some cases, community participants felt that AOD use reflected individual faults or deficiencies, which were sometimes emphasised as more important than economic or social exclusion contributing to health disparities.

**Prevention, Early intervention and Harm reduction strategies**

- Overall prevention and early intervention were highly valued.

- The need for greater regulation and supply control were cited by some participants.

- Participants described feeling frustrated or helpless to assist if a person did not want to stop using AOD. Very little mention was made of what could be done to support a person who continued to use AOD.
Abstinence was often cited as the preferred harm reduction strategy particularly by parents and older participants. However, concerns about the limitations of this approach were raised by various community members.

While the role of the religious leaders, particularly in African and Pacific Islander communities was cited as an important first point of contact for assistance, specific concerns were raised about the promotion of abstinence by traditional communal supports and collectivist parental norms.

Several participants also raised that fears about confidentiality of information discussed would act as a barrier to disclosing AOD issues in the former settings.

Particularly in the African and Pacific Islander groups, advice and assistance for these issues was sought from friends and peers. This view was concurred by several professionals spoken to.

The value of these personal connections was also extended to services by some participants in terms of encouraging access.

Strong cultural, identity, familial, collectivist and historic traditions and ties were cited as important arenas to reduce AOD harms and strengthen culturally responsive harm reduction strategies.

Specialists and their respective knowledge were particularly valued amongst Arabic speaking participants with both participants and professionals commenting that GPs are highly valued and trusted amongst this cohort.

Providing training and support opportunities for families, community leaders and organisations with an emphasis on intercultural exchange and information relating to harm reduction which is sensitive to familial and community attitudes and structure is highly valued.

Safety and Quality of AOD treatment and other health related services

In support of former findings, safety and quality of AOD treatment and other health services was largely measured by interpersonal and relational qualities. These include the importance of:

- Rapport building
- Deeper interpersonal engagement
- Client centred approaches

Both community members and key experts spoke of the importance of time and flexibility in establishing the former qualities of service provision.

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6 Intercultural learning is an area of research and application of knowledge about cultures with the intention of negotiating between people and cultures to account for difference. The intention is to learn the encoded logics of cultural differences to formulate mutual understanding and shared outcomes which combine and include different worldviews. (see Bennett et al., 1999; Hofstede, 2001)
Integration of service delivery and continuity of care was felt to be important due to the complex bio-psycho-social influences on AOD use amongst CALD communities. This would include supported referral pathways through pre-established connections.

Cultural responsiveness of services is a KEY marker of quality service provision. This included adaptation and integration of service models to meet the relational and collectivist orientation of CALD Clients.

**Workforce Development in the former sectors**

- Participants highlighted that the quality of the workforce was variable and required further regard for the importance of trust, rapport, time and interpersonal culturally responsive engagement.
- Many participants highlighted the importance of diversity within the workforce including Bicultural and non-Bicultural workers, with the recognition that there are preferences for CALD communities to engage to workers outside of their own cultural groups due to fears related to confidentiality and stigma.
- Bicultural workers need to have complex combination of cultural knowledge, strong engagement/interpersonal skills and be adequately supported for such an approach to be truly effective given that there are multiple differences and complexities within communities. Furthermore, to avoid essentialism of CALD groups as a single entity, bicultural workers should not be expected to represent entire communities.
- Several professionals interviewed raised that they had experienced difficulties accessing interpreter services when required.

**Client, family and community participation**

- Encouraging client, family and community participation was felt to be underpinned by two elements: strong bonds of trust and being able to demonstrate real advantages from involvement.
- In line with the above findings, trust was fostered by rapport building and cultural sensitivity towards issues of privacy and confidentiality.
- Personal connection including word of mouth, bicultural workers and community members acting as a conduit for service access were also important to client willingness and trust in services.
- The value of ‘lived experiences’ as a tool to aid a person’s individual treatment such as sharing one’s story or life lessons to assist people experiencing similar issues was also valuable in fostering trust.
- Given the findings highlighted the levels of distress of families and disconnection from support networks being a risk factor for AOD use amongst CALD communities, family involvement in terms of education, family inclusive practices and utilising the strengths of collectivist orientation whereby the problem is owned by the family while gaining the trust and cooperation of family members is also important.
Taking a long-term community development approach including building links with community-based organisation and leaders and utilising credible bicultural staff to do so was cited by both community members and key experts to encourage participation.

Key recommendations (for further details please see page 79):

1. Expand AOD health literacy educational opportunities for CALD communities and those supporting them including harm reduction strategies.

Greater education in harm reduction programs including safer consumption patterns and responding to addiction should be provided in ways that utilise existing help seeking strategies within CALD communities. This would include offering educational opportunities in partnership with religious institutions, migrant resource centres, ethnic associations and community leaders. Specific attention should be paid to identifying AOD use as a health issue and addressing concerns around shame and stigma that may inhibit help seeking.

2. Encourage opportunities for expanding family involvement in support, education and treatment programs.

As well as fostering AOD health literacy, interventions to enhance intergenerational communication, parenting skills and bonds of trust within the family unit would address underlying risk factors identified by a range of participants in this study. This would likely involve building up service capacity to deliver family inclusive interventions and fostering opportunities to partner with other family support services.

3. Build peer education and leadership capacities with CALD communities

This recommendation relates to the strong evidence from the study that peers and friends were a trusted source of advice and support, including in terms of group help seeking behaviours. Useful gains could be made by enhancing the capacity of experienced organisations already working in this space to outreach and offer targeted programs to increase capacity within these communities to equip peers to encourage pathways to treatment as well as to act as support persons within existing treatment programs to enhance the quality of treatment experiences.

4. Enhance the capacity of the sector to provide flexible, long term support

The elements discussed that were felt to enhance CALD client, family and community engagement and outcomes in the AOD treatment system, namely: being flexible to outreach into communities, rapport building, and walking with a person through all aspects of the system are clearly time and labour intensive. It is important that services are supported to be able to have staff capacity and treatment systems in place to offer this degree of assistance. Addressing siloing issues and promoting intercultural learning for example through joint service networking meetings between AOD and CALD services should be considered.
5. Adequately resource the AOD workforce to address CALD individual, family and community needs in a sensitive and culturally responsive manner.

There is need for additional workforce development programs to enable current staff to meet CALD communities’ needs. However, given the systemic issues identified in the study, it is unlikely that short-term training on its own would solely address the sector’s capacity to respond in a culturally appropriate way to community needs. A level of choice also needs to be offered in terms of the workforce available i.e. bicultural and non-bicultural staff. Increasing diversity within the AOD workforce will need to be accompanied by an appropriately trained and resourced interpreter service.
Background

Alcohol and Other Drug (AOD) Use in CALD communities

It is very difficult to identify rates of alcohol and other drug use in CALD communities. Australian national surveys tend to be administered in English and there are limitations in the way data is collected, which undermines understanding the differences in substance use, prevalence and harms within CALD populations and comparatively between groups (Rowe et al, 2018).

Recent analysis of data from the National Drug Strategy Household Survey indicates that overall CALD populations in Australia have lower rates of lifetime and recent use of any illicit substance compared to populations born in Australia, United Kingdom, or New Zealand who speak only English at home i.e. non-CALD populations (Rowe et al, 2018). In terms of specific substance-types; CALD populations were less likely than non-CALD populations to drink alcohol overall. Findings suggest moderate or high risk of harm for those who use cannabis or methamphetamines. There was no difference between CALD and non-CALD groups in the use of analgesics, tranquilizers, or sleeping pills; or administering drugs via injection (Rowe et al, 2018).

However, a cross-sectional survey of CALD groups in Sydney conducted in 2008 reported higher rates of binge drinking in some CALD communities (Donato-Hunt et al., 2012). Higher rates of tobacco use and community norms that normalise tobacco consumption, including waterpipe tobacco have also been reported in some CALD communities (Cancer Institute NSW, 2013; Phillips, Monaem, & Newman, 2015). There is also some evidence that people who inject drugs and identify themselves as being from a CALD background may be at greater risk of blood borne infections (Maher, Li, Jalaludin, Chant & Kaldor, 2007; Rowe et al., 2017).

The National Drug Strategy 2017-2026 notes that CALD communities are a priority population and may be more vulnerable to risk of harmful use of AOD (COA, 2017). Exposure to pre-arrival stressors, such as refugee displacement, torture and trauma can be a risk factor for problematic substance use (VAADA, 2016). Recent research in Melbourne with African youth found that alcohol and other drug use consumption patterns change as a result of migration and resettlement (Horyniak et al, 2014). A complex interaction of multiple influences may increase AOD consumption for migrant CALD communities including the loss of economic, family or social identity, disruption to traditional parenting relationships which can impact on the ability to discipline young people, and acculturation to Australian settings where certain substances (such as alcohol) may be more widely available and use is tied to social practices (Ethnic Communities Council of Queensland, 2012; Anile, 2018).

Nevertheless, it should be noted that research has found that CALD communities possess a range of strengths and resilience features that may be protective factors against problematic alcohol and other drug use. These include strong community and social networks, religious or cultural practices that discourage alcohol or other drug use, and ethnic or cultural pride when combined with more conservative parental attitudes towards substance use (Castro & Alarcon, 2002; Goren, 2006).

Service Access and experiences of AOD treatment for CALD Communities

Under-representation of CALD communities in AOD treatment is continuing with little improvement in recent years (AIHW, 2018). Previous research has also highlighted concerns about a lack of access to
supports for early intervention and CALD persons with AOD issues “bypassing treatment services”; with the first contact with treatment often arising after involvement in the criminal justice system (VAADA, 2016). Whilst there is some evidence that shame in some CALD communities is particularly acute, leading to greater reluctance to seek assistance from Australian mainstream treatment services; other research has noted that CALD communities in fact have similar or even more supportive attitudes towards harm reduction measures such as NSPs, methadone/buprenorphine, naltrexone, regulated injecting rooms compared to non-CALD respondents (VAADA, 2016; Rowe et al, 2018).

When people from CALD backgrounds access AOD services they often receive less than adequate care. A national survey of 226 AOD sector staff in 2015 found that half of all respondents reported that they had concerns (low level to high level) about their agency’s approaches to working with CALD clients (Rowe & Santos, 2016). Concerns about cultural relevance and responsivity is also an acknowledged issue among CALD community members who have sought AOD treatment (Flaherty & Donato-Hunt 2012; Rowe 2014; VAADA, 2016).

There are a range of different models that exist for providing a more culturally responsive delivery of health of care, although evidence of efficacy compared to standard evidence-based treatment is contested (Huey, Tilley, Jones & Smith, 2014; Smith & Trimble, 2015). Most studies have been conducted in the United States and include AOD treatment within a broader investigation of mental health treatment. Existing research has largely concentrated on the adaption of various elements of treatment to be more culturally congruent with the target population, including language, matching worker ethnicity, or incorporating cultural health beliefs, cultural values and practices into treatment (Resnicow et al, 2000; Huey et al., 2014). Australian research has noted structural constraints in treatment pathways and systems, such as lack of bilingual positions, centralised intake systems and shortcomings in data collection that can make it difficult for the sector to adapt approaches to the needs of CALD communities (Rowe & Santos, 2016; VAADA, 2016).

When considering differences in responses to health issues and help seeking including alcohol and other drug use in CALD communities, the distinction between individualistic and collectivist community structures is often raised as an underlying explanatory factor. In individualistic communities (typically ‘mainstream’ Australian communities), ties between individuals are loose, people see themselves as autonomous personalities, and individuals are only expected to look after themselves and their immediate family. Relationships are characterised by independence and equality, for instance children start to leave the parental household earlier. In collectivist cultures people see themselves as members of tight-knit communities, often extended families (with uncles, aunts and grandparents) that continue protecting them in exchange for loyalty. Problems may be viewed in communal/familial terms, and difficulties or conflicts may be expected to be resolved by the wider group with a focus on achieving harmony in group relationships (Hofstede, 2011; Renzaho & Vignjevic, 2011, Beugelsdijk & Welzel, 2018). For instance, in treatment planning workers may need to recognize different approaches to client confidentiality, if families expect to be included in sharing of treatment information (VAADA, 2016). If a person engages in a practice that goes against established social norms or rules, such as AOD use, this create feelings of guilt in individualistic cultures while people from a more collectivist orientation are more likely to experience feelings of shame (Hofstede, 2011).

The BES Study in Western Sydney: Aims and Objective

Scholarship has highlighted that for AOD treatment intervention to be effective, services need to be capable of responding to diverse communities where there are unique risks or resilience factors, or different explanatory models of health and health behaviours (Resnicow et al, 1999; Castro, Barrera &
Holleran Steiker, 2010). Yet as noted above there is no existing state-wide or national cultural assessment framework within the drug and alcohol sector that considers the specific needs of CALD communities while the small amount of Australian research on culturally responsive AOD clinical practice has tended to focus on single treatment types or streams (Rowe, 2013; VAADA, 2016).

With under-representation of CALD communities in AOD treatment displaying little improvement (AIHW, 2018), the Drug and Alcohol Multicultural Education Centre (DAMEC) remains the only service in NSW that is specifically dedicated to clinical interventions, community development and research in reducing AOD related harms within CALD communities. With the expansion of its services in Western Sydney including a new outpatient clinic established in 2017 at Blacktown and the small amount of research in this area as highlighted in the former section, DAMEC is committed to sharing its expertise in culturally responsive practice in reducing AOD related harms with the highly diverse and complex population of CALD communities and related services within this region. In 2017 the agency was also commissioned by WentWest Primary Health Care Network (PHN) to undertake a study entitled Boosting understanding, Enhancing Communication and Supporting Change (BES project): Alcohol and other drug treatment needs among Western Sydney’s CALD communities.

Western Sydney houses a total of 43% residents who were born overseas and 45% of its population speak a language other than English at home (Western Sydney Local Health District Strategic Plan in Western Sydney PHN AOD Needs Assessment reporting template, 2013). Some of the more sizeable communities relevant to this study in Western Sydney include people of Arabic speaking backgrounds, Pacific Islander communities and members from the Sub-Saharan African diaspora. Further information related to the former communities is highlighted in Table 1 below.

Table 1. Target Communities

<table>
<thead>
<tr>
<th>Arabic-speaking</th>
</tr>
</thead>
<tbody>
<tr>
<td>According to Census 2016 data, Arabic is one of the main languages other than English spoken across all LGAs in the WentWest Region. Criminal justice statistics, which can be an indication of drug and alcohol use issues among communities with lower utilisation of treatment services, show that Arabic is the second most common language spoken (after English and Vietnamese) among NSW prisoners (data supplied to DAMEC by Corrections Research Evaluations and Statistics).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pacific Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blacktown has the largest number of people of Pacific Island ancestry in NSW (Australian Bureau of Statistics). Research has identified higher rates of risky drinking, tobacco use and marijuana use as contributing to health and social problems (Donato-Hunt et al., 2012; Ravulo, 2015). Pacific Islander youth are also consistently over-represented in the Juvenile Justice system (Liddell, Blake &amp; Singh, 2016).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-Saharan African</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Census data shows that Western Sydney has some of the largest Sub-Saharan African born communities in NSW including Sudanese/ South Sudanese, Nigerian, Kenyan (Blacktown LGA); and Somali (Cumberland LGA). Compared with other migrant communities, many Sub-Saharan African</td>
</tr>
</tbody>
</table>
Like its title suggests, the BES study aims:

1. To **BOOST** understanding of the specific AOD needs and experiences of people from Arabic speaking, Pacific Islander and African backgrounds in the Western Sydney catchment area including AOD related usage, harms and help seeking behaviours

2. To **ENHANCE** communication through grounded research between CALD communities, AOD treatment providers and other relevant service providers within Western Sydney to improve access and equity

3. To **SUPPORT** change that emphasises culturally responsive policy and practices for CALD communities in the following areas:
   
i. Early Intervention and Prevention including harm reduction strategies, AOD information and health promotion
   
ii. Safety and Quality of AOD treatment and other health related services
   
iii. Workforce Development in the former sectors
   
iv. Client, family and community participation

To our knowledge this is the first research study of its kind that has attempted to explore how major CALD communities in Western Sydney manage any alcohol, tobacco and other drug support needs across the AOD treatment spectrum. The study will also highlight how communities use their own resources, strengths and skills to respond to these needs.
Methodology

To develop the data collection approach, DAMEC undertook a review of the small number of existing Australian studies conducted in this area (see background sections), supplemented by a consultation process with various institutions and individuals in Western Sydney including relevant university departments, academics, community members and service providers/workers to inform the research design for this study. The researchers established an advisory committee of stakeholders from the multicultural, health, justice and tertiary sectors in the former region to support and advise the research process.

Data was collected using separate focus groups for the respective CALD communities and a series of individual interviews with community members and ‘key’ experts’ from relevant services.

Community based focus groups employed a mix of approaches as follows:

- Open ended questions. For example, questions that invite participants to give examples of experiences where substance use takes place in their lives, where they have been affected by others’ substance use, if and how they use substances and what harm reduction strategies they use.

- Hypothetical scenarios. For example, questions that ask participants to explore possible options and consequences, particularly exploring participants’ current knowledge of treatment services, and where they would or would not consider seeking help.

- Ranking questions. Two tables were distributed to participants to complete. The first table asked participants to rank the use of a range of different legal and illegal drugs from (1) least concerning to (5) most concerning in their community. The second table asked participants to consider a variety of formal and informal sources of support and to rank where people from the community would seek help from for health issues (it was explained to participants that this particularly meant drug and alcohol issues). Participants were asked to give each source a rating from (1) Least common, people would almost definitely not seek help in this way to (5) Most common, people would almost definitely seek help in this way. Due to literacy levels within one of the African community focus groups this activity was completed as a discussion question.

- Interactive budget allocation exercise. Each participant will be asked to allocate a budget to a short list of broad intervention possibilities, according to which they think is the most important and would be most effective in their community (Shakeshaft, Petrie, Doran, Breen, & Sanson-Fisher, 2012).

One-to-one interviews were also offered as an option for those community members who do not wish to participate in a focus group due to privacy or other reasons. These interviews typically lasted for 20-60 minutes. All participants were compensated with a $30 voucher for travel expenses.

A variety of culturally responsive and risk mitigation strategies were employed to ensure safety and inclusive participation for these focus groups and interviews. These included the recruitment and training of bicultural and gender matched facilitators for each community, separate male and female

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7 Missing cases are excluded variable by variable meaning that even if an answer is not given for one item on the ranking sheet the rest of the persons answers are still counted. This is to maximise use of available data.
sessions, as well as a youth session(s) for people between the ages of 18 and 26 years. For focus groups conducted at migrant resource centre locations, personnel from these associations also attended these sessions to act as supports for at least part of the discussion. Additionally, participant information and consent forms were translated into four languages: Arabic, Samoan, Tongan and Swahili. Qualified interpreters were engaged to assist in discussions where initial feedback from key workers or stakeholders indicated it would be required. The subgroup targets for this project were approximately met and even exceeded in the case of the Arabic group (see Table 2).

Table 2. Participant numbers

<table>
<thead>
<tr>
<th>Group</th>
<th>Participants</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific Islander communities</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Arabic communities(^8)</td>
<td>73</td>
<td>60</td>
</tr>
<tr>
<td>African communities</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Professionals/ Key experts</td>
<td>18</td>
<td>20</td>
</tr>
</tbody>
</table>

All focus groups and interviews were conducted at a variety of venues including DAMEC’s office in Blacktown, relevant service locations, community centres and other locations amicable to participants and researchers’ safety including Occupational, Health and Safety obligations and human ethical requirements. Ethics clearance was obtained from Nepean Local Area Health District and Western Sydney Local Health District HRECs.

Recruitment of community members

Participants comprised of a purposive sample of 148 adult women, men and young people (18-26 years) based on the following criteria:

- Are from an Arabic-speaking, Pacific Islander or African Community
- 18 years old or over
- Currently or have recently lived in Western Sydney
- If they, a family member or friend has tried to get help for alcohol or other drugs

\(^8\) One participant spoke Arabic but did not identify with this community, and as such is not included here
Recruitment was conducted through DAMEC’s existing other networks with community members, organisations and leaders, social media announcements through DAMEC’s Facebook page and through poster advertisements and participating Western Sydney LHD drug treatment and harm reduction service sites.

Initially, recruitment for the study progressed slowly. Whilst the exact reasons for this are not clear, it may be due to a combination of factors including:

- Low numbers of communities using treatment services, combined with the difficulty of working around participant’s other commitments to have enough time to engage in the research.
- Where people were accessing treatment services as a group of peers, it sometimes happened that vocal members of subgroups decided to decline participation for others in the group.
- Shame and stigma related to the areas for discussion.
- One of the members of the research team was from a similar cultural background to a subgroup of one of our target communities. There is some evidence that on at least one occasion concerns about privacy and community reputation may have acted as a barrier towards study participation.

In order to address recruitment difficulties; the study approached two large migrant resource centres in Western Sydney that offer a range of settlement, employment, psychosocial and community development programs for local CALD communities. This formed a second wave of study recruitment and assisted in engaging a considerable number of participants in the research. Key staff from these organisations assisted with dissemination of information about the study and helped to organise focus group discussions.

After the study commenced; it was decided to double the target size for the Arabic community. This decision was taken due to the large size relative to the other two target groups and diversity within this community, including countries of birth, varied waves of migration and migration stream; where it appeared that data saturation for the issues explored would not be reached with original targets.

For more information related to numbers and composition of focus groups see Table 3.
Table 3. Breakdown of focus groups conducted

<table>
<thead>
<tr>
<th>Community</th>
<th>Gender</th>
<th>Age</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>Mixed</td>
<td>Adult</td>
<td>5</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>Male</td>
<td>Adult</td>
<td>2</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>Mixed</td>
<td>Adult</td>
<td>23</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arabic-speaking</td>
<td>Male</td>
<td>Adult</td>
<td>11</td>
</tr>
<tr>
<td>Arabic-speaking</td>
<td>Female</td>
<td>Adult</td>
<td>8</td>
</tr>
<tr>
<td>Arabic-speaking</td>
<td>Mixed</td>
<td>Youth</td>
<td>8</td>
</tr>
<tr>
<td>Arabic-speaking</td>
<td>Mixed</td>
<td>Adult</td>
<td>9</td>
</tr>
<tr>
<td>Arabic-speaking</td>
<td>Female</td>
<td>Adult</td>
<td>9</td>
</tr>
<tr>
<td>Arabic-speaking</td>
<td>Male</td>
<td>Adult</td>
<td>13</td>
</tr>
<tr>
<td>Arabic-speaking</td>
<td>Mixed</td>
<td>Adult</td>
<td>12</td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African</td>
<td>Mixed</td>
<td>Youth</td>
<td>12</td>
</tr>
<tr>
<td>African</td>
<td>Female</td>
<td>Adult</td>
<td>5</td>
</tr>
<tr>
<td>African</td>
<td>Female</td>
<td>Adult</td>
<td>4</td>
</tr>
<tr>
<td>African</td>
<td>Mixed</td>
<td>Adult</td>
<td>4 (All female)</td>
</tr>
</tbody>
</table>
Key expert interviews

Eighteen individuals for ‘key experts’ interviews of 20-60 minutes were conducted with health care service providers, CALD community leaders or representatives of CALD organisations based in Western Sydney. Typically, these were held face-to-face although telephone interviews were offered as an option to accommodate community and professional staff schedules. A renumeration contribution of $100, as per standard General Practitioner rates, was offered to participant’s respective organisations if this was in line with organizational policies.

Interviews followed a set of planned, primarily open-ended questions on the following topics:

- Where do Arabic/Pacific Islander/African communities currently seek health information and whom do they trust for health-related information?
- What kinds of AOD issues are Arabic/Pacific Islander/African communities presenting at your agency/organisation/service/clinic? What do you think is the most important AOD-related issue confronting each of these groups?
- What have been the experiences of Arabic/Pacific Islander/African communities who have tried to access AOD treatment (including the strengths and weaknesses of current treatment approaches)?
- What kind of additional support, or actions that would assist Arabic/Pacific Islander/African Community members to seek help from community and healthcare providers?

Table 4. Professional/Key expert interviews

<table>
<thead>
<tr>
<th></th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOD workers</td>
<td>8</td>
</tr>
<tr>
<td>Other health or community welfare professionals</td>
<td>8</td>
</tr>
<tr>
<td>Community Leaders</td>
<td>2</td>
</tr>
</tbody>
</table>

Methodological Limitations and Strengths

The sample had a higher representation of women in some groups, and for the Arabic language group, it is possible that the sample relies heavily on new arrivals. This is due to the sites in which the research was carried out (the migrant resource centres) as a result of difficulties experienced in recruiting participants already engaged with AOD treatment services. It also means that the research is limited in its ability to comment on if and how people’s opinions and preferences change over time. However, access to minority voices and their experiences including women and newly arrived people is a potential strength of the data for future planning and service provisions with the AOD sector.

Specific demographic data was not collected on individual participants. This was a choice made in order to minimise potential concerns about confidentiality and potential identifiability among small samples. The study opted to use general group names, however imprecise, to name loose community affiliations and avoid stigmatising smaller groups within them. As the diverse subjectivities of people within the groups illustrated, ‘African’, ‘Pacific Islander’ and ‘Arabic speaking’ are historical constructs. However,
these terms do obscure the rich diversity that is present in these communities and comments from community members. At the same time broad communities’ references can be helpful in providing an informed overview rather than an authoritative reflection on behalf of all community members.

There were number of culturally responsive considerations incorporated into the study’s methodology which proved to a major strength. Bilingual Facilitators were a significant asset to this study. They provided often essential language and communication support. Recruiting these facilitators was surprisingly difficult and relied on using existing connections that members of the Research team and other DAMEC staff held or sought through other sources such as Western Sydney LHD Multicultural Health team. This meant that it was not possible to train all bilingual facilitators at one time, and the need to stagger training sessions meant that less time overall was allocated to this training. It would have been useful to allow time in this training to explore with participants differences between Western research methods, with strong emphasis on objectivity and detachment, and more culturally relevant forms of expression, such as storytelling and mutual information sharing. Nevertheless, staggering out the training did provide an advantage in that when conducting later trainings we were able to use reflections and discussions from the conduct of previous focus groups to provide more targeted information to support Bicultural Facilitators.

As well as bicultural facilitators, interpreters registered through the TIS program were utilised to bridge language differences and proved to be a strength in ensuring that non-English-speaking participants were not disadvantaged or marginalized in focus group discussions. Due to timing and logistical constraints, it was not always possible to secure an Interpreter with the highest level of qualification offered, and on one or two occasions in focus groups conducted at migrant resource centres, the liaising NGO worker had to provide interpretation assistance. For Research staff that did not speak the participants’ language, working with Interpreters posed some challenges in terms of being able to capture all participants comments all of the time; especially in a focus group situation where the Interpreter was sometimes required to summarise comments and debates. Whilst attempts were made to utilise DAMEC staff to overcome shortcomings in interpretation coverage by listening to de-identified recordings and transcribing directly from these; due to the number of groups conducted, the high costs of translation and transcription alongside the amount of participants involved it was not possible to cover every conversation that occurred.

Conducting the focus groups at the migrant resource centres provided significant support for the study, as we were able to utilize staff knowledge and the strong rapport, they already had with clients to help explain the research and address concerns about potential implications. Staff also sat in these focus groups to provide assistance and reassurance for participants. The use of existing networks and trusted intermediaries including bicultural staff is a major strength of the methodology in providing a safe and culturally responsive environment for participants.

However, it is possible that because of this, some participants may have felt slightly uncomfortable or reluctant to discuss issues relating to AOD use in front of these staff, even though the confidential and voluntary nature of the discussion was explained. Questions were also designed so that participants did not have to reveal personal information about themselves or their families if they did not choose to do so. Such issues may not only have affected groups conducted through migrant resource centres, but as well as in Pacific Islander focus groups where Bilingual Facilitators were people that were well-known in the community and in some cases known to have had a prior connection to DAMEC’s work.

Social desirability bias also may have influenced the way participants addressed certain topics during the discussion. For instance, opinions about the problems of using certain substances came through strongly in many groups, however there is some evidence that more permissive attitudes to certain practices,
such as waterpipe smoking, were conveyed as an aside to the Bilingual Co-facilitators rather than to the wider group and the Researchers. Conversations about using substances were also dominated by what participants themselves had stopped using, particularly tobacco products in the Arabic groups.

Across the focus groups conducted in migrant resource centres there were typically some participants in each focus group who stated that neither themselves or their families used alcohol, tobacco or other drugs. This may have been due to a variety of factors including presence of NGO workers at the groups, the sensitive nature of the topics discussed, or social desirability bias. However, it may also be that the focus groups did capture those who were not the primary target of the study. Whilst face-to-face meetings were held with NGO staff to explain the study and the desired target group prior to recruitment, due to the sensitive nature of the research and language barriers prior checking of study eligibility on the part of the Research team was very difficult.

Data analysis

Analysis was undertaken by the researchers using a range of tools including the use SPSS version 25 to categorise the quantitative data while qualitative material was initially analysed through an inductive grounded approach with data cleaned and checked separately by Authors One & Two, with a total of 65 major and minor codes assigned. A deductive stage was then incorporated into the analysis for further thematic refinement given the breadth and size of data collection. These themes were constructed with consideration given to established service improvement and accreditation frameworks in relation to the data.

Whilst frameworks exist for guiding treatment for Indigenous clients (e.g. Western Australian Network of Alcohol and Other Drug Agencies (WANADA)’s Standard on culturally secure practice, 2012), in DAMEC’s knowledge to date, there is no existing state-wide or national cultural assessment framework within the drug and alcohol sector that considers the specific needs of migrant and refugee communities. The National AOD Workforce Strategy 2015-2018 features one outcome area (8) related to increasing the capacity of the workforce to respond appropriately to AOD issues among CALD groups, including through increasing consultation with CALD groups and ensuring CALD representation and participation in planning (Intergovernmental Committee on Drugs, 2014); however as it forms part of a broader workforce plan, the scope and extent of guidance it can provide is naturally limited.

Given the absence of a state wide or national framework for the AOD sector on culturally responsive workforce practices, the researchers adapted the Mental Health in Multicultural Australia’s Framework for Mental Health in Multicultural Australia: Towards Inclusive Service Delivery (2014) to include considerations related to the AOD context. Whilst there are important distinctions between the AOD and mental health sectors; the four outcome areas of the framework: (1) Consumer, carer and family participation; (2) Safety and quality (3) Promotion, prevention, and early intervention and (4) Workforce; are broadly congruent with the data and important areas of focus within the AOD sector.

However, in the analysis presented in this report, where we have used the framework, we have made some adjustments to its language (e.g. ‘consumer’ to ‘client’) to be consistent with terms used in the AOD sector. We have also made some alterations when areas of health practice do not match up completely between the two sectors; namely including a discussion on harm minimisation and focusing on ‘prevention’ rather than ‘promotion’. Furthermore, as the framework is largely a workplace assessment and evaluation tool, there is little space to explore specific cultural practices relating to AOD consumption preferences and behaviours. We have felt however it is important to include information
relating to this; as enhancing worker’s understanding of these practices in the lives of CALD clients can help provide a better quality of support. We have included a discussion of this as an addition to the four outcome areas, similarly to how the original framework provides extra information about cultural responsivity, risk and resilience and other key concepts to support implementation. We have titled this section: *Experiences of Alcohol and Other Drug (AOD) use amongst CALD communities in Western Sydney.* 

Our adaptation of the framework retains the structure of the four pillars, adjusting their titles as follows:

1. Early Intervention and Prevention including harm reduction strategies  
2. Safety and Quality of AOD treatment and other health related services  
3. Workforce Development in the former sectors  
4. Client, family and community participation  

It is important to note that these pillars are not mutually exclusive. For instance, a safe and quality treatment service relies on an appropriately trained and skilled workforce. Themes from the data also crossover between the different sections, for example rapport building and cultural responsivity skills are important in treatment safety and quality, as well as in fostering client, family and community participation.
BES Study Findings

Experiences of Alcohol and Other Drug use amongst CALD communities in Western Sydney

This section highlights findings related to participants’ perceptions of AOD awareness, social categories of AOD users and some of the attributing factors to use and related harms including acculturative and intergenerational tensions and other cultural factors.

Substances of most concern

Across all communities; licit drugs (alcohol and smoking tobacco) were consistently rated as of the highest concern. See Figures 1-3 below for outline of quantitative data related to ranking exercises on drugs of most concern.

Figure 1. Ranking alcohol, tobacco and other drugs of concern- African community focus group responses

9 N=21
Figure 2. Ranking alcohol, tobacco and other drugs of concern - Arabic community focus group responses\textsuperscript{10}

![Bar Chart](chart1.png)

Figure 3. Ranking alcohol, tobacco and other drugs of concern – Pacific Islander community focus group responses\textsuperscript{11}

![Bar Chart](chart2.png)

\textsuperscript{10} N=67
\textsuperscript{11} N=30
Many participants discussed the widespread use and acceptability of these substances in their communities.

“In Arabic communities in general, actually, the tobacco and the alcohol are like, normally being used, but the drugs are rarely, rarely to be, you know, dealt with.” [Group 2 Adult- Male Speaker]

“I think we should have just said alcohol in general because there's like, a lot alcohol”. [Group 3 Youth- Female Speaker]

“Yeah, because in our country it's like, all of them, it's old or young people is [smoking shisha]” [Group 2 Youth- Female Speaker]

This view aligned with many of the key experts interviewed. For example:

“With Pacific Island communities...there hasn’t been any...you know, research information to suggest that they deal in hard drugs, or anything like that, but...research that’s available does suggest they do have a problem with alcohol and tobacco”. [Pacific Island community leader]

These findings correlate with previous research related to CALD alcohol and tobacco use (see Donato-Hunt et al., 2012). Past research has also shown higher rates of tobacco use have been found in some CALD communities, including waterpipe tobacco smoking (Cancer Institute NSW, 2013; Phillips et al., 2015).

Generally, the long-term health impacts of tobacco smoking and alcohol use were well known among community members (such as liver disease; cancers and heart problems). In discussions whilst some participants displayed quite comprehensive knowledge about health impacts of AOD use; other participants sometimes displayed some confusion about alleged health benefits of using these AOD.

[Discussion in Group 2 Adult]
Female Voice:  …for the alcohol, [she] was working somewhere [overseas] where they had people with cardiac problems, and they used to tell them that a little bit of whiskey, every day, would be good for the veins and for the vessels of the heart, to open the veins and the vessels of the heart. And some people use it, like very small sips every day, but if you overdose it, it could go to being an addiction.

Interpreter:  So people were saying that it might be [a] reason for people to say “I’m doing it for my heart”, they keep drinking. [Laughter].

Male Voice:  They tell people about this whiskey, that it could be only the size of the cover of the whiskey bottle, so one or two of the covers of the whiskey bottles a day, would be good for the heart. We hear this but we don’t know if that’s true or not –

[Talking together].
Voice: ...I don’t think that’s right.

Given the lower rates of illicit substances other than cannabis more broadly in the community (COA, 2017), it is somewhat surprising a substance such as cocaine across the three groups as well as heroin and ecstasy in the Pacific Islander group received relatively high rankings. Particularly as many participants, especially in Arabic and African groups, reported comparatively lower knowledge about the different types of illicit substances with some conveying confusion when confronted with illicit drug procurement in Australia.

“I just was walking in Merrylands...someone came to me, and he was, he was just looking at me and he said...“Do you like white or blue” or something like that...I said, “What do you mean?” He said, “White or blue?” I didn’t, I swear I didn’t- white or green, white or blue, something like that and he, he told me, drugs”. [Group 2 Youth- Male Speaker]

Information about these illicit substances was said to be mainly gained from media reports. Examples include:

[Cocaine and Heroin] “The famous issue, this is the two things they are hearing about from people, from media...” [Group 2 Adult – Female Speaker]

[Researcher has mentioned Cocaine]: “So that one...some people when they come to airport, they hiding [it] in the bag...like some people come over [from] other country, they put it in the bag... “[Group 3 Adult – Female Speaker]

It is possible therefore that the relatively higher rankings given to substances such as cocaine in the former tables were influenced by portrayals in media coverage. Given the predominance of sensationalist discourses and a disproportionate focus on the ‘dangers’ of illicit substances in Australian media (Bright, 2008) versus the overwhelming evidence that the socio-economic harms of licit substances with Australia (Commonwealth of Australia (COA), 2017), for those participants who are sourcing information from the media alone poses concerns relating to appropriate public health information and the potential need for wider dissemination of health literacy for some members CALD communities.

Media discourses may be associated with the assertion from some participants that illicit substances were more dangerous than licit substances; with several participants stating that the fact that substances could be legally purchased meant that they were different and, in some cases, less harmful than other substances. Again, this is concerning given the harms and costs associated with ‘legal’ drugs. Examples of such ideas in data collection include:

“Not correct [you] put alcohol and smoking, and drugs at same level. There has to be a hierarchy, because there are two things [alcohol and smoking] that are allowed...but drugs are banned...The way of addressing, it should be different”. [Group 2 Adult- Male Speaker]

“Drugs...you can be addicted to it, it’s very hard to leave it, but alcohol, if you have a strong will, you can stop it”. [Group 2 Adult- Female Speaker]
However, some participants problematised such ideas. For example:

“I think...when you’re having discussions...I know that’s a bigger conversation cause legislation, you know, but, I think someway you have to have that discussion because, you know, as soon as people say drugs you go to the ...Illegal one, but people forget about the legal ones that are doing so much damage it’s just, it’s not the flavour of the month... “ [Group 1 Adult - Male Speaker]

[Discussion in Group 2 Adult – Female]
Researcher: ...I would be wondering, do people think that medicines like the Panadeine or cough medicine...would people see them as more dangerous overall than ecstasy or heroin or would people see them as less dangerous?
Female Voices: No.
Researcher: Not as dangerous?
Interpreter: No, they are not. No, not dangerous like heroin or the ecstasy or whatever.
Female Voice: [Another participant said] most of them, they are very dangerous. Most of them actually, they kill you if you take a lot.

[Talking together].
Female Voice: The side effects of Nurofen [inaudible], it’s really bad [inaudible].

Greater ambivalence was found with reference to some illicit drugs such as cannabis. Some participants saw cannabis as less of a concern while others spoke about the harms. For example:

“[Some of them said] that marijuana, [they said] it’s...like hashish and it’s [a] very light drug [not very strong]”. [Group 2 Adult – Female]

“When people talk about marijuana, I think what you can get now, like, there’s so many different strands, and there’s so many, stuff that’s laced with extra stuff to make it a lot more, uh, addictive, you know, like...that, in itself has...a, a changed chemistry...” [Group 1 Male Speaker]

“And now they call it the gateway drug. They call marijuana the gateway drug”. [Group 1 Mixed - Female Speaker]
“I feel sorry about my friend... he have hashish, you know?... Marijuana, yeah... Ah, I really tried to help him, many times... but actually I failed, I failed with him because, you know, it’s not easy [to stop using]”. [Group 2 Youth - Male Speaker]

Many participants recognized that AOD use problems were not unique to CALD communities, and that AOD use amongst CALD communities is influenced by similar factors, including financial and environmental, as those in non CALD communities.

“Yeah we see a lot of them. So... but not only them, wider Australian community, anybody. So, we see, so many cases in this, in here, yeah. But not particularly from different specific community, it’s all across the board”. [GP]

“I think the question is, what’s not being used, cause everything’s being used... I think that list will be a lot less compared to what’s used, you know. And depending on... your age bracket and where you are, like certain demographics use more. They’re more prevalent and more access to certain things, you know, coke is a rich man’s drug cause it’s not cheap... But you don’t see that used out here as much as what you would in, in the city, you know”. [Group 1 Adult - Male Speaker]

“... like I know some Arabic... populations like who never really take to the drink, but then through their drug use, have then, found alcohol as well... but I don’t, I don’t really think you could kind of say one group is more likely to choose, it really, really depends on the environmental factors, and who they’re with...” [AOD worker]

Substances with strong cultural links, particularly kava amongst some Pacific Islander communities and shisha for some Arabic participants raised considerable ambivalence towards consumption and related harms. For some, such substances are culturally and communal sanctioned and are therefore more acceptable and less harmful.

“For the argileh, I can talk about our community, specially ladies or... young girls who gather. They usually smell the argileh, and they enjoy the smell of the argileh at the start and they say it gives a nice environment, and it makes us feel good, especially that argileh now is made with different fruit flavours. So that’s the idea of using it, people feel like it’s a nice thing to present in any gathering”. [Group 2 Adult – Female Speaker]

“All the research that you would come across you would never find any fatalities related to kava; you will never find any sexual abuse cases related to kava not that I know about or ever read about. From a purely cultural perspective it has medicinal values; as far as ritual cultures, its ritual...” [Group 1 Adult - Male Speaker]
There were however other community members who spoke to the dangers of such substances. For example:

“We try and stop it at our church, because we think...it’s not Christian like to ... a group of men just sitting around, you know, drinking [kava] ... Their conversations aren’t-aren’t clean...”
[Group 1 Adult – Female Speaker]

“There’s a common problem between the use in our community. If you ask one user and ask them “Do you smoke?” They say “No. But I only take the argileh”. So they don’t consider it smoking. And they don’t know that the argileh is much worse than the normal smoking of cigarettes. So, if we could introduce...the difference between saying “I don’t smoke” and “I take the argileh” it would be good because they seem not to know all the harms that argileh can do to them”. [Group 2 Adult – Male Speaker]

“People who used the shisha told me that it’s much worse than smoking because what happened when you use – it’s the same – firstly, ...the cover they share it, from mouth to mouth, first, and secondly...when you smoke a shisha then you get more smoke coming in into your lung that goes in so it’s much worse than a normal cigarette”. [Group 2 Adult- Female Speaker]

Such culturally sanctioned and communal forms of drug use require further qualitative and in-depth enquiry and analysis including intercultural learning and consultation between mainstream AOD and health related services and relevant communities to understand both the cultural implications of use versus the potential harms. The incorporation of peer-based education by bicultural workers who are aware of the harms of such substances may also be important and will be discussed further in latter sections of this report.

What was encouraging to the potential for intercultural dialogue within the current data was some participants’ recognition that cultural practices related to specific substances do change over time. For example:

“You know when you go to a wake or when someone passed away and you participate together, usually we offer the tobacco...and now it is not kind of like, a ritual anymore, it’s not like a culture or a custom which is accepted”. [Group 2 Adult- Male Speaker]

[Discussion in Group 1]
Male Voice: But, it’s when you use it excessively and everything...in a lot of Pacific Islander cultures I think Kava was, you know, a ceremony thing.
Male Voice: It’s a ceremony but then it’s been abused, yeah. It is supposed to be ceremonial and negotiation kind of things...one clan come, they drink Kava to establish [relationships] but then the young generation they, they overused it.

Intergenerational and Acculturative Attribution to Drug Use and Harms

The majority of participants felt that AOD consumption and related problems were issues that particularly affected young people. Even though a number of participants discussed AOD use amongst older community members; it was the impacts on young people that raised the most concern.

“…In our country, we have what is called Combatting Drug Intake or Drug Usage. Despite everything, it is affecting – it’s a harmful substance that is affecting young people. We fear for our children as well as fearing for this thing affecting other people’s children. We wish that this could be combatted, or done something for this issue…” [Group 2 Adult- Male Speaker]

[Discussion in Group 3 Adult- Female]

Researcher: … does that mean that people aren’t seeing any problems with, with older community members, or is it mostly a young people’s…?

Female Voice: Yeah, mostly it is the youth that has, there are few, few –

Female Voice: Yeah, mostly been the youth.

Female Voice: - few older people...few that are using alcohol, but mostly that just the young people that’s struggling in the community.

Participants discussed a range of reasons as to why young people were particularly vulnerable, including that it was considered a normal phase of a person’s development and the feeling that older members of the community were better able to control themselves when it came to consuming substances.

‘So it’s a normal, it’s a youth thing that passes [with] age”. [Group 3 Youth – Male Speaker]

“Before, the alcohol [was] for the oldest people, because they know how to control themselves, but the young people they don’t know how to control themselves. So this is the danger side of it”. [Group 3 Adult – Female Speaker]

Several participants noted that issues of acculturation for young people related to drug use. This was described as especially astute amongst young people who are experiencing a perceived struggle between wanting to fit in with peer groups where particular types of substances were more likely to be consumed.

For some adult participants these acculturative stressors experienced by CALD young people were perceived as leading to confusion for the young person about their place in the world and AOD use was seen as a way of establishing identity with a new peer group. For example:
“Our young people have lost their way because we have lost our part of our identity of who we are as a people. And we’ve taken on.... our young people they don’t even know who they are. There’re two different cultures they have to try and fit into. So, after they go to school and their peers and the culture that their parents are trying to teach them the values that they were bought up with and it’s really hard to jump into two and the kids are confused; their brains are not fully developed”. [Group 1 Adult - Male Speaker]

Often, this kind of AOD use and related behaviours were juxtaposed against parental expectations of appropriate behaviour. Perceived intergenerational differences between parents and young people were often cited by participants as problematic with parents citing the past i.e. when they were growing up and the cultural mores from the home country as more ideal or appropriate.

On the other hand, some participants saw AOD use as a coping strategy for the resulting intergenerational tensions between young people and their parents.

“...cause I’m second generation as well, it’s teaching the parents to be educated onto why the children pick up alcohol and drugs. Um, most of the times it’s because, those that are born here, um, the expectations gets too high... but I think educating parents, you know, really what’s behind the children”. [Group 1 Adult – Female Speaker]

These intergenerational tensions may have been heightened by parents’ perceptions that they were unable to supervise young people appropriately as parents also trying to build a life in a new and changing society; while trying to maintain communal based support systems. Examples include:

“We try our best to teach them it’s not good for them, for their future if they are using drug, cigarettes, alcohol, for their future, we can [teach] them. But, because they, as we told you, even other parent[s]...they do that [teaching children about substances and being role models] but their children doing what the parents [don’t want]”. [Group 3 Adult – Female]

“People are busy here, everybody’s busy. So, you got young people busy on their own, their mums and, or parents are busy on their own, so...nobody’s listening to them...But if you have time, try to help your son, your kids, or your relatives. Yeah, take them to sports, supervise them, talk to them. Look, and then the kids will ‘Oh look the, the, our parents, the people are caring for us’ and there will be less then. Instead of just leaving them, catching the train on their own then, around the city, you don’t know what they’re doing, what are the people out there with them”. [GP]

“And we’ve seen a cultural shift or a demographic in the home. And that’s where we need to stop and concentrate more on how the kids are educated at home and those core values have got to be reinstated because we see it every day. Kids coming to school and they say “Oh yeah man I was down with my boys last night or I was up all night playing Fortnite” That’s the reality
that we face now with the kids; nowadays; you know’ the absent parents because we’ve got these bills to pay. Dad is out somewhere else; trying to make ends meet”. [Group 1 Adult]

[Conversation in Group 3 Adult – Female]
Facilitator: It takes a whole village to raise a child up, but here it takes, it’s like -
Female Voice: Just a parent
Facilitator: It takes just a parent. Yes, that’s the difference.
Female Voice: And it’s too much -
Female Voice: To play the whole role

Against the backdrop of societal demands, many parents described feelings of helplessness, confusion and a loss of control in being able to protect their children from using AOD or change their use. For some participants this was exacerbated by the feeling that they were no longer allowed to discipline their children using ways in ways they were accustomed to and which they believed to be more effective (i.e. physical discipline).

“So back [in] our country we had the solution, you know, to physically punish them, that’s the solution. So my question now, how we can advise our children to avoid [drugs]?” [Group 2 Adult - Male Speaker].

“Sometimes I think ... if I was like maybe a part of the government, or if I have a voice to speak, you know? The way they said how we were brought up with it, anyone can discipline you, so for me like you know these Australian rules or something, they are really affecting our community cause all the kids, like the white kids and our kids, African, they are really different. If you talk to a white kid now, he will listen more, but our kids, they need to be disciplined, [laughter]. So, if they give us parent to do that and not police case or anything from the government, I think there would be no problem on the media”. [Group 3 Adult – Female Speaker]

Ideals of communal and collectivist social relations were preferred by some participants and juxtaposed against the metropolitanism, urbanized and individualistic realm of Sydney. These ideals espoused by some participants are useful to consider in terms of both intercultural learning relating to parental and community ideals of psychosocial forms of health and wellbeing and potential harm reduction strategies related to AOD use.

[Conversation in Group 1 Adult – Male]:
Male Voice 1: Do-do you remember being back home? Do you remember being in a small village or a small community?
Male Voice 2: Me? Yeah.

Male Voice 1: Why don’t you have that same feeling here?

Male Voice 2: It, it’s different.

Male Voice 1: ...they’re not built to know that many people, to have that many people, you know what I mean? ...there’s a lot of bad things that are around a small community as well don’t get me wrong but, you know, that, you feel like there’s more of a family network, you feel like a community. Like you go to small towns around, like you know around Australia and you walk down a street and people say, “hey, how are you, hi, ra-ra-ra”...So why is that feeling not here? And even though...you go to schools and principals say this sense of community and blah, blah, blah, why, you know, it’s, walk into Westfield not one person said hello, but then again, I didn’t say hello to anyone either....But then when you go to these small communities like everyone says hello and ...if I can grab that, and then bring it here, you know, I think that sense is something to be explored a little bit more”.

However, some participants, especially in the Pacific Island group, felt that traditional parenting norms exacerbated problems; and prevented the development of quality interpersonal family relationships based on trust, openness and understanding; which were more effective in preventing AOD use harms.

“....[but] if they’re suffering at home and they can’t speak up, because we’re all taught...“You only speak when I tell you to speak” , so, then our brains don’t fully function and grow, and then we, we become fearful...You know, um, working with a lot of youth it’s hard...to do what they want to do, because then, they’ll get a hiding...” [Group 1 Adult – Female Speaker]

“But even parents don’t know how to have conversation on an everyday basis. Like; how is school? Good? Ah good you didn’t get into trouble? No. Good. Got homework; ok go do it. You know what I mean? It’s like that you know? And parents ask me you know because they can’t hit them anymore. They go “how do I talk to my kid now; like what do I do?” Because that’s like that was my right as a parent; like I was able to hit them....But you’ve got to teach them how to talk... one day will come as you keep long suffering perseverance, love and all that; one day they will go “oh Dad can I talk to you about something? You know like my friends were all smoking and I was really wanting a cigarette. And then you ask so how was that for you?” [Group 1 Adult – Male Speaker]

These issues of acculturation and intergenerational differences are significant and require further consultation and intercultural learning between CALD communities and mainstream services. Researchers and service providers require a deeper understanding of how important these sociocultural factors play in informing identity, health and wellbeing for CALD communities. In turn, mainstream services may need to do more to respond and adapt AOD treatment, information and education programs to accommodate the realities that most CALD communities will face these tensions of acculturation and intergenerational difference in light of dominant discourses and institutionalised norms in Australian society which emphasise individualism. However, issues of access and equity and a multicultural focus are also relevant to the Australian legal and institutional framework and this might
include greater emphasis given to collectivist and communal worldviews when working with CALD communities

Other Contributing Factors for AOD use amongst CALD communities

Other contributing factors for AOD were also cited by participants. Some community members felt that AOD use and harms were a complex issue, with a variety of bio-psycho-social causes cited, including social and economic exclusion, coping with mental-ill health and intergenerational transmission of behaviours.

“- and, that is also come with social issues like Domestic Violence, induced, you know, through alcohol and that sort of stuff”. [Pacific Islander community leader]

“When you talk about and this is my perception of what I see and what I hear when somebody says this young person has a drug and alcohol problem issues, we don’t look at the drug and alcohol issues, we look at the trauma that’s pushing the drug and alcohol issue. That in itself extends from the home front; it is what they know, it is what they see; it is what they understand”. [Group 1 Adult speaker]

“Because I’ve lost my family, I just got out of jail, I’m bored, I’ve got no job. It’s hard, life is hard today, and if-if there’s no services available, for people like us what do we do? Are we going to be homeless, we’re gonna be start doing crimes, we’re gonna be using more drugs, we’re gonna be more, doing stupid things?” [Group 2 Adult - Male Speaker]

“...there’s many alcoholics [sic] in the, Pacific Island community. Just treating them, just, drying them out or take them to a place where they could dry out...these services [are] just treating them...from a medical model...Invariably they’ll...drink again. I think, mainly because, the underlying issues are not being...addressed. Yeah. So, just purely from the medical model, does not work, effectively”. [Pacific Islander community leader]

“...when you take too much alcohol that can lead to mental damage, you know, they can bring stress, create stress and all these things, they can create other diseases in the body, too, so maybe after, maybe you can advise them to go to the doctor first and maybe explain, we have these counselling sessions...You have other community organisation that helps provide [food] maybe if he lacks that, so you have to connect them through the variety of the organisations and services that maybe...related to his problem, yeah”. [Group 3 Adult – Female Speaker]

Participants cited cultural influences that influenced how AOD use occurred amongst CALD communities. This included ideas about community members trying to demonstrate belonging with a cultural group. For example:
“...and some are still doing it because of [camaraderie]. I want to find my belonging, you see, so if I know that my mates as having, having the drug and whatever I’ll go connect because I want to have that belonging within the culture, you know, because, you know, the Palangis [white people] will have theirs, the Islanders will have theirs...Fijians or, or whoever, you know. So, wherever my boys are...to be part of that, part of that inner circle I have to connect with a drug...I want to feel that I have a self-belonging...so that anything my problem whatever comes [clicks finger] one phone call away I’ve got boys coming”. [Group 1 Adult - Male Speaker]

Interpersonal relationships were referenced by many participants as influencing another’s AOD use.

[Discussion on hypothetical scenario Group 3]

Female Voice: [She said] Deng, used to be a good boy. He was [brought up] properly that’s why he got married. And when he got married, maybe he went to marry that lady and that’s where he got alcohol and drug, maybe from the wife. Because [seeing] the family still trusting Deng, that they call him, to come and help, that’s mean Deng was a good boy, with the hand of the mother and the father.

Bilingual Facilitator: But, he was actually drinking and smoking before he got married...

Female Voice: [She said] okay, he used to drink when he was with the mother and the father, but, maybe there’s a problem in the house with the wife, that’s why he was increasing [his drinking].

One academic interviewed explained such phenomenon as being linked to strong communal influences and collectivist culture amongst some people from CALD backgrounds.

“So, from my own research that I've done on AOD consumption and usage within Pacific communities, it's collectively driven. So, the idea is that you consume to be involved, communally. Rather than withdraw from the community. So, in other communities - even from a western point of view - you may consume individually for pursuit of happiness individually. But the communal consumption that may occur in Pacific and other collectivist cultures - even Arabic cultures - is more around being involved in the wider participation of the group in and of itself”. [Academic]

The risks of communal based drug use were also highlighted by this scholar.

“So with this notion of the collectivist consumption also comes this idea of...collectivist completion. So, people will consume, together, but they will also ensure that it's completed together. Which opens up a lot of the concerns around binge drinking. Because, they're consuming collectively everything that has been brought together. So, there might be five or six
people; they’ll all bring their own, cases or whatever and generally from what I’ve seen and experienced - even from a home personal experience let alone professionally - people will consume collectively until completion". [Academic]

Further to the idea of consumption as a way of relating to a broader group, several participants also described AOD consumption as a ‘performance’ and signifiers of mobility and power including economic affluence or masculine prowess. Examples include:

“people coming over here, there’s a tendency, there’s a phenomena that[s] happening here...When they are above their basic human needs hierarchy here, they can afford to buy drinks to do things, then they start imitating those who were wealthy back home. They start doing that, that’s creating problem[s] for people. Buying alcohol, bringing people then and somebody renting in the two bedroom, they have a whole room, that’s the, that’s their little bar...

People go out of their way to create fake happiness for themselves. Everybody want[s] to look the ‘big shot’, this, that. They’re all drinking like yesterday somebody went and pick up another boy from the airport and...everybody got alcohol in their hand drinking. And, that’s to show up yeah”. [Allied Health Worker]

“...you just want to also have money in your pocket. You want to look different, you know...okay, you people work for money? Okay, I’m going to show you [how] I make money easy. I want to have this. I want to have this”. [Group 1 Adult - Male Speaker]

“...who doesn’t smoke is not a man. The one who is not drinking alcohol or is not taking drugs, he’s not a man. He’s a man when he’s doing this bad stuff”. [Group 2 Adult – Female Speaker]

Nevertheless as highlighted in the previous section, while some participants cited the loss of communal and collectivist ties through acculturation and intergenerational stresses, there was a tendency for participants to blame themselves and their familial unit rather than recognizing that some of the wider structural and cultural phenomenon of marginalization and disadvantage which can increase health disparities.

[Discussion in response to hypothetical scenario] “....because when kids have no room in the school life....they are seeing some people they are not supporting them, and when they come back home, as you say, we parents, we don’t take care of them or we don’t see what is, what is wrong with this child, like, asking the child that, what is happening?” [Group 3 Adult – Female Speaker]

As noted by previous scholarship (see Ethnic Communities Council of Queensland, 2012; Horyniak et al, 2014; Anile, 2018) these findings indicate that AOD patterns of use change in complex ways as a result of migration and resettlement and are linked to loss of communal, familial and cultural identities. These issues are critical to informing AOD and health related mainstream services’ response to community behaviours.
The next section for analysis utilises the four adapted pillars of the Mental Health in Multicultural Australia’s (2014) *Framework for Mental Health in Multicultural Australia: Towards Inclusive Service Delivery* to include data related to prevention including harm reduction strategies and early prevention. Other pillars highlight the centrality of deepening ‘cultural responsiveness’ in terms of quality of AOD and health related service provision, workforce development and the integration of individual, familial and community participation within the former services for CALD communities.

**Early Intervention and Prevention including harm reduction strategies**

Overall prevention and early intervention were highly valued as many participants felt it was more effective and cheaper to intervene before problems became entrenched. Again, a focus on young people and the importance of intergenerational harmony were privileged in these discussions.

“And I think that’s the key; before they access AOD services what’s been done prior to that. We should be able to identify before that they are risk before they are even referred to AOD”. [Group 1 Adult]

“And I think the best way to help the society get rid of a problem is to start with the younger generations. Because for example, looking at us, we are past the age of 50, so it’s difficult to change habits at this age, and it’s also easier for people to change habits in that age, and also, more impacting to the society”. [Group 2 Adult– Male Speaker]

“So, if you establish the educational programs, family programs, and counselling, you will not need the…other things [treatment services]...” [Group 2 Adult – Female Speaker]

**Prevention strategies**

Several participants discussed how maintaining strong cultural identity through retaining family and historical traditions, can act as a preventative factor against AOD harms. This was particularly raised in Pacific Island community groups.

“It’s...really important for the...people to have their identity that’s why I heard you when you said the dancing, even though if they’re here and it’s something that doesn’t hurt anyone, I believe it should be done and people should keep...their own identities and culture...and learn about it, to make them stronger people. If you don’t know who you are, it’s very hard to live life”. [Group 1 Adult – Female Speaker]

“[Culture] It’s like a jewellery box...it’s a value, it’s something you value”. [Group 1 Adult – Female Speaker]
“Let’s just say specifically for young people, they, to understand where they want to go, history’s important. And when I talk about history I not, I not only mean, history from their own, people and their own culture but history within their own family. Like with what’s, a lot of, like you’d be very surprised at, like, you come from a family that have A, B, C and D, you know, and, that sense of self is-is, can be life changing...” [Group 1 Adult - Male Speaker]

“We do cultural stuff, like, sew. There’s no drinking. Um, but it’s all about family. All our kids play outside, and, if you’re not dancing, you’re playing the drums”. [Group 1 Mixed – Female Speaker]

Many participants felt families had a vital role in preventing AOD use harms, although schools were also felt to have an important role to play. Participants reported discussions in families where parents tried to educate children about the harms of AOD use or role model behaviours they wanted their children to follow; including some highly creative strategies. Examples include:

“I think, um, my husband is fully like going on to them every day about what he sees out there, this could happen to you, “Don’t do this.”... So, that, you know, just educate them in, on... what can happen”. [Group 1 – Female Speaker]

“So...easy to get access to movies and videos...about the drugs...And that really sometimes it...give them an idea how to deal with it... show you how the police targeted the dealer...within the movie...” [Group 2 Adult- Male Speaker]

“We can tell our children about the harms of smoking, and we can give them examples. We can tell them “Look at these people how smoking have harmed them”. Or otherwise we can use live examples in front of them, we can put some of the cigarette smoke in a balloon, or in maybe a cup or something, and show them the effects that the smoke can do to things. If they see it with their own eyes, they could tell, what are the consequences of smoking on the body. This way, we can have a community and a family that is cleaner and clearer from all smoking”. [Group 2 Adult – Male Speaker]

“Being a good role model with the family, yeah, so when parents are good role model to the kids, because we have some other families that the parents are drug and alcoholic, so what do you expect from their child, it, so they’re just going to grow to that, that system, you know?” [Group 3 Adult – Female Speaker]

While participants emphasised the role of parental guidance in terms of prevention, relatively few participants mentioned educating their children on ‘safe’ consumption practices. Prevention and early
intervention in relation to AOD use was mainly discussed by parents and older participants in terms of wanting others, especially children and young people, to avoid consuming various types of AOD. “The only way is never start. Once you start its gonna be very hard to stop. It’s like a train with no brakes. That thing is going to take years to stop. To get yourself out of that mess never start! If you don’t want to stop, never start”. [Group 3 Adult - Male Speaker].

The underlying understanding was that the best outcome was to have the person to move from use to non-use.

[Talking about a past experience helping a friend] “…and then afterwards she starting drinking alcohol, and then she used to say like I have a problem, I don’t know how to stop it, so we used to tell her maybe we see the GP and then they’ll tell you where to go for the counsellor... “. [Group 3 Adult – Female Speaker]

Participant comments also indicated traditional sources of help seeking and support for CALD communities reinforced an understanding that the avoidance of AOD use was preferred (especially for illicit substances); and again, if someone did engage in AOD use, the preferred solution was complete cessation.

“Like, one of my teachers talked on Saturday about it... like he was having one of these family members who was really in a bad drugs, even he said that the family...they said that they wished he was dead, but he said that I [this person] came...I gave myself time for eight months [supporting] that drug addict. He said that person now, if you look at him, he got married two years ago, he has one daughter now, and he’s at work. So, he helped that person to come [off] drugs”. [Group 3 Adult – Female Speaker]

“In the communal level they would just try to talk to the person. They would say you’ve got to stop, this is not good for your family, your kids. They don’t go to the reason why you are drinking; they just want that person to not be drinking. And also, in that regard they don’t know why they are drinking. Some of them don’t know why they are drinking and its sort of a lack of awareness” [Group 3 Adult – Female Speaker]

These issues related to abstinence being the preferred method of communally generated responses and parental preferences alongside the relative absence of references to ‘safer use’ may highlight a need for further intercultural dialogue relating to the concept of harm reduction strategies and greater support for familial and communal strengths of CALD communities as highlighted by the following quote by an academic in the field of AOD use amongst Pacific Islander communities.

“With the community [church] leaders, definitely health literacies. AOD literacies would be amazing. Just more around harm minimisation, rather than abstinence. That would be amazing. Because I think they all see these AOD issues but they’re all about abstinence because that’s all they know...So I think it’s about, ensuring church leaders...not necessarily they don’t have to go
against their morals, but they're also understanding the health implications of not having a good conversation or relationship with substances”. [Academic]

In turn some participants felt that there was scope for greater education of families and communities around safer consumption practices, addiction and help seeking strategies, particularly among those who had come from countries where the level and exposure to a range of AOD was less common.

“They don’t understand drugs is addictive, they don’t know about relapse, don’t know about addiction. They don’t understand that. Cause they weren’t growing up around drugs and all that, you know what I mean? They think drugs is not addiction, they think you can wake up one day and stop it just like that. But they don’t know you need to do courses or do programs or, they don’t know you need to do all of that or get counselling or help. They don’t understand all that stuff”. [Group 2 Adult – Male Speaker]

[Conversation among Group 3 Youth]

Female Voice: Our parents haven’t been educated about that, they don’t know about all those...

Female Voice: They’re not exposed to that and I think when you come to a new place you get exposed to that and then also like, with Australian families like, they allow their kids to drink and stuff like that at a certain age and they say – they allow that is because they are going to eventually and they’d rather do it in a safe environment. Whereas Sudanese or like other communities, they don’t want that for their kids cause it’s bad.

Female Voice: At all.

Female Voice: So they don’t teach you about it because they don’t do it and then that’s why we do it and you don’t know the effects and you don’t know how it affects you because they don’t teach you about the effects, they don’t say you can do it safely and that’s why in moderation…with us because we don’t know anything about that, we just kind of jump into it…That’s why people they abuse it and they drink....

Female Voice: Cause they don’t know...

Participants described feeling frustrated or helpless to assist if a person did not want to stop using AOD. Again, very little mention was made of what could be done to support a person who continued to use AOD.

[Discussion about experiences of people who had tried to stop using substances-Group 2 Youth]

Female Voice: ...if I go through this, I will never let him go. I will just tell them this is wrong...you have to go to this community [organisation] to get help... Like...I will show him people killed all the time the news, show him that, look, this person
died from these things. I will show him the movies that what happened to the people.

Male Voice: He know already that; he know already that and if you try to do that always and you will stay behind him and follow him...he will go far already from you and...you will feel that...he hates you....[Reverts back to earlier discussion about experiences helping a friend using cannabis] Yeah, so I just, I try, and I saw that he try to go far from me so I just told him...enough, I will never follow you and I will never give you advice about this section. You are my friend and I respect you and do whatever you want, that’s it. Because otherwise...he will really feel uncomfortable when he saw me.

For many participants, this sense of powerlessness came from the view that AOD use was governed by individual choice and control, where the decision to change consumption was a matter of the person’s own volition and could not be forced on them by an external party.

“Like, it’s somebody’s personal decision in what they do and what they take as a grown person. I just personally feel it’s your own personal decision when and when not to stop”. [Group 3 Youth – Female Speaker]

“To quit any bad habit, this needs a drive or a motivation. It has to be a strong motivation. To have that drive or motivation, we would be able to overcome any bad habit”. [Group 2 Adult-Male Speaker]

“I had an experience in smoking, I used to smoke a day about four packets. I noticed that this was giving a bad reaction or reflection to my body, so I voluntarily decided to quit smoking. This was 3 March 1969.......I quitted gradually, I didn’t want to quit smoking. I said to myself “today I will smoke one cigarette after breakfast.” Then I delayed it till after lunch, then I delayed it till after dinner... I kept on delaying it until I quitted it...I stopped [also] beverages including tea and coffee. I was able to quit smoking after I was smoking 80 cigarettes a day”. [Group 2 Adult-Male Speaker]

Even though this view was shared across the three groups studied as well as for some key experts; participants still felt that there was a role for programs and strategies to address the social and economic disconnection that was seen to contribute to substance use. One participant described taking a proactive approach to this:

“At the start when we first came from [Country], we had a lot of sadness and a lot of issues to do with the background that we came from. The first thing that came into our mind is to participate in different programs for adults and for children. And we put our children in soccer and in tennis and make them very busy all the time, so they wouldn’t have time to think about things that happened in the past, and not to get sad about it, but to try to be happy and busy most of the time. I even advised my friends of the different programs to put their children in, and most of them listened to me.” [Group 2 Adult – Female Speaker]
Some participants also called for broader approaches that involved greater regulation of access to AOD and supply side control.

“So if you are really concerned about the smoking habit, why don’t you just to prevent and stop plant [of tobacco] and agriculture here? [Group 2 Adult - Male Speaker]

“Keeping a close eye on drug dealers and having more strict punishment to such activities. [Group 2 Adult – Male Speaker]

“I heard about a similar thing... like with the Centrelink money that they give them, they should ask the parents if your child, you know that he's an alcoholic, they give them that card that can only buy them food and other things, something not to do with alcohol or drugs. So, if they have the card and usually they'll bring it back home to the mother and go and just bring, buy food, yeah... But with them now, they’re getting the money, they go and use it on something else like alcohol, but I think that card can help them. [Group 3 Adult- Female Speaker]

Although others acknowledged the limitations of abstinence-based approaches.

“You can take away the alcohol, you can take away the drugs; um, it’s not the substance that we’re addicted to, it’s the why behind we’re getting addicted to these substances”. [Group 1 Adult - Female Speaker]

“I think is the drug and alcohol gonna be more in the ...the country who more believing in, like a...no freedom in the country...everything is “No”, so people...what they do, they [do it] under the table like she say...they drink everything under [the table]”. [Group 2 Adult- Female Speaker]

“You know we have a saying that when you prevent something it will become more familiar, more common, more people ask for it”. [Group 2 Adult- Male Speaker]

Help-seeking options

Particularly in the African and Pacific Islander groups, many participants talked about seeking advice and assistance for these issues from friends and peers; as these were seen as trusted and non-judgmental sources of support (see Figures 4 - 6).

“There’s two that I put other relative or family friends...they’re comfortable going and getting information maybe a trusted one”. [Group 1 Adult - Male Speaker]
[Discussion in Group 3 Youth]

Female Voice: It’s mostly friends because they’re scared their parents will know.
Female Voice: …normally judge them and stuff.
Female Voice: Least common for our parents.

“Generally, the health information may come from peers, and other people that they know; older siblings, trusted relatives, but mainly…the peer group. Like it’s within the peer group that they would actually obtain such information”. [Academic]

As discussed earlier with regards to the importance of communal and relational sources of support, participants also emphasised the role of familial and community ties as a strength and strategy to resolve AOD issues over and above service provision.

“but like, with most of the mothers who have the kids now, like teenage, I don’t think they, they are aware of them, they just think they can talk to their kids and just automatically change, they don’t feel like it’s something that needs treatment, somewhere to seek help from”. [Group 3 Adult – Female Speaker]

“Like, we’re talking about taking it to…the church. There are other people, there, the youth leaders…the youth leader is a paid person…and you know…[these youth leaders] they take very strong part…in community, and I think…we’re really stepping up, and there’s…other people coming in, [mature age] people…that have had experience from work with community… [Group 1 Adult – Female Speaker]

In the few examples of people who had sought or were thinking about seeking assistance from an external service for someone they knew who was experiencing an AOD-use issue; the relational dimension of help seeking continued to pay a role with participants citing an existing personal connection to a service being a driving force to access.

[Talking about friend that uses cannabis] “I wish that he accept me and, to go somewhere…and I try to help him with the company...like [NGO] [Group 2 Youth - Male Speaker]

Talking about 16-year-old son who is smoking]: We tried with our son with all civilized ways, in the end we found no solution...we came to our [NGO Worker Name], he helped us so much and tried to help us. He went with us to police so that they can monitor him and find out what is a problem. [NGO Worker Name], he followed the issue seriously, police, the things that they promised us to do, didn’t happen, didn’t action”. [Group 2 Adult - Male Speaker]
[Discussion in Group 2 Adult: Participants have been talking about where they would send ‘Adnan’ who is experiencing AOD use issues in a hypothetical scenario]

Male Voice: About Adnan and the community, if he agrees us to give him an advice, the first thing we must do is to take him somewhere he can have help. Some sort of a counselling, psychological counselling, so people can tell him what are the harms of what he’s doing...

Researcher: ...you were mentioning a counselling service – does anybody know the name of a service?

Voices: [Service Name]!

Male Voice: [Service Name] is a very good organisation. It’s in Auburn and in everywhere.

Male Voice: All the workers in [Service Name] are really good people, and they make you feel really comfortable.

Male Voice: I had an experience, when I came from Syria; I suffered a lot in Syria and in Lebanon, we suffered. And the minute I came here [Service Name] [helped] me a lot. And until now, I still go to [Service Name]. It’s a very nice organisation and all the people working there are really perfect.

These patterns around help seeking behaviours point to the potential for a greater role for peer support programs, an issue that will be addressed in more detail in later sections.
Figure 4. Ranking help seeking strategies – African community focus group responses\textsuperscript{12}

Figure 5. Ranking help seeking strategies – Arabic community focus group responses\textsuperscript{13}

\textsuperscript{12}N=21

\textsuperscript{13}N=67
The role of religious leaders, particularly in African and Pacific Islander communities was also felt to be important; although some participants raised that particularly for second and younger generations, feelings about religious institutions were changing. Several participants noted that concerns about being judged and fears about confidentiality of information discussed would act as a barrier to disclosing AOD issues.

“Cause religion plays a big part...in the PI [Pacific Islander] life, yeah?” [Group 1 Adult – Female Speaker]

“And a lot of the first, second generation, specifically Samoan people like, they ran away from the church. They couldn't care less about what the church is saying”. [Group 1 Adult - Male Speaker]

[Discussion in Group 3 Youth]

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Figure 6. Ranking help seeking strategies - Pacific Islander community focus group responses

N=30
Female Voice: African community churches, you don’t really want to tell them anything because they’ll probably go tell someone -

Female Voice: Well, you have a youth leader.

Female Voice: The way they – yeah, but not every youth leader keeps it confidential, you know. They have a friend that they talk to about.

Such concerns were also conveyed amongst some Arabic speaking participants.

“...people in the mosque they make him scared and they say...you should smoke, and go back to your country and go to Mecca, and this stuff will come back...will going away while you’re in the Mecca. So, he listened to this people here, and went to Iran and went to Mecca and still he’s sick”. [Group 2 Adult – Female Speaker]

The perceived importance of social media as a source of information was variable both between and within communities. However, even in communities where overall social media did not rank highly, in focus group ranking exercises, there were a small number of individual participants for whom social media had played an important role in framing their response to AOD use, indicating that this medium could be utilised as an educational resource for CALD communities.

“Since we came to this life, we used to hear that the drugs and alcohol are not useful. According to social media regarding drugs, they found out these things are good for a lot of things. That these can be used as a treatment for cancer and also in other countries they have legalized, in Denmark, in Mexico that these can be sold legally. Doctors have gathered regarding this topic, but they have not come up with a resolution. [Group 2 Adult – Male Speaker]

“but in our community we may know them like, we go through internet... when you’re using the Facebook and see something has been shared, maybe somebody had a problem, or any alcohol, any article talking about alcohol or drugs, we just read it and that’s it... the young ones that are using the internet, [inaudible] you can learn from there. [Group 3 Adult – Female Speaker]

With regards to help seeking behaviours amongst Arabic speaking populations noted in Figure 5, doctors and medical centres rated highly. Both participants and professionals commented that GPs appeared highly valued and trusted in the community.

[Discussing Adnan scenario Group 2 Adult – Male]

Male Voice: Just not only hospital, he need some advice or someone trust. [Researcher asks who?]

Male Voice: Like Doctors.
“I feel like they trust doctors a lot of the times. Especially with Arabic speaking...background [communities]. So, I feel like a lot of the times it’s always like going to the doctor. They rely on the doctor a lot... and they trust the doctor because the doctor- like, as seen in...Arabic speaking background [populations], like, they’re seen as a very high up, the doctor”. [Health Worker]

It also may be that doctors were ranked highly among help seeking strategies in the Arabic group due to prior discussions about what people had observed occurring in their communities. Many participants in these groups described knowing someone who had gone to a doctor for assistance to quit smoking.

“I have experience with my son...Yeah, he tried, all types like, the patches...But it didn’t work with him...He went to the doctor and the doctor advised him to do this but it didn’t work with him...Yeah, it helps a little bit but after that, [but] because he’s addicted [to] smoking, he came back”. [Group 2 Adult – Female Speaker]

“I know somebody, he had a problem with smoking, he used to smoke a packet a day and then he used the help of a doctor and he stopped smoking. He quit smoking for two and a half years...” [Group 2 Adult – Female Speaker]

It was somewhat surprising that AOD services were preferred strategies for supporting someone with a possible substance use issue. This was particularly the case with respect to the Arabic community focus groups because many people stated that they either did not have knowledge about illicit substances, or that they or their family were not consuming alcohol, tobacco or other drugs. It is possible this may be out of politeness, as when Researchers introduced themselves to each group an explanation of DAMEC was also provided. However, it also may reflect that for some participants, there was an existing knowledge about support services available alongside a privileging of specialists’ authority, either here or from prior knowledge in their home country.

“Yeah, in Australia there are special places here and not like in our home countries no - its organized. it comes in stages, it’s not in one go they can stop everything for someone who is addicted. No! it comes in stages, that’s what I know”. [Group 2 Adult – Female Speaker]

[Comment on hypothetical scenario]: ...psychologist, psychiatrist, a specialist, there’s centres to help people with addiction. [Group 2 Adult – Female Speaker]

[Comment on hypothetical scenario]: About Adnan and the community, if he agrees us to give him an advice, the first thing we must do is to take him somewhere he can have help. Some sort of a counselling, psychological counselling, so people can tell him what are the harms of what he’s doing. For him to agree to come with us to this place of help, we have to try to tell him nicely that you need to get rid of all the poisons that you’ve put in your body... [Group 2 Adult – Male Speaker]
Among Pacific Islander participants there was comparatively more conversation around the types of treatment services people were aware of, either through their own experience or that of someone they knew (also see Figure 6).

“Like there are heaps of programmes out there”. [Group 1 Adult - Male Speaker]

“And, just finding that one service, that I was directed to, like, helped me a lot along the way”. [Group 1 Adult – Female Speaker]

While the above figures highlight some preference for services, during focus group discussions participants rarely described a drug and alcohol service as the first point of contact for seeking assistance for AOD use issues. Some participants reported that they hadn’t been or were not currently aware that these services were available:

“I think it was just a lack of me not being educated, him not being educated in, um, knowing what services were out there, cause at that time, I didn’t know…all I was doing was, like, just chasing him, trying to stop him from getting that next hit, you know?” [Group 1 Adult – Female Speaker]

“No, we’ve not heard so far…maybe we’ve got some of the folk who attend such programmes … but so far we’ve not heard or anything, for myself, haven’t heard of any programme that is tackling the Sudanese alcoholic people”. [Group 3 Adult – Female Speaker]

In terms of improving health information, promotion and prevention, outreach into communities was widely described as one way in which service providers could build that personal connection to communities.

“Where I’ve been into a service, and I’ve delivered an in-service, and then they get to know me, and then they will also then refer because of that”. [Family Worker]

“Approach them. And ask them what activities they want to get involved. Because usually, in my community, if you bring something in form of activity, the more you get people. But if you…say “Oh, I just want you guys to come and listen to information”, you will never get anyone there...If you’re lucky you will get two people or one. So it will be good...when refugees week, for example, coming, or mental health week coming, or other week coming – we target these days, and say BBQ, mental health week BBQ, and then we go somewhere in the park, the hall, and then give them the information there”. [African community leader]
“So, I think maybe, like, someone from the community can probably go around the churches. Because I feel like...Islanders are very prideful, even though they know there’s help out there, they won’t go to it. They won’t...make the effort to go and find it. It’s like, it needs to come to them. [Group 1 Adult – Female Speaker]

However, recognition of diversity and difference in communities when undertaking outreach was also raised as an important factor.

“No, we’ve not heard [of any programs] so far, because Africans is diverse...but when you say...this programme is for Sudanese...then that’s when we will be able maybe to get the information”. [Group 3 Adult – Female Speaker]

**Barriers to early help seeking: Shame and Stigma**

Although there were a number of participants who spoke very highly of treatment and support services from across all three target communities; many participants still acknowledged that there were strong elements of shame and stigma about both AOD use and seeking support that made it very difficult for people to initiate seeking support. It was noted that fears about consequences of shame and stigma related not only the individual but also for their whole family acted as an impediment that could lead to serious ill-effects.

“And then I think we come from, shame and honour culture, instead of, you know, the guilt/innocent culture so, guilt/innocent is [that] “Oh, I think I am guilty; I should, you know, I should fix this”, but we come off like, “Well, this is shame and if someone find out from my community then my family will be ashamed and I’ll be ashamed. It’s not that I have a problem or it’s not that I’ve done something wrong, but I am wrong, like, you know, just [being] me, wrong.”, you know? “Being myself is wrong.” That kind of thinking exists so, that’s a problem. So, there’s a bigger stake in our community, compared to the Anglo-Saxon community which usually the western mindset is that, you know, “I, I’ve done wrong and, you know, I need to fix it.” So, if person A did something wrong, his whole family is not going to be persecuted. But in our case it’s that if you’ve done wrong your mum, your dad and everyone is gonna suffer. So that’s the way, you bring shame to the whole family, so I think those are the things that makes it even harder for us”. [Community Worker]

“...and they [young people] worry so much about what people are going to think of [their] family”. [Group 1 Adult - Female Speaker]

“They will not want to get help. I know, I know a man that lost his ah son to drug, you know. But I didn’t know that the guy was using drug, I didn’t know until the guy passed away and then they were talking about it, and then I started asking how come? You know, so, they said the guy has been dealing it for some time, you know, but nobody opened, nobody said, it was handled as family, family matters. You know this shame of it, or if we said this people would think we are
not normal, you know, our family is not good and all those things. So those cultural things that we came from back home just stay within the dark here, still hanging on our subconscious, you know. [Health Worker]

Whilst some felt shame and stigma existed throughout the community; some in particular claimed that it was a view held by older community members; which impacted their own help seeking behaviours as well as those of their family and wider community around them.

“That’s why when you see our young people, they are doing things out there, they go out, do some drugs and things, they don’t do in front of the elders in the community. That’s why the young people avoid us...Because the community’s chasing them away. “If you do it here, you are useless, we don’t like you”’. [African community leader]

“Specially for the old people that they came like now arrived here to Australia they have to see the counsellor, they have to talk to someone about their problems. They are, they don’t know the community here so counsellor can help, but in our community, you know, someone go to the...psychologist, they-they, they tell “he is crazy, he going there, he is crazy.” That’s why they don’t like have these like good connecting with the counselling, because their...they say, they thought that crazy people go to the psychologist”. [Group 2 Youth – Female Speaker]

Again, the importance of addressing intergenerational differences through intercultural dialogue and providing more health education and promotion of harm reduction and the health implications of drug use will be important. This assertion was supported by some participants who felt that there was a need for particular educational programs targeting stigma in communities to move from conceptualizations of AOD use disorders as a moral or personal failing to that of a health issue.

“I guess breaking down stigmas within the community itself. You know, it’s okay to-to ask for help, you know, if they’ve- if the person’s got a drug problem, they can get help and this is where you can get help, for that. Then, I guess family members would be, more open to the idea of “okay this is what you need to do”, you know refer other family members or, whoever it is to-to get the counselling and-and the help that they need. Um, so, yeah, so, I guess, more...putting it out there, [yeah], into the community…” [Justice Worker]

“We talk to the big group, because the big group is the problem. They’re the one[s] shutting down the individual. They’re shutting the individual down because of the stigma...Because if you have drug and alcohol issue[s], or mental health issue[s] they think, you are weak, you are useless...[so telling] the community, say, “no, it’s not true, these people, they need help, anyone who needs help [will] come. Anyone who tries to [hurt] people when [they’re] down, these people deserve to go to gaol even. Cause you imagine someone who need help, not to come because...you imagine him weak. Yeah. To challenge these people in the [community]- in the bigger picture, and some people will make sense of it “Yeah, you are right, you are right”, you know? And then, even they will encourage them”. [African community leader]
“And bringing it out in the open and, you know, uh, de-stigmatising and ... You know, the other whole thing is, you know, I talk the language, or education, around people who use drugs that they’re not bad people. They’re not weak people...all of that stuff is so important. So, so, removing the moral sort of framework from people”. [Family worker]

Safety and quality of AOD treatment and health related services

Rapport building

Being able to build a strong rapport with clients, showing care and a genuine interest in the client’s wellbeing and navigating around pre-existing assumptions and biases were highly valued. This was emphasized by both clients and professionals.

“So, people is the first remedy; if you have people around you; people who knows your problem; people who knows how to handle your problem. As I told you people who have a listening ear; everything is going to be easier. [Group 3 Adult - Male Speaker]

“...the people who are in the office need to be educated and trained on how to maybe, not be so ‘on the paper’. Um, uh, nursing for example, nursing for example. You have, five nurses that do by the book, come and look after you, and you have one nurse that comes in and says, “How are you today?” It makes a huge difference to someone who’s looking for help. So, if as, if as a worker, you can be trained a little bit just to, show that bit of empathy, bit of sympathy, towards the - the one who needs help, then, that would be good as well. Just so that you feel that you’re...asking for help is being heard”. [Group 1 Adult - Male Speaker]

Whilst no cases of discrimination were articulated a few participants noted concerns about worker’s holding inter-cultural or inter-racial stereotypes would affect the responses to help seeking.

“...especially young Africans when you ask them...whether they want to go to the drug counselling, they will say “No, I don't want to go”...when you say “Why?” they say “Well, if I go they still, like, I will be judged or maybe I wouldn't be, you know, getting services or, I'd be too different of them...” [Youth Justice Worker]

“...it’s not my fault that people are 6.2, 150 lbs- kilos like, you know, they're big boys...I think, intimidation, can’t help the way we look, you know, ...[that affects]... like services either coming to them or them going to services, you know”. [Group 1 Adult - Male Speaker]

Professionals articulated three broad strategies that they felt was important to rapport building. Firstly, several participants highlighted the important of quality interpersonal engagement strategies were
important in overcoming communities’ reluctance to openly discuss AOD issues. It was felt such strategies were particularly effective with young people:

“Approach them. And ask them what activities they want to get involved. Because usually, in my community, if you bring something in form of activity, the more you get people. But if you...say “Oh, I just want you guys to come and listen to information”, you will never get anyone there...If you’re lucky you will get two people or one. So it will be good...when refugees week, for example, coming, or mental health week coming, or other week coming – we target these days, and say BBQ, mental health week BBQ, and then we go somewhere in the park, the hall, and then give them the information there”. [African community leader]

“I guess just the way we do it at the youth centre; how you engage with the people that you are counselling you need to do something physical, I guess. Whatever they are interested in. I guess it would look weird at a counselling place but it’s so important. It’s just the way us Islanders open up. If you are gonna be into sports you’ve got to get in there and throw a ball around or something. That’s just the way they initially open up. You need to be a bit physical whether it be a ping pong table there; have a ping pong session first before the session. It works here”. [Youth worker]

“[Name] is a really, really very good organisation and [young people]...they go and...decide to go in for the counselling. They go there because there’s free internet. They go there because...when you go there you have, like, free foods, you can eat as much as you like or take some at home. And also you go there because you’re gonna play some games and you’ll find like lot of people there”. [Youth Justice Worker]

Professionals also argued that it was important to take a client centred approach; constantly adapting strategies to suit the needs of any client, regardless of the community from which they came from and not assuming homogeneity of CALD clients’ needs.

“So, it depends on each particular...case, the patient, yeah, so...that, that’s how we deal with it”. [GP]

“And if I find them - they're not engaging today, so, I wouldn't be pushing that hard to engage. Just say “Look okay we just, maybe chat normal and then next time we're gonna do things better or differently.” [Youth Justice Worker]

“I think the biggest is just that willingness to kind of really, um, learn from what the client is telling them. To really listen and hear that. Uh, maybe not necessarily try and make it fit in their particular model or way of working. That may not always work. So, being a little bit more creative or flexible or fluid in that space. So, still having that model but finding more creative ways to get that client to fit into it”. [Psychologist]
Thirdly, several participants emphasised that rapport building takes time. Several professionals felt that people would rarely disclose their substance use at the first meeting. The importance of taking time to develop and good client-service relationships with a client or families; and where possible, being able to continue to continue supporting the client in all stages in their treatment journey were felt to be particularly valuable. Examples of this include the following quotes:

“Some of the boys that you know I work with or girls I work with when I ask them have you ever used the drugs before as I mentioned they would say no. And then when we go deep into the [conversation] they will say “Yes. I use it, a lot”. And - across all the three community or the three, like, group that you mentioned [Arabic, Pacific Islander and African]; the same pattern”. [Youth Justice Worker]

“And that’s why some doctors, sometimes they, they fail if you don’t listen, some, because some of them feel they are too busy, and they do everything in a hurry, they call them in, and ‘look, what, what do you want me to do?’ and then send them off. And then you won’t, you won’t know exactly what’s the problem with this patient...And try, give them time, listen to them, that would be trust. Look, this doctor, is listening to me and he would like to help me. And if you tell them next time, ‘please, I want you to do this’, he will listen to you. He will listen to you, because you are caring, you, you show that you caring for them. You know, it’s just not a patient you want to see and send them off and call another patient. You want to look after them”. [GP]

“We have this young guy. Went to rehab, and then after one year rehab, and then come back...the case-managers there refer him back to where these things happening, like alcohol and drug, and people who are doing these things...There is no follow-up, like, a caseworker, or case manager to follow up. And if you don’t have that it’s hard”. [African community leader]

“And I think with CALD families, you need more time. You need, more empathy... It’s like that with families. I’m doing that all the time. Most services can’t work with families. They don’t have the time”. [Family worker]

In particular, the ability of a professional to personally support a person through supported referrals into AOD treatment systems, especially where there were not high levels of knowledge or issues relating to trust, was highly valued.

“...just to refer back to what you were talking about getting someone involved if he, if he or she wanted to...stop something, you know, it’s not easy. Yeah, you have to know ins and out of the system how it is because some of, some of the Islanders they’re not educated, you know, so they don’t know this, you- you can’t just put everything onto, “No you gotta do this, you got to – “. No, man, you’ve got to take them, hold them by the hand and give them, say “this is the process”...Don’t just tell me, walk me through. If you know it tell me. Do it together. Hold my
hand together. Let’s do it. This is how you’re going to do it...but, just telling someone, it won’t work”. [Group 1 Adult Male Speaker]

“...I do take them, myself. I will ask the young person “Okay, can we go together?” Because sometime when you say “Okay I’m gonna take you”, like you know, I will refer you to that person and when you go there, they will start from the beginning. And, I will always ask them “Okay, I will accompany you to the, services. We’re gonna go together and sit down with that person and talk about, like you know, what you have to do then; from there you can come next time.” [Youth Justice Worker]

Several participants noted that when efforts weren’t made to build rapport and strong communication patterns with the client, poorer outcomes resulted; particularly when clients were not familiar with mainstream treatment systems.

“....You know, I’ve tried so many times, you know, to try and, [educate community members filling out services’ forms]...what they put there, you know, do you have support, you know, from your family when you come out of gaol? “Oh, yes, they tell me to go to church.” [That] is not - doesn’t support the problem you went to gaol with. So, it needs to get deeper than that...It’s been a long, long time and it still hasn’t changed”. [Group 1 Adult - Female Speaker]

“..not having really any assumptions of what they know and understand in that space about what we do...in my role with clients, I often spend a lot of time in the first few sessions really just nutting out the service and explaining things, um, you know, taking the time to kind of build that connection so on and so forth and there’s a lot of things that we can easily miss with our kinds of clients and they won’t disclose because they didn’t think it’s relevant. Um, they just, they’re not sure what – what the service is really about”. [Psychologist]

**Cultural Responsiveness: A key marker of Quality**

Alongside the various qualities of rapport building for CALD communities described above, the ability of services to understand and work with a client’s cultural needs also forms a critical part of providing quality service provision. The importance of this issue will be further extended in the pillar of workforce development.

“I’m [from a particular cultural background], so I may go and utilise a service...that’s understanding of my cultural background. So that’s more of a safety thing possibly, so that people can utilise those services if they feel comfortable”. [AOD worker]

“But if they don’t get someone who understands some of those cultural influences or factors that could lead to disengagement of a sense that it’s not – I’m not really being understood here....” [Allied health worker]
A few specific examples were noted of particular changes services had made to integrate culturally responsive service provision. They are as follows:

“I think you know everyone says it’s easy...to use the telephone interpreter but...we find ourselves it’s much, much easier to have someone face-to-face, that can interpret for us; we get much better, we get a much better outcome with patients if we’ve got face-to-face interpreters”. [AOD Worker]

“We, as a group, really had to re-examine how we provided clinical services because there’s different expectations from that cultural group compared to how we would normally provide treatment services ...when we provide opiate treatment that when patients come in, every now and again we have [to] ask them... “Here’s a cup. You need to go and provide a urine.” Nursing traditionally is a female-based population. We had a lot of teething problems initially because of the, the men from the Arabic-speaking populations. “I’m not weeing in a cup for you.” And it was, it took us - we had some teething problems but we eventually worked it out”. [AOD worker]

“We did a project, with DAMEC, for the Pacific Islanders...in Mount Druitt. And, so we were very conscious of the language that we were using...we actually did produce a, um, a drug and alcohol information session...So it was really important to make it culturally appropriate”. [Family worker]

However, many participants felt much more was needed to enhance service capacity to be culturally responsive. In particular both participants and non-AOD professionals spoke about the importance of the relational and collectivist orientation of CALD communities and integrating this into direct forms of practice.

“I give you an example...when I talking about ah bringing our young people or parenting, is now, we start differentiating between collectivist mentality and individualistic mentality. For...individualistic mentality, one of the most important thing[s] is autonomy...Completely opposite ours... Like disconnecting is not normal for us. But you, being independent is what is normal...Twenty-one-year-old um, uh, mainstream guy here, twenty-one-year-old Sudanese, is not the same. The other guy, mainstream guy more responsible, he been taught that from the beginning. And that, and that, all the mainstream time when these guys wants to get his autonomy, his self-competence, this that, they were all opposite, he didn’t get a kind of the milestones... “[Allied Health Worker]

“...that conversation [about extended familial and cultural heritage] is and, and that sense of-of-of self can only happen within that conversational thing, like your own individual family and extended family, I think that needs to be a part of that treatment as well” [Group 1 Adult - Male Speaker]
[Conversation in Group 1 Male]:

Male Voice: ...when you talk about family unit, sometimes in...in our definition or in the community services definition a family’s mum, brother, sister, you know. But in our culture like, you know, we’re raised by aunts and uncles and things, like, you know, there’s no such thing as half-brother, half-sister. Like I didn’t know that word existed...in our culture there’s no such thing...So, I think [the] family unit the definition needs to change as well, from an organisation’s perspective. I know in the Aboriginal culture they have it, you know, but I don’t understand why it doesn’t filter through to other cultures...

Male Voice 2: Cause here it’s more individualistic culture.

Some went as far to critique the systemic focus on pathologisation and the centrism of individualism in service provision and the prospective dangers of this focus on CALD people’s health and well-being.

“So, from a systems level...we pathologise the individual and we just focus on the individual alone as part of our understanding of wellbeing. We don’t really think about the collective and how that then flows onto the bigger picture. For example, when we do treatment plans. Yes, it’s focus on the individual; and yes, we talk about the family and how they may contribute. But we really again put the responsibility back on the individual and not really think about the collective context in which that individual operates...In a collectivist context, it’s very much more communally oriented...what support do we-we provide communally, without a siloing or pathologizing, this particular context of the person. So, the individual is seen, not just for their alcohol and other drug consumption and harm minimisation response to [such] consumption. They’re seen as part of how do they connect to other parts of their wellbeing and how is their wellbeing offset by the communal context in which they operate and exist”. [Academic]

Other participants also highlighted the importance being flexible in appointment setting; in terms of being sensitive to other obligations in CALD client’s lives, as well as in understanding that individualist practices around attending meetings at a set time are not practiced universally across all cultures.

“Then you just want to deal with me normally as you deal with someone who is in your situation. I don’t fit that...Let’s say, for example, how many, how many relative you, you, you, you need to see on the weekend, normally?...But some of these people, Sunday is like a day to see, the whole weekend is like to see everybody. Then you gonna have a program on that time, you wanna call a person to come in, you competing against many thing. On the Monday they have to go to English class, to come. And you work a particular time, and they don’t, they have a shift work...half of that going back to family back home. You get different priorities...” [Allied Health Worker]
“I mean back in [home country] we don’t make appointment we just go knock on the door and say, “how are you, no appointment, sorry, mate what are you up to...?” [They say] “Oh, you’re in wrong time”. I don’t care if it’s wrong time or not”. [Group 1 – Male Speaker]

Integration of Service Delivery

The importance of service integration was highlighted by multiple speakers due to a multiplicity of intersecting issues affecting AOD use among CALD and the need to keep clients engaged with supports.

“You know because we find sometimes that some of these groupings of, some of these cultural groups are really, really hard to engage. When we do get them engaged and we get them coming regularly, and then for us to turn around and say, “Well, no, now you have to go and see someone else now for counselling”. [AOD Worker]

Several participants also noted that integrated models of care aligned particularly well to how health issues were conceptualised in collectivist communities.

“...this idea of not siloing health issues. Ensuring that we're, you know, understanding the mental health, the AOD, and-and other NCDs or even other chronic illnesses...I think one of the key things in this context is to ensure that we are having robust conversations around holistic wellbeing. I mean that's a common concept; but, because again we're collectivist in nature, I think it's important not to silo one over the other. So that we're actually understanding the bigger picture of the, other things that tie into those areas of need”. [Academic]

“Back home we have a model called, [te whare tapa whā]. Have you ever heard of that? Yeah, and so, that there were other [chambers], the spiritual side of that person, the, physical side of that person, the wellbeing of that person and the mental state of that person...and that's what we do back home, so...that’s what [Name] and I have been trying to do here... when we deal with the kids, initially we were dealing with just the child, but then we had to evolve from that... because it's the-it’s the family systems that works. And if we can heal that, and its, completeness, then we’re healing the child...” [Group 1 Adult – Female Speaker]

Several participants also mentioned systems constraints where services were not able to meet existing demand. This was not discussed as an issue specific to CALD communities; but rather spoke to a broader issue of supplying adequate coverage.

“...we have only few services in Western Sydney. If, young person is living in, Blacktown - and as I mentioned they do have rival among them self. They don’t want to come to Mt Druitt to come to [Service Name]. And if they live in Mt Druitt and you refer them to Blacktown, to go and see someone for that drug - the same issue he will not turn up. Sometime if I ask young person “Okay, I have an office - we have office in Mt Druitt, do you want to come with me to Mt
Druitt?" He say "No, I got some people. That when they see me, and they will smash me. So, do you want to take me there? I don’t want to go there." [Youth Justice Worker]

"...is just like the general public because, there is...not enough...services there to assist people, to help people, you know. I know a lot of guys that have been trying to go into rehab for some time..." [Health Worker]

**Workforce Development in AOD and health related services**

**Diversity**

Having choice available, in terms of access to bicultural or non-bicultural workers, was seen as important, as CALD community members were seen to differ in how comfortable they felt with a worker from their own or similar background. Concerns about confidentiality and fear of judgement by workers from one’s own community was reported as a particular concern among some professionals interviewed.

“I know that some people will think that, if you are an African and the African person might relate to you easily...it doesn’t really... it’s not really feasible as such, because some of them will look at you and will think that you know them or you will judge them or prefer to seek for that help where they are not [known]”. [Health Worker]

“...if shame and guilt and those kinds of things do exist for certain clients, maybe seeing...an AOD worker from their own background may not work favourably for them. If they’re concerned about being judged in that space...” [Psychologist]

“...it’s funny that I find...they will trust me, a complete, complete stranger, and white...rather than they get very panicked if I say, “well, you know let’s get an interpreter”...[they’ll say] “No, no, no, no. What if they know him, who knows her, who knows somebody?” and they’re very, very afraid of the confidentiality aspect. So, I find that sort of, interesting in a way...they’re terrified of being exposed in their culture”. [AOD worker]

Nevertheless, the cultural knowledge and language skills brought by bicultural workers was seen as a useful and valued component of the workforce.

“...but at the same time, there’s a lot of benefit to [seeing a worker from the same community] because...that’s a huge understanding of the cultural, influences that might be at play in this behaviour”. [Psychologist]
“This might sound really biased but it’s something I always say; you have to have your own people to serve your own people [echoed by two other participants]”. [Group 1 Adult - Female Speaker]

“...[and] through my conversation with them, I was able to get them, I think about two of them, came to our service to have Hep B shots, and so being [from the same cultural background] that really helped me...” [Health Worker]

As such, several participants felt that an expanded bicultural workforce would enhance the sector’s capacity to meet communities’ needs. However, participants also acknowledged that it wasn’t a matter of simply adding any worker from a CALD community; bicultural workers needed to have complex combination of cultural knowledge, strong engagement/interpersonal skills and be adequately supported for such an approach to be truly effective:

“I agree with argument someone will put, for that it doesn’t necessarily mean because you’re from this a, community ‘A’ and will make you a good worker. No, I agree, doesn’t mean that. But what we mean, what’s in our community, that could be good for people who a) they have the know-how, in terms of understanding, skilled, and knowledge-base, understanding what is talking about and two, they have the access, in terms of their ability to access their community from within”. [Allied Health Worker]

“The Pacific Island community, a lot of them are pretty, pretty laid back and, they don’t really like to- I guess it’s most people, some of them don’t want to be preached to or...about, you know, their drug problem. So...Having a Pacific Islander worker, there, definitely helps especially with that community but, you know, the right Pacific Islander worker I think, is needed as-as well”. [Justice Worker]

“Like, I’ve got, like, a lot of people know that I’ve got a lot of contacts, you know, within the community, within the Department, with...I can pull them all in, but I need, the support behind me from other community groups...Like, I’ve got [Name], you know, I’ve got [Name] and that, but we can’t do it by ourselves...we can’t keep going around to these places...we’re only a three man [person]- you know, team, and the Pacific Islander community is huge...we don’t have a voice loud enough to scream out to them”. [Group 1 Adult – Female Speaker]

One community leader also drew attention to the need to be aware of diversity within communities that are often labelled as a single unit, as this also affects preferences in utilising bilingual workers.

“I think it’s really, really good for, organisations to, be aware of...that there are people who will only go to people of their own community that speak that language, or some familiar face...[the] Pacific community is also a diverse community in itself, you know, and, Tongans...don’t necessarily go to a Samoan-background worker or vice-versa, you know”. [Pacific Islander community leader]
Quality

The ability of individual professionals to meet the needs of CALD clients appeared variable. In particular, key experts within and outside the sector raised concerns about some professional’s capacity to communicate and build rapport in cross-cultural situations. This may reflect the importance given to these skills as outlined in the previous section regarding service safety and quality.

“...I’ve had some run ins with referring young people to counselling. The counsellor they didn’t feel comfortable with. I’ve even come into a counselling session with somebody; 24 years old. He just asked oh could you sit in with me because I am not relating to my counsellor and I would like you to see this. The problem I see is that the counsellors these days; a lot of them they don’t have the skills in them to create rapport with their clients and I guess I see there’s judgement there with counselling and they shouldn’t ever judge the clients and it’s not helping them at all. They should know this! But I see where I am referring the people to; where they are coming from and it doesn’t last a long time because they just don’t feel that trust with the counsellor. I guess the problem is that the counsellors themselves; they need to be re-trained or something different because it’s not working with the young people that I am referring them to”. [Youth worker]

“I see, all these three men who come and, they were not open, like you know, they, they very closed, they very quick. They come, get their medication and go...And, because of the communication barrier, we had a couple of instances with these people...maybe they were struggling with some other, you know, issues, [but] because of the communication barrier they’re not able to open up...it gets out as a frustration, aggression, and, you know, agitation. Which goes to a level where...you gotta to manage otherwise”. [AOD Worker]

The level of access to appropriately qualified interpreters was also raised as an issue by several professionals:

“But like, for us the problem is...we’re happy to do...the interpreter service...as long as, you know, we get a heads-up, you know. Sometimes, you know like, there’s, there’s a problem...communicating, saying..."You need to be here on Monday” and, and they say, “Oh, I can’t do Monday.”... [AOD worker]

Some professionals felt that the shortcomings presented by working with interpreters could be met by a larger bicultural workforce.

“The, the problem with interpreters, sometimes, particularly with the, something to do with the medical jargons, and they even themselves struggle, and they don’t communicate the exact words, like what is being asked by doctor, or err, allied health. It won’t be 100%...So, and the
patient will end up with wrong information, because the interpreter did not convey the messages in there....please try to employ few from their background, and empower them to have access into their own communities, talk to them about drug and alcohol, other issues, it, it would work, it would work. And uh...instead of, err, going through interpreting and all this, and it would, just is not working. I think that's the major thing that if implemented I think it would help a lot, it would help a lot”. [GP]

“That way, I think language speaking clinicians are better than, just the interpreters who actually interpret for the clinicians. You understand what I mean?” [AOD worker]

Culturally responsive workforce development

Cultural responsivity training needs appeared to be varyingly met among AOD professionals. Some reported that they were regularly able to access cultural awareness training, others identified needs for further skills development to better support CALD clients.

“So, throughout the year we do go through um, some CALD training, so CALD competency training. Um, so we do go to in services, two-day workshops, just to get a better understanding on how to work better with our clients”. [AOD worker]

“We need education really as, as health providers as to...the actual culture...and how we can work better with that, with those groups to make it more appropriate for them to come and access healthcare...That’s our, that’s our bigger, biggest thing...when we get a new grouping of people come through we need...education...on that cultural group as to how we can make...the setting more culturally appropriate for these people”. [AOD worker]

“But I think we need a family inclusivity called training, you know around skilling up workers, building their confidence, understanding confidentiality. You know, working with the barriers of shame and stigma and all of that. And how do you actually be inclusive in your practice”. [Family worker]

Some key experts interviewed also suggested that non-AOD workers who come into contact with CALD communities would benefit from upskilling to be better be able to identify possible AOD use issues and link clients in with appropriate support.

“I think for us, what can we do is, be aware that what you guys do...I should educate myself with this. So, one is that for us to, be educated, you know, with that... Even though the clients we do see, hardly, you know, open up that-those conversations. It’s for us that, how do we engage... Someone can come in for electricity, but how do we, with that one...you know, small window of opportunity we have, can we optimise that?...so, I think it could be the small conversations that
we have could change someone’s life. And for us to have that skill, if we can have that training and how to use that”. [Community Worker]

“I think Centrelink have, those professionals…Community Liaison people there. I think, they are very good positions to be linking with…community people of their own background, yeah…So, I think…it’s really important that those Community Liaison Officers…placed in various organisations, whether it’s government or NGOs, they must be really, you know, well-trained…with additional information about what else is existing out there”. [Pacific Island community leader]

Client, family and community participation
Encouraging client, family and community participation was felt to be underpinned by two elements: strong bonds of trust and being able to demonstrate real advantages from involvement.

Trust
The issue of whether and how clients trusted services was a constant theme throughout the research. Several professionals reported that there were strong connections between clients that meant that when one person could vouch for a service, this person would then act as a conduit to refer on other members of the community to that treatment.

“I’ve already recommend one of my mates from gaol, he’s coming out he’s going to be on parole, so I said, man, this program is great”. [Group 1 Male Speaker]

“I think, the particular communities we’re talking about, it seems to me a bit more word of mouth. So, if…and I think this is all based on, probably trust. Because a lot of the time, you know, trust, trust is a really difficult thing. So, if, if we have one person and he’s had a, had a good experience or she has had a good experience, are much more likely to then say “hey”, you know, because…what you often find in, in groups, is they’re using the same sort of street drug, right?” [AOD Worker]

“Because I’m previously from a Detox Ward and you know like one of the you know like a Middle Eastern population comes in, and then um…and then [after completing the assessment], they say, “You know like I, I even have a friend who’s struggling with the drugs and alcohol as well” and he says you know, like, you know like “he’s even more struggling than me.” And I usually just advise them... [if willing] be a bridge between the service and your friend we’re happy to help you with that and we usually give leaflets or....flyers just to...get the message across”. [AOD Worker]

“So, often what will happen is we will help, someone will come and access services here and then they’ll, they’ll have a friend that they were, they’ve been using substances with and that
friend will come along; we’ve had that happen quite a bit, or they’ve had a family member, that they’ve brought their family member along as well”. [AOD Manager]

As highlighted earlier having a personal connection to a particular service worker fostered trust, and the importance of bicultural workers was particularly highlighted by some.

“I think trust’s a big thing or rapport. Because we’re relationship driven from a cultural point of view. You know, we’re not going to come to a service cold...because we don’t know. We might know the service is there. ‘Yeah, I’ve heard about that, I’ve heard about this. But I don’t know anyone there...who am I gonna go to?’ [Academic]

...as soon as people know what you’re about they’ll come to you...it’s putting a face to the service and my faith is in the person, not in your service... [Group 1 Male Speaker]

“Now if someone is part and parcel of them, it did, it doesn’t necessarily mean that we use Sudanese, you work with Sudanese, now you being a Sudanese does not make you a co-worker...But if you not part of it, you don’t have many characteristics in common with the community, people get disconnected”. [Allied Health Worker]

Developing trust between individuals, families and communities was seen to require similar skills and processes in rapport building and cultural responsivity, as well as attention to privacy and confidentiality concerns.

“...for community leaders, it’s all about building relationships as well and having an understanding that, you know, a service or a person or a party isn’t simply coming in, doing something and then going away. You know, where, being very clear about where is this leading to, what does it mean for the community? Uh, where is their place in all of this? Is there an ongoing relationship?...there needs to be a lot of groundwork or foundation work ... and ensuring that their ideas are heard. That they’re not sort of dismissed but rather explored or kind of, you know, trying, uh - uh, making some effort to understand it and where it’s coming from, how it fits in for that community”. [Psychologist]

“Definitely no one would go to the doctor, initially, at the beginning, maybe last steps. [Is asked to explain]... So, because if the person is a young person, they wouldn’t know the consequences of going to the doctor, they might think that maybe the doctor will call the police, or something worse can happen. So, they would [stick] to someone they trust, like a friend, or maybe a family member, and probably they will trust friends more than family members”. [Group 2 Adult – Male Speaker]
Some professionals also mentioned the importance of offering other options where there were difficulties in creating bonds of trust and rapport with participants.

“...what I've found especially with male adults; Pacific Islander male adults is that the face to face thing; they are not really ready for the face to face thing. They grasp the texting stuff; it really opens them up. They get a bit face to face; they are really shy and withdrawn. They can’t look at you in the eye because it’s to do with matters of the heart but when it comes to texting and messaging, they pour their hearts out; their soul. I find that Pacific Islander males that works for them because it’s easier for them”. [Youth worker]

**Demonstrating tangible benefits**

Being able to identify and provide a tangible benefit to service participation was also seen to foster client and community participation.

“I don’t care how many degrees you have, I couldn’t care less, couldn’t care less if you were at Uni for ten years and you have a doctorate, don’t care. How can you help me now? Give me something that I can do now, who can I go with now? If you can’t do that, what we talking about?” [Group 1 Male]

“[Program] are practical steps, but they don’t focus on past. They only focus on seven days, last seven days, what did you do? What went wrong? Okay, what are the practical steps? So, we team, we come sit together...and they will start, okay mate, what do you think...what do you think, what kind of advice are you going to give to a person, maybe one? And then they write, oh, maybe this, this, this. Mm, that’s good. What do you, what do you guys think, yeah, do you think it’s going to help you? And the person will say, “yeah, I think so,” ...Well, try it for the next seven days, next, when you come next week for the meeting, we want to hear any success or any failure or what went wrong, and we try”. [Group 1 Male]

“And sometimes we do offer them incentives to attend, to appointment or information session...I run a soccer group here, with boys...nearly 30 or more boys comes every Thursday. And sometime when we say okay we’re going to organise these events; and, if you come...this is what you’re gonna get in return. So, we’re not, bribing them, but we are trying to tell them you come, we want you to know this but also when you come you have this to take back as an incentive”. [Youth Justice Worker]

“There’s a concept we use it, they call it generativity. Where, uh, it’s a concept that talks about everyone wants to do something that outlive them. And many of the leaders they will make you identify the generative output, something that gonna benefit them...they saw that, then we join the partnership”. [Allied Health Worker]
Taking lived experience seriously

Several participants mentioned using lived experience as a tool to either aid an individual’s treatment, such as the therapeutic benefit of sharing one’s story; or as a way of sharing life lessons to assist people experiencing similar issues.

“...how someone can recover, um, is getting them out there in the community...taking them in groups like excursion or something [like to share their story at a school]... it makes them feel like they've been valued, you know, and all of a sudden they’ll...think, wow...I better leave what I have just shared to those little young ones there in the school...And then they go there and then they share their story and...pass onto the next generation coming up. You see, it makes them feel, and then it makes them to think... and then the more they talk about it, they’re bringing it out...And then they, they will say, what am I going to pass on to my next generation? And they’ll give positiveness...whatever they sow they’re going to reap it. You plant apple seed you reap apple. The good positiveness that they give to the community out there”. [Group 1 - Adult - Male Speaker]

“...so if you can help maybe some people that have been out of that, maybe bring them into the community and let them explain how they were into that thing and then now they are changed and they are now working happily...So it will give that person a [confidence] that, yeah, that one might help, and that, feeling of scared, maybe it will help them to change and maybe seek help”. [Group 3 Adult – Female Speaker]

“...I don’t know if they have programmes like this but I feel like they should have programmes where they have people that have things like, in those situations in the past that can come together and like do talks or whatever or just have a centre where, if somebody was to be going through the same situation they could, you know – like, we always feel comfortable talking to people that...you can relate”. [Group 3 Youth – Female Speaker]

For other participants, learning from the experiences of those with lived experience was seen as a way to enhance access to CALD populations and improve their experiences and outcomes from seeking support.

“I’m saying that from practical experience as social worker and I work for [an] organization where, over the years, it has changed. We came, we were, we were client, and we became workers, and we know...we lived the both, and we know how to access our people”. [Allied Health Worker]

“Train, pass it on to the uh, um, clients or the um, service users you know...Like if these communities you...do up a program or a sort of call it a...seminar or a training...[and] they are
able to send one or two persons, they will come and get the information from you...when they go they will now pass it onto the community”. [Health Worker]

“I think having a support, a support person with you at that first appointment, I think is really helpful...could be a language barrier, could be a confidence barrier, could be trauma-related, there’s a lot of things that go on for these people”. [AOD Worker]

“...it could be their immediate peers. Just having them involved and onboard...it’s those people who they turn to for advice and for feedback on anything. So, if we're educating their peers as part of the process of recovery, amazing, because...the individual’s always consistently and constantly positioning themselves in that communal context which includes their peers”. [Academic]

Community member knowledge of existing services and programs that utilized peer led skills and experience, such as user-led services were rarely mentioned, apart from a few references to groups such as Alcoholics Anonymous or SMART Recovery. One participant suggested again that this may be due to a lack of personal connection to those affiliated with such organisations.

[Discussion in Group 3 Youth]
Female Voice: Someone who’s been through or going through the same thing you're doing.
Female Voice: They do actually, they do have stuff like that.
Female Voice: Oh I’ve never heard of it.
Female Voice: It’s like those groups, those groups what do they call it?
Female Voice: AA meetings.
Female Voice: Yeah, like those meetings, at these meetings where all these others come, they sit in a circle and then they all talk about their issues.
Female Voice: No, I mean like, ones that have already like, they’ve gone through it, now they're like, okay.
Female Voice: Yeah, usually those teachers are people who have some form of experience with it.

“A lot of these different organisations, people aren’t gonna go if they don’t know anyone...location, access, but it’s more of like people forget that it’s person-centred. So, you know, right now I can see a phone number. But if I can see a face, it’s different. If I know a name, it’s different...in this life of technology and phone numbers and everything, like that’s awesome...but it’s worthless if...I don’t know who I’m talking to, I don’t know anything really about them”. [Group 1 Adult - Male Speaker]
Family involvement

Participants spoke about family involvement in services in three ways. The first was that participants spoke of the difficulties and distresses families were currently experiencing, indicating an unmet need for support.

“...a lot of CALD families are, can't handle the fact even, that it's a shock, you know. They've never even taken drugs or experienced this themselves, especially mums. Um, they don't know anything about drugs”. [Family worker]

“Yeah, and it hurts and sometimes I'll relapse, and I try and explain that to them...[but] it’s hard getting through that generation...But we need our families to come on board so that they can understand what the, what the problem is, why we do what we do. All they do is they scream, they shout, they worry, they stress, without understanding what, what is the major problem behind our actions”. [Group 2 Adult - Male Speaker]

“...[she say when she first arrived in Sydney, her] son immediately saw these people, who are become their friend, and then from there, he start drinking, and then from there he was being gaol three times, and [she] was in the lawyer’s office for the whole day, the other day. And [she] was just telling the lawyer “Thank you because you’ve been running after him, but I know you are tired now. Leave him alone because [she’s] tired and the lawyer’s tired”. And then [she] give up, [she] told the lawyer “I know you did your best, because he’s been [in] gaol three times, he should be learning, and should be aware not to involve in any crime any more. But he’s still doing it.”. [Group 3 Adult – Female Speaker]

The second way in which family involvement was discussed was that this was viewed as an approach that aligned well with communities with strong collectivist orientations, i.e. where problems were owned as a family or group rather than as an individual concern; as well as where the group or collective had strong influence on health behaviours, and so gaining the trust and cooperation of families positively influenced engagement of the client in the service. This was particularly raised as a factor for Pacific Island communities.

“In a collectivist context, it's very much more communally oriented. So, it's this idea of: we as a community have a concern with one of us, and we as a community need to be behind and rally support to ensure that this individual is able to then come back into the fold...” [Academic]

“I guess the big thing; I’m talking about my community the Islanders is to get the family on board because Pacific Islanders are very family based. And to get parents even older siblings on board that would support the young person who is having AOD issues. I guess that’s the first step to go because without the family support the kid would never go or to attend any sessions to do with that issue he’s got or she’s got. So, trying to build that rapport with the family and
trying to get them to a service that they can feel comfortable with. That’s the biggest tip, I guess”. [Youth worker]

The third issue was that across all groups many participants reported a disconnection in family relationships and skills as a risk factor for AOD use harms. Participants felt that services and programs to support quality family relationships would in itself be important in reducing AOD use harm.

“I think in the Pacific Islander [because of] broken families, and I feel like…I know at home, that’s where it all begins, like that’s where you learn everything, and, if they actually get the help to keep the family together, I think [that] it will help...down the road”. [Group 1 Adult – Female Speaker]

[Talking about what type of family programs would like to see]: “I think what would be good...teaching them how to support the person with the drug addiction. Uh, we can be very harsh...we don’t realise, sometimes, the way we’re saying it, to that person, can automatically switch them back to - Because they’re vulnerable, you know, and I think maybe support services, of how to teach us to, deal with...our family member that has that drug addiction, how to have the patience with him, how to...not talk to him the same way we’re talking to the other brother, because that [person] is a bit more vulnerable at the moment, maybe something like that, to teach us how to support out family member, in a situation like that”. [Group 1 Adult – Female Speaker]

“...like [question] number 3 here, says, “What would help you, your family, and your community to manage those issues?” Well for an example, why can’t me mum and dad come with me counselling and see the process?”. [Group 2 Adult – Male Speaker]

“Also, like with the family programme, if we learn how to interact with our kids in Australian environment, not back home when we have to use physical violent, our physical thing to stop them, we learn other ways of talking with them, like doing it the way that also can fit in with this, where we live, yeah”. [Group 3 Adult- Female Speaker]

However, participants acknowledged that this would have to be done sensitively, especially when addressing family communication or discipline practices that were strongly linked to traditions:

“For me you can’t really...say to [parents] you can’t hit your kids. In the Islander culture there’s a boundary there. You can’t come into my house and tell me...but if you just say it in an educational way. Like your kids are born and raised in this country where there is all these rules that you abide by where you’ve got to go to church. You’ve got to respect the laws of the land so if they understand and are educated in that way; they could help make our job easier with the kids”. [Group 1 Adult]
Community involvement

Several participants also advocated for taking a community development approach; in terms of partnering with community leaders and organisations to raise the level of education and awareness among CALD communities about AOD-use issues and help seeking options to encourage participation.

“...our, our background there are completely different from here...there’s a different environment, different language, different a lot of things... and if they don’t hear from their leaders, they wonder. So that’s why we need to tell them, we make sessions, do lot of seminars, workshops, we come and sit down and talk...So that, that’s, that’s I think that’s all it, organization of the... community leaders and more interaction, more interaction. And involving the community and the service providers. Yeah because there is access. They’re all ready to help”. [GP]

“But we don’t have the resources. That’s why we looking for people who can partner with the community and then we can apply [for the] resources...we can work hand in hand together...we apply for grants for example...apply together and look into how you can auspice us...and then we help the young people [together]... “ [African community leader]

Many participants felt that linking in with community organisations and community leaders, particularly within African and Pacific Islander communities, would be an important way to go about this. It was raised that these organisations and individuals held close relationships with their communities; and that working more closely with these stakeholders would help with tailoring approaches that would better suit community needs.

“Together we plan a project together. So, what is important? What is it you think or you know, would make you run your group effectively? They identify the topics, identify these areas so could...What do you think we can do for you to get this knowledge? They identify it as well, ok then, how we gonna do it, bringing people on, we want they will do it. It was very, very effective, it was very short and we report at the same time”. [Allied Health Worker]

“So, well, that jumps to my mind because there we’re running a project...which will be about inviting all the elders in the community to...give them a chance to work out what it is they would like to develop in terms of a culturally appropriate tool”. [Family worker]

However, several professionals cautioned that knowledge about and willingness to engage on AOD use and treatment topics were highly dependent on the personal and environmental circumstances of different community leaders and key community groups.

“As to the role of the church in these sort of social and welfare needs, it's still, a mixed bag. So I think some of the more, liberal denominations, are more proactive in seeing their leadership in
assisting in those types of social and welfare needs and being a bit more progressive in those conversations around alcohol and other drugs; and even mental health and wellbeing and other areas of need. Where I think more of the conservative denominations...are less likely, to be as proactive and progressive in their understanding of substance issues. As a result, it’s not talked about”. [Academic]

Our problem in the community leaders, the people who come here in their, in their 20s or- and above, know only about alcohol...When they drink alcohol, they say, “Oh, this person is [using]; this person needs help”...So they don’t know about other type of drugs until we come here, and then our kids being exposed”. [African community leader]

“I’ve been in the community leadership for, like, sometime, and I do know that like not everybody will be in the same kind of, knowledge or understanding of what is happening and what need to be done. And, you know, sometime when they have, you know, when they face the problem, they will just either disregard or ignore or forget about it or [will] say “Look, that’s not my problem. It's parent’s problem.” [Youth Justice Worker]

As such, some participants argued for additional training and support for education and awareness raising among community leaders and elders. One participant noted that this would likely be a long-term approach, that would require particular sensitivity to community attitudes and structures.

“I guess even, with them, giving them [community leaders and elders], some understanding of, you know the, what’s-what’s out there, what is affecting the community, the young people, middle aged people, you know, right now...So, [I] guess it’s about approaching them and saying “hey”, as well, giving them the, the information about, where their people can turn to for, for support and, and assistance. So the more educated they are, of what’s out there and...what can affect the community...will better help the community as a whole. [Justice Worker]

“Being able to maybe present factual evidence or information about things that may have occurred... Sort of trying to remove some of the...emotive side of what might come up. I think people, community leaders might need time to sit with something and being able to give them that as well. Um, letting them know that they can ask questions. They can, you know, um, seek other information about something if they need to. They can talk to other community members or do they want to nominate other community members that might be more interested in this and trusted in the community to – to move forward with an issue. There’s various ways but it really depends on the specific community and how much, um, a party or service wants to kind of get into that space as well. But it needs to be done delicately...I think a lot time needs to be given, a lot of patience needs to be given to the process”. [Psychologist]

One professional raised the powerful role that can be played by credible bicultural staff in shifting community leader’s opinions.
“...we have with the suicide issue that was epidemic this year, [Bicultural worker who had set up a youth suicide prevention program]... he went into the churches and he works with our pastors/ our priests and he highlights the importance of getting our young people to talk about mental health; talking about what’s going on in their life and suicide especially if they have any thoughts/fears talk about it; be open and talk about it. It’s been well received because one of the pastors in this area he [Bicultural worker] went to the church sermon and he conducted a workshop for the young people there. He told them to get in a circle and he asked the question if anyone has had any suicidal thoughts in their life? And he stepped in the circle which made it to break the ice. And the pastor at the church said no none of my young people ever thought about suicide but then one by one [13 out of the 20 young people there] stepped into the circle and that was powerful. And the pastor took a step back and took back his words because before that he was saying people that think of suicide are cowards and they go to hell and things like that. But when he saw that most of his young people are suffering; had thought about suicide he had to change his ways. And that was a powerful thing because he just got to see it from the young people’s point of view. And he never knew that they were suffering that way”. [Youth worker]
Discussion

Scholarship has highlighted that for AOD treatment intervention to be effective, services need to be capable of responding to diverse communities where there are unique risks or resilience factors, or different explanatory models of health and health behaviours (Resnicow et al, 1999; Castro, Barrera & Holleran Steiker, 2010). To date, there is no existing state-wide or national cultural assessment framework within the drug and alcohol sector that considers the specific needs of CALD communities while the small amount of Australian research on culturally responsive AOD clinical practice has tended to focus on single treatment types or streams (Rowe, 2013; VAADA, 2016). Under-representation of CALD communities in AOD treatment is continuing with little improvement in recent years (AIHW, 2018). In response to these gaps and the high diversity of the Western Sydney catchment area, this research has attempted to further understanding of the AOD needs and experiences of three CALD communities from Arabic speaking, Pacific Islander and African backgrounds in the former region. To our knowledge this is the first research study of its kind that has attempted to explore how major CALD communities in Western Sydney manage any alcohol, tobacco and other drug support needs across the AOD treatment spectrum. The study also looked at ways that communities use their own resources, strengths and skills to respond to these needs. Through a grounded approach which is based on the voices of relevant stakeholders including community members themselves, AOD, health, multicultural and social and human services workers alongside other key specialists including community leaders, this study has boosted channels of communication and understanding related to the former issues.

We acknowledge the challenges related to identifying specific AOD practices amongst CALD communities as highlighted in previous scholarship (Rowe et al, 2018), nevertheless this study has enabled a further understanding related to people’s concerns and awareness. This includes understanding more about people’s perceptions and awareness of AOD use and related harms, prevention, harm reduction strategies and culturally responsive preferences related to treatment and services. As found in previous research undertaken by DAMEC (Donato-Hunt et al., 2012) and other studies (Hossain et al., 2014, Phillips et al., 2015), issues of alcohol and tobacco were identified as areas of concern. The study has also highlighted the need to explore further ambivalence related to some culturally and communal forms of AOD use while drawing attention to the need for more health-related information concerning illicit drug use outside of media discourses particularly for more newly arrived communities.

While the study has highlighted the strength of cultural and collectivist ties as a potential source of protection and harm reduction for CALD communities, the research also identified that risky AOD consumption practices can arise from strong collective ties as individuals seek to affirm or project an in-group identity. Furthermore, while issues related to acculturation and intergenerational differences between parents and young people has been identified in previous work (Ethnic Communities Council of Queensland, 2012; Anile, 2018) this study has identified them as a major source of concern and contention amongst participants. These issues are significant and play an important role in informing identity, health and well-being for CALD communities.

Research on culturally responsive methods has described numerous ways in which a range of health services have adapted interventions to be more culturally congruent with the target population, including incorporating cultural health beliefs, cultural values and practices into treatment (Resnicow et al, 2000; Huey et al., 2014). However, comparatively few examples of actual adaptations to AOD health promotion messages, treatment and support provision was articulated by participants in this study. Scope exists to learn from contemporary efforts in this area, for instance the extensive range of Pasifika methodologies in New Zealand such as Talanoa (Ioane, 2017).
Both clients and key experts spoken to in this study noted the complexity of bio-psycho-social issues contributing to AOD-related harms in CALD communities, including social disconnection, readjustment of family and parental norms, and economic exclusion. These issues require more than simply building individual client/patient capacity through education, awareness raising or recovery planning. As noted by many participants and articulated in particular by one key expert, relying on a medical model of AOD treatment, or treating consumption without addressing contributing issues was likely to produce little benefit. While increasing sector capacity to respond holistically to AOD needs in CALD communities has also been noted in sector reviews in other jurisdictions (VAADA, 2016), this study furthers the need for such considerations in service planning within NSW for CALD communities.

This research highlighted preference for abstinence amongst older and parental participants through the use familial and traditional communal forms of support. However, this could prove difficult for people who face addiction while participants’ sense of helplessness in responding to these issues highlights the importance of further education relating to the full spectrum of harm reduction strategies. Prior research has indicated the promise of CALD communities’ displaying positive attitudes towards particular strategies (see Rowe et al, 2018; VAADA, 2016). At the same time the values of interpersonal connection and support from peers and other members of people’s social networks highlights the need for incorporating peer-based programs, family inclusiveness, community development programs with a long-term approach of services and researchers engaging in intercultural dialogue with CALD communities.

Previous DAMEC and other research related to concerns about cultural relevance and responsivity of AOD treatment by CALD communities (Flaherty & Donato-Hunt 2012; Rowe 2014; VAADA, 2016) strongly resonated within this study. However, these concerns were also raised by most key experts in the study as well and there were multiple insights of culturally responsive service provision in the AOD sector needing further improvement through the study’s adaption of the mental health multicultural framework. This was particularly astute in the areas of what constitutes quality service provision and in the area of workforce development including the emphasis of relational and interpersonal, familial, collectivist and communal preference amongst participants.

It is clear from the study’s findings that a deepening of cultural responsiveness is required within the sector that goes well beyond current practice and training. Opportunities for workforce development did not appear to be uniformly available for professionals. This is consistent with research conducted by DAMEC, a 2016 survey of 226 AOD professionals found that only approximately half of respondents had attended any training on working with CALD clients while in their current role (Rowe & Santos, 2016).

While a small amount of Australian research has noted structural constraints in treatment pathways and systems, such as lack of bilingual positions, centralised intake systems and shortcomings in data collection that can make it difficult for the sector to adapt approaches to the needs of CALD communities (Rowe & Santos, 2016; VAADA, 2016), this study has emphasised that there are number of structural and organizational barriers for people from CALD backgrounds. The importance of time and rapport, integrated care, supported referral pathways, the need for regular use of interpreters, a diverse and culturally informed workforce and the need for more understanding and adaptation of mainstream services within Australian society concerning the value and strengths of personal, collectivist and communal networks within CALD communities are just some of the study’s findings related to service adaptation.

As noted above the value of peer and other interpersonal relations highlighted in the study validates the power of peer-based programs in both education and psychosocial support programs for CALD members affected by AOD issues. Further equipping peers with knowledge and resources can have a significant
and positive influence on health behaviours. Even though experiencing shame and stigma is influential, the communities engaged displayed willingness to identify and engage in peer or targeted bi-cultural roles. Given the importance of peer relationships to the three communities in this study, and as the value of using lived experience was raised by a range of participants, such factors should be used to act in this area. As noted in previous scholarship (Hofstede, 2011; Renzaho & Vignjevic, 2011, Beugelsdijk & Welzel, 2018) the issue of utilising communal and familial ties to manage difficulties or conflicts; in this context responding to AOD related harms was also emphasised by participants. Additional time and resources should be allocated to address such barriers and build trusting relationships with potential CALD peer leaders.

Furthermore, the elements discussed that were felt to enhance CALD client, family and community engagement and outcomes in the AOD treatment system, namely: being flexible to outreach into communities, getting to know a client’s individual situation and needs, and walking with a person through all aspects of the system are understandably time and labour intensive. It is important that services are supported to be able to have staff capacity and treatment systems in place to offer this degree of intervention. In turn, mainstream services may need to do more to respond and adapt AOD treatment, information and education programs to accommodate the realities that most CALD communities will face these tensions of acculturation and intergenerational difference in light of dominant discourses and institutionalised norms in Australian society which emphasise individualism. However, issues of access and equity and a multicultural inclusive focus are also relevant to the Australian legal and institutional framework.
Key Recommendations

1. **Expand AOD health literacy educational opportunities for CALD communities and those supporting them including harm reduction strategies.**
   - Health promotion tools and resources should seek to raise awareness raising about different types of substances, signs of overuse or dependency, and treatment options available among CALD communities.
   - Such strategies should also aim to support a shift in the way substance use and dependence are understood: towards an understanding that they are health issues. Tools should promote harm reduction strategies that include options and stages.
   - Messages should be adapted to reflect the particular stress factors relevant to CALD communities e.g. acculturation and collective influences on consumption.
   - Education should not only target community members themselves, but also places where CALD communities would be likely to seek support, including migrant resource centre workers, bicultural GPs, Religious/Spiritual leaders and community elders.

2. **Encourage opportunities for expanding family involvement in support, education and treatment programs.**
   - This would involve expanding family inclusiveness training, funding and related programs within the AOD and related health sectors. While we acknowledge that some services may be unable to integrate such programs within their own organisation, partnering with relevant providers is important.
   - Support for family’s needs to go beyond providing AOD health literacy, as many participants felt that without enhancing intergenerational communication and parenting skills alongside bonds of trust within the family unit, were essential.

3. **Build peer education and leadership capacities with CALD communities**
   - Identify and building upon the capacity of CALD community and AOD sector organisations already working in this space to offer targeted programs that use the skills and knowledge of those with lived experience.
   - Peer roles should not just be considered as information provision but also part of the delivery of quality treatment.
   - Given the importance of family and community-level influences on health beliefs and practices in these communities, the definition of ‘peer’ could be expanded to include a person’s extended networks.
4. **Enhance the capacity of the sector to provide flexible, long term support**

- ‘Warm’\(^{15}\) referrals should be promoted as standard practice.
- Increase opportunities for AOD service outreach into support spaces currently being utilized by CALD communities. This would accompany increased awareness raising of external supports available, bearing in mind that some individuals may wish to seek support anonymously.
- Expand current efforts to break down sector siloes, such as inter-agencies and joint service networking meetings (such as efforts undertaken to bridge disconnections mental health and AOD services) to foster inter-sectorial dialogue and relationship. In particular, opportunity for mutual education and information sharing should be enhanced between AOD and CALD services.
- Funding longer term AOD interventions that allow for the building of relationships with clients, families and communities should be prioritized over time-limited, short-term interventions.

5. **Adequately resource the AOD workforce to address CALD individual, family and community needs in a sensitive and culturally responsive manner.**

- More collaboration with language services, peak bodies and educational institutions and workforce development services.
- Increase diversity within the AOD workforce through a longer-term strategic focus to allow for adequate choice to become available in terms of bicultural and non-bicultural staff.
- Ensure that interpreter services are adequately resourced to respond to client needs.
- Workforce development should move beyond time limited cultural competency training, but engage in ongoing workplace supervision and training while also valuing difference and intercultural learning to build trust and rapport with clients from a cultural background that is different to one’s own.

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\(^{15}\) “Warm” or supported referrals include: Making the referral with the client and/or assisting the client to make a phone call to introduce themselves to the service; Providing a verbal and/or written handover; Setting up joint meetings with the person and the new service for initial appointments; Following up with referral organisation to check and further support client progress.
References


What is the alcohol, tobacco, and other drug prevalence among culturally and linguistically diverse groups in the Australian population? A national study of prevalence, harms, and attitudes

Rachel Rowe, Y. Gavriel Ansara, Alison Jaworski, Peter Higgs & Philip J. Clare

To cite this article: Rachel Rowe, Y. Gavriel Ansara, Alison Jaworski, Peter Higgs & Philip J. Clare (2018): What is the alcohol, tobacco, and other drug prevalence among culturally and linguistically diverse groups in the Australian population? A national study of prevalence, harms, and attitudes, Journal of Ethnicity in Substance Abuse, DOI: 10.1080/15332640.2018.1484310

To link to this article: https://doi.org/10.1080/15332640.2018.1484310

Published online: 31 Jul 2018.

Article views: 159

View Crossmark data
What is the alcohol, tobacco, and other drug prevalence among culturally and linguistically diverse groups in the Australian population? A national study of prevalence, harms, and attitudes

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\textbf{ABSTRACT}

In Australia, one in three people are born overseas, and one in five households speak languages other than English. This study explores substance use prevalence, related harms, and attitudes among these large groups in the population. Analysis was conducted using cross-sectional data ($N = 22,696$) from the 2013 National Drug Strategy Household Survey. General linear model and binary logistic regression were used to assess substance use and harms, using stabilized inverse propensity score weighting to control for potential confounding variables. Between culturally and linguistically diverse populations and the population born in Australia, United Kingdom, or New Zealand who speak only English at home, there is no statistically significant variation in the likelihood of current smoking; using analgesics, tranquilizers, or sleeping pills; or administering drugs via injection. Culturally diverse populations are less likely to drink alcohol or use cannabis or methamphetamines. No difference between these two major groups in the population is observed in substance-related abuse from strangers; but culturally diverse respondents are less likely to report substance-related abuse from known persons. Lower substance use prevalence is not observed among people from culturally diverse backgrounds who have mental health issues. Australian-, UK-, or New Zealand–born respondents who speak only English at home are more likely to oppose drug and tobacco policies, including a range of harm reduction policies. We discuss the practical and ethical limitations of this major Australian data set for examining the burden of drug-related harms experienced by specific migrant populations. Avenues for potential future research are outlined.

\textbf{KEYWORDS}

Drug, alcohol; tobacco; ethnicity; culture; inequality; prevalence; national population survey

\section*{Introduction}

In Australia, one in three people were born overseas, and of these people nearly one in five immigrated to Australia after 2011 (ABS, 2016). More than
20% of households in Australia speak a language other than English (ABS, 2016). To date, little evidence is available on the prevalence of substance use among culturally and linguistically diverse (CALD) populations in Australia. Research seeking to document and challenge existing social inequalities is likely to benefit from population-wide studies that are attentive to differences in the burden of substance-related harms to health, health care access, and attitudes toward drug and alcohol policies. To address this gap, this study examined data from a triennial Australian household survey.

For long-term risk of harm from alcohol drinking, the limited available evidence indicates that overall drinking rates among CALD populations in Australia are lower than among non-CALD populations (NSW Health, 2016). In cross-sectional surveys with specific CALD communities, some groups have reported drinking practices associated with higher risk to health (Donato-Hunt, Munot, & Copeland, 2012). Tobacco use has been found to be higher among some CALD groups than in the general population (Donato-Hunt et al., 2012; Greenhalgh, Bayly, & Winstanley, 2015). Knowledge of population prevalence for use of other substances such as cannabis, methamphetamine, tranquilizers, and analgesics is virtually nonexistent.

Reports on the prevalence of substance use alone are of little value without parallel examinations of harms. The burden of alcohol and other drug-related harms—as represented by the incidence of preventable health issues and in criminal justice statistics—has been shown to disproportionally affect groups from culturally diverse backgrounds (Maher, Jalaludin, Chant, & Kaldor, 2007; Coffey et al., 2004; Youthlaw, 2008). Factors that are known to shape substance use practices and help seeking among CALD communities include migration and resettlement experiences (Posselt, Galletly, de Crespingny, & Procter, 2013), length of time since arrival and age at arrival (Agic et al. 2016; Bayley & Hurcombe, 2011), strength of community networks and other support structures, usefulness of health services (McCann, Mugavin, Renzaho, & Lubman, 2016; Flaherty & Donato-Hunt, 2012; Reid, Beyer, Aitken, & Crofts, 2001), intergenerational change (Renzaho, Dhingra, & Georgeou, 2017; Horyniak, Cogger, Higgs, Dietze, & Bofu, 2016), alienation (Schwartz, Unger, Zamboanga, & Szapocznik, 2010), and structural racism (Smith & Reside, 2010; Coffey et al., 2004). These factors are the backdrop to the present study and contextualize the present underrepresentation of some CALD populations at AOD treatment services (AIHW, 2017; Macfarlane Burnet Centre for Medical Research, 2000).

This study was commissioned by the Drug and Alcohol Multicultural Education Centre, which is currently the only AOD service provider in the state of New South Wales whose work specifically focuses on documenting and reducing the burden of drug-related harms among CALD communities. The Centre is frequently approached with requests for evidence of substance
use prevalence. In this article, we use the term *culturally and linguistically diverse*, or CALD, advisedly to correspond with current Australian health policy. **CALD** refers to the portion of the Australian population whose recent ancestry is from countries that were not settler-colonial states under the British Empire and where the primary languages spoken are not English. While we argue that this term has little practical or explanatory value (and we return to this in our discussion of limitations), the differences and similarities highlighted in the study findings can inform where national strategies target resources and clarify paths for further investigation.

**Method**

**Participants**

We compiled self-reported data from the 22,696 non-Indigenous participants aged over 18 years from across Australia who took part in the National Drug Strategy Household Survey (NDSHS or National Drug Survey) 2013. The survey methods have been described in detail elsewhere (Roy Morgan Research, 2014). The current study represents a secondary analysis of this national, population-based sample.

**Outcome variables**

**Alcohol use**

The Alcohol Use Disorders Identification Test for Consumption (AUDIT-C) is an abridged, three-item version of the 10-item AUDIT tool developed in 1989 by the World Health Organization. Participants were categorized as having a low, medium, or high risk of alcohol-related harm based on the reported frequency and amount of alcohol use. Respondents who reported not having had an alcoholic drink in the past 12 months were excluded from the analysis. We used the AUDIT-C in two forms, as an ordinal variable with a score and as a categorical variable of risk.

**Alcohol Harm Reduction Scale**

The Alcohol Harm Reduction Scale contains seven items for safer drinking practices on a recoded 5-point Likert scale (1 = never to 5 = always). The seven Likert scale items were counting the number of drinks; alternating between alcoholic and nonalcoholic beverages; eating while consuming alcohol; quenching thirst with a nonalcoholic beverage before consuming alcohol; only drinking low-alcohol beverages; limiting the number of drinks per evening (e.g., when driving); and refusing an alcoholic beverage offered when it is really not wanted. Scores for these seven items were summed and then divided by seven to produce an aggregate mean. Scale reliability
AOD-related abuse from others
Reported experiences of abuse from people perceived to be influenced by alcohol or other drugs were identified using a three-composite variable based on participant responses to six binary items. Three items asked whether the respondent had experienced “verbal abuse,” “physical abuse,” or “being put in fear” by a person “under the influence of or affected by alcohol,” respectively, and three items asked whether the respondent had experienced substance-related “verbal abuse,” “physical abuse,” or “being put in fear” by a person under the influence of or affected by “illicit drugs,” respectively. Given the limited reliability of observer distinctions between forms of substance influence, we combined these six questions into three binary (0 = no; 1 = yes) variables for experiences of substance-related verbal abuse, experiences of substance-related physical abuse, and experiences of being put in fear. We also created a binary variable for any reported harm across the six items.

Reported mental health issues
Mental health issues were coded into binary variables (0 = no; 1 = yes) based on responses to National Drug Survey items about whether the respondent had been diagnosed and/or treated for a particular mental illness or condition in the past 12 months.

Service access
Service access was determined based on five binary (0 = no; 1 = yes) items, each of which asked about use of one of the following AOD-related services: the respondent’s use of a telephone helpline, online support or information and education, opioid pharmacotherapy, peer group or therapeutic community, withdrawal management or residential rehabilitation, and counseling.

Policy attitudes
Policy attitudes were determined based on a series of items that asked about the respondent’s support for a particular policy intended to reduce substance use. Separate items were used to assess support for policies related to excessive alcohol use, tobacco use, and injecting drug use, respectively. These items were coded on a 5-point Likert scale, with 1 = strongly support and 5 = strongly oppose.

Predictor variables
CALD background was operationalized as not being born in an Anglo-dominant country and/or speaking a language other than English or
Aboriginal and Torres Strait Islander languages at home. The 2013 NDSHS questionnaire did not collect disaggregated data on languages spoken at home.

Detailed explanations of variables in the NDSHS survey (e.g., age, sex, SEIFA, etc.) and the ages for which particular data items were collected are provided in the NDSHS 2013 Final Technical Report (Roy Morgan Research, 2014). Binary categorical variables of marital status (living with partner/married vs. not) and high school completion (graduated vs. not) were created by assigning levels of the NDSHS variables into the applicable level of the new binary variable (e.g., people who selected any response that indicated their highest completed level of education as being below high school were categorized as not having graduated high school).

Data analysis

Sample characteristics are reported for categorical variables or means and standard deviations for continuous variables. In addition to reporting characteristics of the total sample, we also report separately for the CALD/non-CALD subsamples.

We used a critical p value of .01. All binary dependent variables were analyzed using binary logistic regression, with significant results presented as odds ratios with 99% confidence intervals (CIs). All interval or ratio-dependent variables were analyzed using linear regression, with results presented as coefficients with 99% CIs.

To control for potential confounding, a propensity-based approach was used. The probability of belonging to the CALD group was estimated using logistic regression, controlling for respondents’ reported age, sex, Socio-Economic Indexes for Areas (SEIFA), household income (low vs. not), marital status (living with partner/married vs. not), and high school completion (graduated vs. not). These propensities were then used to calculate inverse probability of exposure weights, which were combined with the NDSHS absolute person weight. This reweights the sample based on the complex sampling methodology used in sample selection (Australian Institute of Health and Welfare 2014). Analyses, including adjusted odds ratios (AOR), also controlled for other aspects of the survey sample (strata and clusters) to calculate standard errors and confidence intervals. All analyses were conducted using SPSS v24 (IBM 2016).

Results

Demographics

A higher percentage of participants from CALD backgrounds than non-CALD participants were male, and CALD participants were slightly younger (Table 1). A much higher percentage of CALD participants than
Table 1. Demographic Characteristics of Australian National Drug Survey Participants in 2013.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total (N = 22,696&lt;sup&gt;a,b&lt;/sup&gt;)</th>
<th>CALD (n = 3,638, 16.03%)</th>
<th>Non-CALD (n = 17,678, 77.89%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age M (SE)</td>
<td>46.6 (0.2)</td>
<td>44.0 (0.4)</td>
<td>47.2 (0.2)</td>
</tr>
<tr>
<td>Female n (%)</td>
<td>11,890 (50.7)</td>
<td>1,909 (48.0)</td>
<td>9,981 (51.4)</td>
</tr>
<tr>
<td>Region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major cities</td>
<td>14,351 (71.8)</td>
<td>3,096 (89.9)</td>
<td>11,255 (67.4)</td>
</tr>
<tr>
<td>Inner regional</td>
<td>3,716 (16.9)</td>
<td>222 (5.1)</td>
<td>3,494 (19.7)</td>
</tr>
<tr>
<td>Outer regional/ remote/ very remote</td>
<td>3,249 (11.3)</td>
<td>320 (4.9)</td>
<td>2,929 (12.9)</td>
</tr>
<tr>
<td>Household Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>2,250 (11.6)</td>
<td>427 (16.1)</td>
<td>1,823 (10.7)</td>
</tr>
<tr>
<td>Middle</td>
<td>5,613 (33.5)</td>
<td>816 (34.8)</td>
<td>4,797 (33.2)</td>
</tr>
<tr>
<td>High</td>
<td>8,087 (54.9)</td>
<td>1,169 (49.1)</td>
<td>6,918 (56.1)</td>
</tr>
<tr>
<td>SEIFA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (lowest)</td>
<td>3,553 (16.9)</td>
<td>601 (19.5)</td>
<td>2,952 (16.3)</td>
</tr>
<tr>
<td>2</td>
<td>4,204 (19.6)</td>
<td>720 (20.2)</td>
<td>3,484 (19.4)</td>
</tr>
<tr>
<td>3</td>
<td>4,094 (19.6)</td>
<td>727 (20.3)</td>
<td>3,367 (19.4)</td>
</tr>
<tr>
<td>4</td>
<td>4,736 (22.4)</td>
<td>786 (20.5)</td>
<td>3,950 (22.8)</td>
</tr>
<tr>
<td>5 (highest)</td>
<td>4,729 (21.5)</td>
<td>804 (19.5)</td>
<td>3,925 (22.0)</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently employed</td>
<td>11,786 (59.4)</td>
<td>1,947 (56.9)</td>
<td>9,839 (60.0)</td>
</tr>
<tr>
<td>Retired/pensioner</td>
<td>5,345 (19.9)</td>
<td>732 (16.2)</td>
<td>4,613 (20.8)</td>
</tr>
<tr>
<td>Student</td>
<td>740 (5.6)</td>
<td>225 (9.6)</td>
<td>515 (4.7)</td>
</tr>
<tr>
<td>Home duties only</td>
<td>1,317 (6.4)</td>
<td>185 (5.4)</td>
<td>1,132 (6.6)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>870 (4.7)</td>
<td>274 (8.1)</td>
<td>596 (3.9)</td>
</tr>
<tr>
<td>Other</td>
<td>669 (3.0)</td>
<td>116 (3.2)</td>
<td>553 (3.0)</td>
</tr>
<tr>
<td>Volunteer/charity work</td>
<td>265 (1.0)</td>
<td>34 (0.7)</td>
<td>231 (1.0)</td>
</tr>
<tr>
<td>Highest level of education (for age 25 or older)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>4,620 (22.4)</td>
<td>534 (15.5)</td>
<td>4,086 (24.0)</td>
</tr>
<tr>
<td>High school graduate</td>
<td>2,141 (11.7)</td>
<td>412 (13.6)</td>
<td>1,729 (11.2)</td>
</tr>
<tr>
<td>Certificate or diploma</td>
<td>7,096 (36.8)</td>
<td>970 (29.4)</td>
<td>6,126 (38.6)</td>
</tr>
<tr>
<td>Undergraduate degree</td>
<td>3,234 (17.2)</td>
<td>771 (24.0)</td>
<td>2,463 (15.6)</td>
</tr>
<tr>
<td>Postgraduate degree</td>
<td>2,374 (11.9)</td>
<td>596 (17.5)</td>
<td>1,778 (10.5)</td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/de facto/cohabiting</td>
<td>13,499 (67.4)</td>
<td>2,462 (69.4)</td>
<td>11,037 (66.9)</td>
</tr>
<tr>
<td>Never married</td>
<td>3,745 (20.6)</td>
<td>611 (20.5)</td>
<td>3,134 (20.6)</td>
</tr>
<tr>
<td>Divorced</td>
<td>1,801 (5.4)</td>
<td>230 (4.3)</td>
<td>1,571 (5.6)</td>
</tr>
<tr>
<td>Widowed</td>
<td>1,383 (4.4)</td>
<td>189 (3.8)</td>
<td>1,194 (4.6)</td>
</tr>
<tr>
<td>Separated</td>
<td>688 (2.3)</td>
<td>111 (2.0)</td>
<td>577 (2.3)</td>
</tr>
<tr>
<td>Sexual Identity Label</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>19,927 (97.5)</td>
<td>3,142 (98.2)</td>
<td>16,785 (97.4)</td>
</tr>
<tr>
<td>Gay/bisexual/lesbian</td>
<td>527 (2.5)</td>
<td>69 (1.8)</td>
<td>458 (2.6)</td>
</tr>
</tbody>
</table>

<sup>a</sup>Numbers are unweighted, while percentages are weighted.  
<sup>b</sup>N includes respondents with missing data, so columns sum to less than this amount.

non-CALD participants lived in major cities. Fewer CALD participants reported having high household income, and the reported unemployment rate among CALD participants was approximately twice as high as among non-CALD participants, despite higher reported completion of undergraduate and postgraduate university degrees.

Among the CALD participants in the 2013 NDSHS for whom birth region data were available, 53.8% reported speaking a language other than English at home, and 34.3% had migrated to Australia less than 10 years prior to the survey. Among adult CALD participants for whom region of birth data were available, 18.4% were born in Southeast Asia, 14.7% in southern and eastern Europe, 16.8% in southern and central Asia, 12.9% in
Northeast Asia, 8.9% in northern and western Europe (excluding the United Kingdom and Ireland), 6.6% in sub-Saharan Africa, 6.2% in North Africa and the Middle East, 3.2% in Oceania (excluding New Zealand), 5.0% in Australia, 2.9% in the Americas (excluding North America). The category “other” was selected by 4.1% of respondents. Among those respondents born in a predominantly English-speaking country and classified as CALD due to speaking a language other than English at home, almost all were born in Australia; fewer than 1% each were born in the United Kingdom and Ireland, New Zealand, and North America, respectively (Table 2).

**Prevalence**

**Illegal substances**  
CALD participants were less likely than non-CALD participants to report any substance use either in their lifetimes; or during the last 12 months prior to survey. However, variations in prevalence for certain substances were not statistically significant. These include past 12 months use of heroin or extramedical use of prescription pharmaceuticals. Past 12 months drug administration by injection was no less likely to be reported by CALD participants than by non-CALD participants (Table 3).

**Alcohol**  
Among all adult respondents, 89.0% had ever drunk alcohol, and 9.3% reported being ex-drinkers (i.e., current abstainers). CALD respondents were more likely than non-CALD respondents to report being ex-drinkers (AOR 1.82, 99% CI [1.41, 2.33]) and were less likely to report lifetime alcohol use (AOR 0.15, 99% CI [0.12, 0.19]).

Among adults who reported alcohol use, 63.2% presented a low risk of alcohol-related harm, 28.4% had moderate risk of alcohol-related harm, and 8.3% presented with high risk of alcohol-related harm. CALD participants had lower odds than non-CALD participants of reporting moderate or high risk of alcohol-related harm (AOR 0.44, 99% CI [0.35, 0.55]). Among adults who reported alcohol use, CALD participants were also more likely to score lower on the AUDIT-C than non-CALD participants (CALD $M = 1.27, SE = 0.02$ vs. non-CALD $M = 1.47, SE = 0.007, F(1,1357) = 79.52, p < .001$).

Also among people who reported alcohol use, CALD respondents ($M = 3.42, SE = 0.03$) reported more harm reduction practices than non-CALD ($M = 3.27, SE = 0.01$), $F(1,1357) = 26.23, p < .001$.

**Tobacco**  
Among all respondents, 13.2% were daily smokers, 1.4% smoked weekly, 28% were ex-smokers, and just over half of the population had never
Table 2. Culturally and Linguistically Diverse Adult Population Demographics in the Australian National Drug Survey.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Southern &amp; eastern Europe</th>
<th>Southeast Asia</th>
<th>Southern and central Asia</th>
<th>Northeast Asia</th>
<th>North Africa &amp; Middle East</th>
<th>Sub-Saharan Africa</th>
<th>Oceania (excl N. Am)</th>
<th>Americas</th>
<th>Other</th>
<th>Aus &amp; other primary Eng-speaking</th>
<th>Row total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>308</td>
<td>369</td>
<td>240</td>
<td>237</td>
<td>105</td>
<td>141</td>
<td>80</td>
<td>59</td>
<td>79</td>
<td>268</td>
<td>1886 (48.0)</td>
</tr>
<tr>
<td>Male</td>
<td>305</td>
<td>270</td>
<td>288</td>
<td>194</td>
<td>107</td>
<td>111</td>
<td>40</td>
<td>53</td>
<td>67</td>
<td>275</td>
<td>1710 (52.0)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–24</td>
<td>–</td>
<td>42</td>
<td>40</td>
<td>62</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>59 (7.3)</td>
</tr>
<tr>
<td>25–34</td>
<td>53</td>
<td>137</td>
<td>206</td>
<td>140</td>
<td>37</td>
<td>43</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>766 (21.3)</td>
</tr>
<tr>
<td>35–44</td>
<td>67</td>
<td>186</td>
<td>131</td>
<td>88</td>
<td>53</td>
<td>78</td>
<td>33</td>
<td>32</td>
<td>35</td>
<td>77</td>
<td>780 (21.7)</td>
</tr>
<tr>
<td>45–54</td>
<td>81</td>
<td>118</td>
<td>54</td>
<td>72</td>
<td>40</td>
<td>40</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>70 (15.1)</td>
</tr>
<tr>
<td>55–64</td>
<td>136</td>
<td>89</td>
<td>53</td>
<td>37</td>
<td>30</td>
<td>42</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>84</td>
<td>534 (14.8)</td>
</tr>
<tr>
<td>65+</td>
<td>268</td>
<td>67</td>
<td>44</td>
<td>32</td>
<td>38</td>
<td>31</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>187</td>
<td>710 (19.7)</td>
</tr>
<tr>
<td>Migration to Australia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–9 yrs</td>
<td>38</td>
<td>174</td>
<td>279</td>
<td>179</td>
<td>47</td>
<td>90</td>
<td>–</td>
<td>32</td>
<td>67</td>
<td>60</td>
<td>988 (32.5)</td>
</tr>
<tr>
<td>10 years+</td>
<td>540</td>
<td>422</td>
<td>214</td>
<td>125</td>
<td>147</td>
<td>153</td>
<td>95</td>
<td>73</td>
<td>66</td>
<td>350</td>
<td>2281 (67.5)</td>
</tr>
<tr>
<td>Language spoken at home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English only</td>
<td>228</td>
<td>276</td>
<td>328</td>
<td>321</td>
<td>118</td>
<td>35</td>
<td>31</td>
<td>53</td>
<td>66</td>
<td>190</td>
<td>1,688 (46.2)</td>
</tr>
<tr>
<td>Anotherb</td>
<td>368</td>
<td>354</td>
<td>189</td>
<td>106</td>
<td>88</td>
<td>215</td>
<td>86</td>
<td>59</td>
<td>75</td>
<td>351</td>
<td>1,891 (53.8)</td>
</tr>
</tbody>
</table>

Numbers are unweighted; percentages are weighted. Due to missing data for country of birth, the total sample number here \((n = 3,596)\) differs from the total sample number in Table 1 \((n = 3,638)\). Some column totals are also less than the total sample number here due to missing data. Proportions are based on responses to row variable. Cells with unweighted counts <30 are noted with dashes.

aAustralia, United Kingdom, Ireland, northern and western Europe, United States, Canada, and New Zealand.
bExcludes Australian Aboriginal and Torres Strait Islander languages, for which the largest number in any cell was 2 respondents.
CALD and non-CALD respondents had no significant difference in likelihood of daily tobacco smoking. However, CALD respondents were less likely to report ever having smoked (AOR 0.55, 99% CI [0.47, 0.64]). Differences in smoking cessation were not observed. Among respondents who had ever smoked, CALD respondents were no less likely to report being ex-smokers.

### Experience of AOD-related harms from others

Overall, 27.6% of the adult sample reported experiencing AOD-related abuse, with 21.7% reporting abuse from strangers and 13.4% reporting abuse from known persons. This included 3.5% who reported AOD-related abuse from a relative, 4.8% from a partner, and 7.8% from another known person. Among all adult respondents, 23.8% had experienced AOD-related verbal abuse, 13.8% had experienced being put in fear due to AOD-related behavior, and 9.6% had experienced AOD-related physical abuse.

No statistically significant difference in likelihood between CALD and non-CALD adult respondents was observed in reported substance-related physical abuse from strangers or being put in fear. Substance-related verbal abuse was less likely to be reported by CALD participants than by non-CALD participants (AOR 0.60, 99% CI [0.50, 0.72]). With respect to substance-associated abuse from known persons, such as family members and friends, CALD respondents were less likely than non-CALD respondents to report substance-related abuse by all known persons (AOR 0.52, 99% CI [0.41, 0.67]). This included substance-related abuse by a relative (AOR

<table>
<thead>
<tr>
<th>Substance type</th>
<th>CALD n (%)</th>
<th>Non-CALD n (%)</th>
<th>Total n (%)</th>
<th>AOR [99% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any illegal substance</td>
<td>220 (9.5)</td>
<td>2102 (17.0)</td>
<td>2322 (15.6)</td>
<td>0.51 [0.40, 0.66]</td>
</tr>
<tr>
<td>Cannabis</td>
<td>121 (5.6)</td>
<td>1450 (11.9)</td>
<td>1571 (10.7)</td>
<td>0.44 [0.31, 0.62]</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>22 (1.0)</td>
<td>315 (3.0)</td>
<td>337 (2.6)</td>
<td>0.32 [0.16, 0.63]</td>
</tr>
<tr>
<td>Meth/amphetamines</td>
<td>17 (0.7)</td>
<td>302 (2.5)</td>
<td>319 (2.2)</td>
<td>0.28 [0.14, 0.59]</td>
</tr>
<tr>
<td>Cocaine</td>
<td>18 (0.7)</td>
<td>313 (2.9)</td>
<td>331 (2.5)</td>
<td>0.23 [0.12, 0.46]</td>
</tr>
<tr>
<td>Inhalants</td>
<td>10 (0.5)</td>
<td>102 (0.8)</td>
<td>112 (0.8)</td>
<td>0.61 [0.21, 1.79]</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>14 (0.6)</td>
<td>138 (1.4)</td>
<td>152 (1.2)</td>
<td>0.43 [0.17, 1.12]</td>
</tr>
<tr>
<td>Heroin</td>
<td>2 (0.1)</td>
<td>14 (0.1)</td>
<td>16 (0.1)</td>
<td>0.95 [0.11-8.22]</td>
</tr>
<tr>
<td>Ketamine</td>
<td>3 (0.1)</td>
<td>32 (0.3)</td>
<td>35 (0.3)</td>
<td>0.40 [0.08-2.06]</td>
</tr>
<tr>
<td>GHB</td>
<td>2 (0.1)</td>
<td>11 (0.1)</td>
<td>13 (0.1)</td>
<td>0.90 [0.11-7.41]</td>
</tr>
<tr>
<td>Synthetic cannabis/cannabinoids</td>
<td>14 (0.7)</td>
<td>145 (1.3)</td>
<td>159 (1.2)</td>
<td>0.49 [0.25, 0.96]</td>
</tr>
<tr>
<td>Novel psychoactive substances</td>
<td>2 (0.1)</td>
<td>47 (0.4)</td>
<td>49 (0.3)</td>
<td>0.15 [0.03, 0.79]</td>
</tr>
<tr>
<td>Non-prescription injected drugs</td>
<td>4 (0.2)</td>
<td>44 (0.3)</td>
<td>48 (0.3)</td>
<td>0.67 [0.16, 2.71]</td>
</tr>
<tr>
<td>Analgesics&lt;sup&gt;a&lt;/sup&gt;</td>
<td>69 (2.8)</td>
<td>419 (3.1)</td>
<td>488 (3.0)</td>
<td>0.89 [0.58, 1.36]</td>
</tr>
<tr>
<td>Tranquilizers or sleeping pills&lt;sup&gt;a&lt;/sup&gt;</td>
<td>39 (1.7)</td>
<td>245 (1.8)</td>
<td>284 (1.8)</td>
<td>0.96 [0.56, 1.67]</td>
</tr>
<tr>
<td>Steroids&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3 (0.1)</td>
<td>10 (0.1)</td>
<td>13 (0.1)</td>
<td>1.3 [0.20, 8.29]</td>
</tr>
<tr>
<td>Methadone&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1 (0.0)</td>
<td>21 (0.2)</td>
<td>22 (0.2)</td>
<td>0.10 [0.01, 1.51]</td>
</tr>
<tr>
<td>Other opiates&lt;sup&gt;a&lt;/sup&gt;</td>
<td>5 (0.2)</td>
<td>60 (0.5)</td>
<td>65 (0.5)</td>
<td>0.36 [0.09, 1.53]</td>
</tr>
</tbody>
</table>

Numbers are unweighted; percentages and other statistics are weighted.
<sup>a</sup>Extra-medical use (NDSHS questionnaire uses the term nonmedical).
<p><sup>*</sup>p < .01 statistically significant difference in odds ratio.
Mental health and substance use

For non-CALD and CALD populations, we examined associations between mental health diagnosis and/or assessment and past 12-month cannabis use, tranquilizer or sleeping pill use, any illegal substance use, and AUDIT-C scores. The lower overall prevalence of high-risk drinking or other substance use among CALD respondents was not found among the subset of CALD respondents who reported mental health diagnoses (Table 4).

AOD treatment service access

Reported lifetime access to AOD treatment and support services was very low across the whole sample. Among participants who reported having ever used alcohol, tobacco, or other substances, CALD participants were not less likely than non-CALD participants to report having accessed opioid pharmacotherapy (limited to those who had ever used heroin, \(N=221\)); telephone helpline, online support, or education; peer support group; withdrawal management/residential rehabilitation; or counseling.

Attitudes to alcohol and other drugs policies

People from CALD backgrounds were less likely to oppose policies designed to reduce AOD consumption and tobacco consumption (Table 5). CALD respondents were no less likely than non-CALD respondents to oppose needle and syringe programs (\(p = 0.07\)), regulated injecting rooms (\(p = 0.18\)), methadone/buprenorphine maintenance programs (\(p = 0.72\)), and treatment with drugs other than methadone (\(p = 0.46\)), rapid detoxification therapy (\(p = 0.76\)), or use of naltrexone, a substance that blocks the effects of heroin and other opioids (\(p = 0.03\)). The opposition that CALD respondents expressed toward a prescribed heroin trial (\(M = 3.21, \ SE = 0.02\)) was

Table 4. Associations Between Cultural Background, 12-Month Substance Use, and Mental Health Assessment or Diagnosis.

<table>
<thead>
<tr>
<th>Mental illness AOR [99% CI]</th>
<th>Mental illness(^a)CALD AOR [99% CI](^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>2.14 [0.68, 6.78]</td>
</tr>
<tr>
<td>Tranquilisers or sleeping pills(^b)</td>
<td>3.21 [0.95, 10.82]</td>
</tr>
<tr>
<td>Any illegal substances</td>
<td>1.73 [0.72, 4.16]</td>
</tr>
<tr>
<td>AUDIT-C</td>
<td>1.32 [0.64, 2.71]</td>
</tr>
</tbody>
</table>

Numbers are unweighted; percentages and other statistics are weighted. \(\ddagger\) = nonsignificant (\(p > .01\)).
\(^a\)Reference category non-CALD, no mental health diagnosis or treatment in the past 12 months.
\(^b\)Extramedical use (the NDSHS questionnaire uses the term nonmedical).
significantly more than the opposition expressed by non-CALD respondents ($M = 2.98$, $SE = 0.05$), $F (df = 1, 1,365) = 22.88$, $p < .001$.

**Discussion**

This study examined data from Australia’s major population survey of alcohol and other drug use to document prevalence among CALD populations as well as differences in CALD and non-CALD populations’ experience of AOD-related harms from others, mental health and substance use comorbidity, and attitudes to drug policies. In this large national sample, CALD populations were overall less likely to drink alcohol, smoke cannabis, or use amphetamine or methamphetamine; there are no perceivable differences in likelihood of tobacco smoking or using several other drugs.
This study shows that among people who drink alcohol, CALD populations are more likely than other groups in the Australian population to report strategies that reduce the risk of harms associated with drinking. Although we note that size differences for the average number of harm reduction practices were small, this new evidence shows that community experience exists and can inform harm reduction programs. Despite identifying proportionately more practices to reduce harms related to personal consumption of alcohol, this study found that alcohol-related violence in Australia is also affecting CALD communities.

Despite the lower prevalence of drinking among CALD populations, this segment of the Australian population were no less likely to be physically abused or made to feel scared by a stranger who had been drinking or appeared to have been using other drugs. Substance-related harm has been shown to be very common in Australia, with 70% of a randomly selected national sample reporting nuisance, fear, and abuse related to a stranger’s drinking (Laslett et al., 2011). However, little is known about the experience of and responses to alcohol and other drug-related violence among groups in the population who have recently migrated to Australia, people from refugee backgrounds, groups who experience unnecessary or inappropriate police intervention, or groups who experience other forms of racial discrimination. Recent research has examined how CALD youth negotiate sharing public space in the context of others’ substance use (Horyniak et al., 2016) and the role of in-group cultural connection in constituting drinking practices in public places (Manton, Pennay, & Savic, 2014). These studies indicate that AOD policy and related interventions need to keep thinking beyond individual behavioral interventions if they seek to support communities to reduce alcohol-related harms.

CALD populations in the 2013 National Drug Survey were less likely than non-CALD populations to report violence from known persons influenced by alcohol or other substances. It is well known that intimate partner and family violence is more likely to affect women and is underreported, and that groups in the population who experience higher rates of child removal and discrimination from police and service providers are less likely to report these forms of violence (Philips & Vandenbroek, 2015). In 2006, Lee, Sulaiman-Hill, & Thompson (2014) conducted face-to-face interpreter-assisted interviews based on the NDSHS questionnaire with 268 women from 50 different countries who had recently migrated to Australia. That study found that domestic violence and abuse by strangers were concerns that were aggravated by others’ alcohol and other drug use. Lee, Sulaiman-Hill, & Thompson (2014) observed that CALD women in their study were more likely to be physically abused by their partners than by strangers, and they were more likely than the total sample of women in the NDSHS to
report being made to have sex with someone who had been drinking or taking drugs. Reflecting on this important study with CALD women highlights the need for renewed, focused research that explores and supports AOD harm reduction as part of community responses to domestic violence.

Despite a higher proportion of people from CALD backgrounds never smoking, the current smoking population does not vary in a statistically significant way between CALD and non-CALD groups. No statistically significant variation in cessation was observed. Vietnamese men, Pasifika men and women, and Italian men have previously reported higher smoking prevalence than the overall Australian population prevalence (Donato-Hunt et al., 2012). It is important to keep these differences and other potential differences among CALD populations in mind. Marginalization has been shown to fortify in-group practices, which can in turn normalize substance use (Phillips, Monaem, & Newman, 2015). Given this, mainstream quit-smoking interventions may be having limited impacts among some CALD communities.

Extramedical use of analgesics, tranquilizers, and steroids appears in the present study as an important and relatively new consideration. The findings echo observations made by health and social workers, police, and legal services (Khawar & Rowe, 2013). This evidence can be used to inform current responses to the high proportion of drug-related overdose deaths contributed by pharmaceutical drugs in Australia. At a time when real-time prescription monitoring systems are being implemented in parts of Australia, so should educational programs for medical practitioners and pharmacists that serve the general community, as well as for key CALD groups such as refugees, women, and seniors.

The likelihood of CALD and non-CALD populations’ lifetime and past 12 months drug administration via injection did not differ significantly in this national sample. Several studies over the past two decades have highlighted unequal distribution of harms between CALD and non-CALD groups who inject drugs. In 2008, Maher et al. found that recent initiates to injecting drug use who came from CALD backgrounds were more likely to acquire a blood-borne infection than were their counterparts from Australian-born Anglo backgrounds. A recent study involving a large sample of men who inject steroids and other performance- and image-enhancing drugs found that participants from some CALD communities were less likely to have accessed blood-borne virus diagnostic testing in the context of a number of high infection transmission risk practices (Rowe, Berger, Yaseen, & Copeland, 2017). This underlines the need to be attentive to differential risks among groups who may have lower access to AOD services, including harm reduction services and drug treatment programs. Heavy social stigma, isolation, and lack of service access have been shown
to factor in infection transmission among CALD groups of people who inject drugs (Horyniak et al. 2012). Based on this evidence, harm reduction services such as needle and syringe programs need to keep being attentive to the needs of people who inject drugs from CALD communities.

In the present study, respondents from CALD backgrounds who reported mental health diagnosis or treatment appear as a group who may benefit significantly from accessible and appropriate AOD assessment and support to reduce AOD-related harms. A well-established body of literature documents how structural racism in health systems can affect mental health diagnoses among people from minority ethnicities and cultures (Metzl & Roberts, 2014; Balaratnasingam & Janca, 2017; Turner & Mills, 2016) and how psychiatric diagnoses have accompanied processes of colonization, dispossession, stigma, and marginalization (Cohen, 2014). Given this, culturally informed mental health services can play an important role in addressing substance use (Flaherty & Donato-Hunt, 2012).

AOD treatment services in Australia report lower attendance by people born in overseas countries in the Australian population and by people who speak languages other than English at home (AIHW 2017). Given that, overall, few participants reported having ever accessed AOD treatment services, it is not particularly surprising that evidence of lower attendance of CALD communities at AOD treatment services was not found in the 2013 NDSHS. Furthermore, data collection practices at AOD services may reduce their ability to account for cultural and linguistic diversity among groups accessing their services (Reid et al., 2001). However, a more important question is whether current access to treatment reflects need and to what extent it supports people seeking treatment to reduce AOD harms. This is not a given, particularly considering that historically the evidence base for AOD and mental health interventions has been drawn from Caucasian male participants, with services often applying models of treatment without consulting or inquiring into the particular needs of CALD communities or their outcomes in treatment (Lee et al., 2014). Furthermore, in 2015, only half of AOD service providers surveyed nationally reported that their agency actively undertook any service promotion or outreach strategies aimed at engaging one or more CALD communities (Rowe & Santos, 2016).

Finally, this study found that CALD populations were less opposed to most harm reduction policies than were non-CALD populations. Perceptions of drug policies are likely to be influenced by personal experiences of substance use, as such higher proportion of abstainers among CALD populations may influence this result. Yet the findings reported here, importantly, offer grounds from which to refute potential stereotypes about which communities in the Australian population hold conservative views on harm reduction policy.
Practical limitations

As with every study, this study faced several specific limitations. First, countries of birth, language groups (including by regions), and length of time since first arrival in Australia cannot be examined with the 2013 NDSHS due to the small sample size and the failure to collect disaggregated data on languages other than English spoken at home. Second, the 2013 NDSHS sampling strategy does not consider linguistic diversity (with the exception of Aboriginal and Torres Strait Islander peoples’ languages, which are treated as a single category rather than disaggregated) or cultural identity (Roy Morgan Research, 2014). Third, looking at age groups of interest, proportions of particular CALD populations appear to underrepresent the demographics of the general population (ABS, 2017). Furthermore, age at arrival in Australia can also not be examined because participants born before 1950, a significant proportion of the sample, were not asked to report their year of arrival. Fourth, in addition to a 49.1% response rate overall in the 2013 survey (Roy Morgan Research, 2014), participation of various CALD populations in the NDSHS may be further reduced because the survey is only administered in English. Finally, social desirability bias and recall bias are also likely to factor in the participation and responses provided by participants. Particularly with respect to measuring violence attributed to alcohol use, limitations of survey data have been explored elsewhere (Rossow, 2015).

National survey data on the health of CALD populations: Critical limitations

Studies using the NDSHS, an ostensibly representative national data set, will find themselves limited to discussing CALD populations in generalizations that have limited use. There are substantive social justice implications for how ethnic and cultural categories are applied, that is, whether descriptively for pragmatic analysis or attributively for positing some kind of essential difference (Montoya, 2007). Particularly in drug and alcohol research, it is necessary to completely reject the latter—the convention of employing socially designated ethnic and racial categories as biological categories. It is not only because the National Survey data are cross-sectional that they tell us nothing about causation but, more importantly, because the predictor variable “CALD” is not a causal factor for substance use. Descriptive approaches need to be carefully evaluated to ensure that they do not create or exacerbate divisive harms (Hunt, Kolind, & Antin, 2017).

Taking these foundations into consideration, epidemiological research that focuses on the health concerns of CALD communities and addresses uneven distribution of the burden of AOD-related illness and injury is necessary (Epstein, 2008). To make a contribution toward this aim, researchers need robust criteria for population categories. Criteria should be able to comprehend
heterogeneity among and between groups (Unger, 2012), measure the influence of length of time since immigrating and age at immigration on cultural and social practices that involve AOD, and grasp the ways that poverty, gender, and other forms of social mobility align with and shape the experience of AOD-related harms and responses. Researchers also need criteria to identify where important differences truly exist and can inform health and social interventions led by the groups of people most directly affected.

**Conclusion**

This study offers a rare and focused examination of national substance use prevalence among culturally and linguistically diverse (CALD) populations in Australia. However, the NDSHS is characteristically limited in its ability to understand AOD harms among specific groups of people from CALD backgrounds. Future research that highlights AOD harms and harm reduction strategies among CALD communities will be of broad benefit.

**Acknowledgments**

Y. Gavriel Ansara conducted the statistical analyses involved this study with methodological advice from other authors. AIHW and Australian Data Archive provided data release and oversight. DAMEC's Research Subcommittee members Atem Atem, Suzie Hudson, John Howard, Yasmin Iese, and Grenville Rose advised on study design. Kari Lancaster, Israel Berger, and Niamh Stephenson also provided useful comments and suggestions.

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**References**


Alcohol, tobacco and illicit drug use among six culturally diverse communities in Sydney

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Abstract

Introduction and Aims. A survey was conducted in 2004–2005 to investigate the risk of drug-related harm among Chinese, Vietnamese, Italian, Pasifika, Arabic-speaking and Spanish-speaking communities in Sydney. Design and Methods. A self-completion questionnaire, available in six languages, was distributed by bilingual field staff. A representative multistage clustered sampling design was used. Comparisons were made with the New South Wales general population using the results from the 2004 National Drug Strategy Household Survey. Results. The obtained sample was 2212 respondents; 50% completed the questionnaire in English. Daily tobacco use was higher than the general population among Vietnamese men (30%), Italian men (22%) and Pasifika men and women (25%). Reported use of alcohol and other drugs was lower than the general population in all six surveyed communities. Of the six communities, Pasifika had the highest rate of short-term risky drinking (22%). Discussion and Conclusions. Smoking cessation programs should prioritise communities with higher or equal rates of daily smokers compared with the wider New South Wales population. Focus areas vary between the communities, and include increasing help seeking and improving quitting success rates. Short-term risky drinking was not as prevalent among the surveyed communities; however, results suggest a need for prevention targeting Pasifika communities. Understanding the prevalence of substance use among culturally and linguistically diverse communities provides a crucial foundational component in developing culturally sensitive prevention and treatment programs. These results demonstrate the need for programs to be tailored to the needs and contexts of particular communities, rather than treating those from diverse backgrounds as one homogenous group. [Donato-Hunt C, Munot S, Copeland J. Alcohol, tobacco and illicit drug use among six culturally diverse communities in Sydney. Drug Alcohol Rev 2012;31:881–889]

Key words: drug, alcohol, tobacco, culture, ethnicity.

Introduction and aims

Current evidence of the prevalence of drug use among people from culturally and linguistically diverse (CALD) backgrounds in Australia is limited. Results from the Australian National Drug Strategy Household Survey (NDSHS) found that people who spoke a language other than English at home used alcohol, tobacco and other drugs (ATOD) less frequently than the general population [1]. The representativeness of the NDSHS in regard to country of birth, language and English proficiency is, however, limited, with the self-completion drop-and-collect questionnaire available in English only [2]. Smaller studies have shown conflicting results, with studies reporting drug use to be more common, the same or less common, among people from CALD backgrounds than the general population [3].

In light of this, the current study was designed to provide more reliable data on substance use among CALD communities in Sydney through a multilingual household survey. The CALD groups surveyed were Italian, Chinese, Vietnamese, Spanish-speaking, Arabic-speaking and Pasifika. Pasifika includes those who identify as being Pacific Islander or Maori ethnicity. The data presented in this paper will assist in the development of targeted interventions and health promotion campaigns for these communities in Sydney, and potentially in other metropolitan areas across Australia.
Literature review

New South Wales (NSW) has a culturally diverse population with 21% speaking a language other than English at home [4]. Resnicow et al. identify that the process of developing culturally sensitive ATOD programs should begin with an analysis of substance use patterns, the risk factors for use, and the unique predictors of use in the target population [5]. In Australia, however, there is a lack of reliable data on ATOD use among people from CALD communities [3]. Research that is available indicates that drug use is generally lower among those from CALD backgrounds compared with the general population in Australia [6–13], as well as in the USA [5,14] and the UK [15]. The common exception to this in Australia is tobacco use among men, where, compared with men in the wider population, studies have found rates to be higher or similar among Arabic-speaking [9,11,16], Vietnamese [6,11], Italian [11] and Spanish-speaking men [11]. Within demographic variables, the most reported differences among CALD populations have been according to gender, where, in many communities, higher rates of alcohol and tobacco use have been reported among men compared with women [6,11,15,17–20]. Within research examining drug use in the six CALD groups included in this study, differences have also been found according to birthplace [9,14,18,21], language preference or proficiency [20–25], acculturation [18,20,23,26], and, to a lesser extent, education [20,22].

For migrants and refugees migration experiences can be risk factors for mental health and drug use issues. Pre-migration stressors can include torture and violence [27] and the loss of loved ones, possessions and place [28,29]. Post-migration stressors can include continued loss and separation [27–31], anxiety for those left abroad [32], cultural bereavement [33], cultural adjustment [34], literacy and language difficulties [28,30,31], marginalisation and discrimination [27,30,32,35], social isolation [27,34], economic and social disadvantage [31,36], acculturation [31] and inter-generational conflict [35,37]. Depending on the adjustment and coping strategies adopted by individuals, these experiences may trigger substance misuse [38,39]. Some may also engage in substance misuse as a way of adapting to peer culture [40]. The experience of stressors is not homogenous [41]. The availability of internal and external coping resources, and cultural and individual differences impact on the way people interpret and respond to stress [41–44]. Understanding risk factors in relation to the stressors associated with adjusting to a new country has been conceptualised as the Acculturative Stress Model [30,41].

Among US studies investigating substance use, the application of acculturation measures as the primary variable is widespread [23,26,45–51]. Acculturation has been described as an adaption process that involves incorporating the values or characteristics of the host culture while retaining or relinquishing the values or characteristics of one’s traditional background [52–55]. The acculturation measures used are predominantly language-based scales [25,46,51,56]. Acculturation measures have had very limited application in Australia. In order to explore how acculturation affects health in Australia, Rissel developed a language-based measure based on scales used with Hispanic populations in the USA [56]. The use of acculturation measures in health research in the USA has received some criticism. These criticisms pertain to a lack of clear definitions, insufficient conceptualisation, and that acculturation may be based more on ethnic stereotyping rather than objective representations of cultural difference [36].

As outlined above, the process of developing culturally sensitive ATOD prevention and treatment programs should begin with an analysis of substance use patterns, the risk factors for use, and the unique predictors of use in the target population [5]. Failure to appreciate the heterogeneity within and between CALD groups can lead to what has been termed ‘ethnic glossing’, and ultimately the development of ineffective and irrelevant interventions [5]. It is within this framework that the current research is posited, aiming to provide reliable information to assist in informing the development of culturally sensitive ATOD prevention and intervention programs.

Design and methods

This study is based on research conducted by The Drug and Alcohol Multicultural Education Centre (DAMEC) in the 1990s [6–10]. The design of the current study was modified as follows: one large single survey with six discrete subpopulations (strata); a wholly self-completion questionnaire; and the weighting procedure accounting for the probability of selection and non-response bias. These methodological differences mean that only general trends over time can be compared, rather than actual percentage change.

Questionnaire

The questionnaire included questions from the 2004 NDSHS to allow for comparisons with the NSW general population [2]. Included items concerned the perceived community impact of drugs, access to ATOD, ATOD use (including pharmaceuticals), changes to smoking behaviour, environmental tobacco smoke, support for drug-related policy, and self-assessed health status.
These items were also included in the 1990s DAMEC studies. Additional items addressed changes to alcohol behaviour, knowledge of issues related to alcohol and tobacco use, help seeking for drug use issues, and media consumption.

In order to investigate whether acculturation was a predictor of drug use, Rissel’s acculturation scale was added to the questionnaire [56]. The scale asks respondents to indicate: whether they normally speak English or another language when at home and when with friends; the language they prefer to speak in; the language they usually think in; and the language they are better at reading and writing in. The scale also includes two items asking the level with which respondents identify with, and follow, their ethnic tradition. It is an eight-item linear scale with six 5-point items and two 3-point items. A summative acculturation scale score is then calculated.

The questionnaire was piloted in two census collection districts (CCDs).

Sample design
A representative multistage clustered sampling design was used with data collection in clusters based on CCDs. The approach used a probability-proportional-to-size design (without replacement) using a measure of size based on census counts of each CALD group in each CCD, maximising the likelihood of selecting a household from a nominated CALD group. Population information on CCDs was obtained from the Australian Bureau of Statistics 2001 Census. The target was to make contact with 25 eligible households in each CCD, or exhaust the CCD. Based on the yield of usable questionnaires in the 2001 NDSHS, 50 CCDs in each stratum were randomly selected to achieve a target of 500 usable questionnaires from each CALD group. The final sampling frame included 300 CCDs. Thirty-nine CCDs included in the sample were not visited because of being either unsafe, too remote or having extremely small numbers of CALD households. All included CCDs were in the Greater Sydney region of NSW. Responses were returned from 258 CCDs.

Prior to the commencement of fieldwork, an introductory letter was delivered to households in the selected CCDs. The questionnaire and letter were available in English, Chinese, Italian, Spanish, Vietnamese and Arabic. Contact was made with households by trained bilingual field staff using a drop-and-collect approach, similar to that used for the NDSHS [2]. Respondents were chosen from selected households according to the householder aged 14 years and above with the next birthday. The survey period was September 2004 to March 2005.

Complex sample plan
As the sampling design involved probability sampling within a multistage cluster sampling framework, weights were developed to incorporate the inclusion probabilities of respondents and correct any imbalance due to the sampling design. Weights were also scaled by the average household size according to the Australian Bureau of Statistics 2001 Census. The complex sample plan was developed using spss Complex Samples module (IBM, Armonk, NY, USA).

Data analysis
Data were entered and analysed using spss (v14-16). Standardised protocols were used to impute missing responses and correct detectable inconsistencies (e.g. responses to ‘having ever tried a cigarette’ were recoded as positive for smokers). Descriptive statistics were calculated, and logistic regression, controlling for the effects of age and sex, was used to determine significant predictive relationships. Results were deemed statistically significant where \( P \leq 0.05 \), and odds ratios (OR) \( \geq 1.5 \) or \( 0 > \text{OR} < 0.65 \). Comparisons with the wider NSW population were made by comparing weighted data with results reported from the 2004 NDSHS [57]. Weighted data were used in reporting.

Results
Description of the sample
The obtained sample was 2212 respondents from 258 CCDs. The total response rate was 45%. The sample by subgroup was: Chinese \( n = 492 \) (45% male, mean age 39, SE = 1.1); Arabic-speaking \( n = 417 \) (36% male, mean age 37, SE = 1.1); Vietnamese \( n = 425 \) (49% male, mean age 37, SE = 0.9); Italian \( n = 331 \) (41% male, mean age 47, SE = 1.6); Spanish-speaking \( n = 283 \) (36% male, mean age 46, SE = 1.1); and Pasifika \( n = 264 \) (40% male, mean age 35, SE = 1.2). The study included high proportions of overseas born and questionnaires completed in a language other than English (see Table 1).

Tobacco use
In NSW, 17% of the general population smoked daily [57]. Compared with the NSW general population, there were higher proportions of daily smokers among Vietnamese men (30%), Pasifika men and women (25%) and Italian men (22%). The Spanish-speaking and Chinese groups had the lowest rates of daily smoking.

Being male emerged as a significant predictive factor for daily smoking in the Chinese [OR = 7.72, 95%
(confidence interval) CI 1.68 to 35.50, \( P = 0.009 \) and Vietnamese (\( OR = 6.87, \) 95% CI 3.35 to 14.07, \( P < 0.001 \)) groups. In the Vietnamese group those born in Vietnam were more likely than Australian-born to smoke daily (\( OR = 14.74, \) 95% CI 3.13 to 69.41, \( P < 0.001 \)). See Table 2 for substance use by demographic variables.

In the Pasifika, Chinese and Arabic-speaking groups more than half the current smokers had tried unsuccessfully to quit smoking in the last 12 months. Of current smokers who had tried to quit in the Chinese, Arabic-speaking and Spanish-speaking groups, more than 80% did not seek any assistance.

**Alcohol use**

Alcohol consumption was lower in all the CALD groups compared with the NSW population (see Table 1). The Italian group had the highest rate of daily alcohol consumption (19%). In this group 77% of current drinkers usually consumed less than two standard drinks on drinking days. The Pasifika group had the highest rate of short-term risky drinking at 22%, still 10% lower than the NSW general population [57]. The Arabic-speaking group had the highest proportion of abstainers from alcohol (56%).

Being male emerged as a significant predictor of weekly alcohol consumption in the Vietnamese (\( OR = 4.55, \) 95% CI 2.22 to 9.35, \( P < 0.001 \)), Arabic (\( OR = 3.86, \) 95% CI 1.71 to 8.70, \( P = 0.001 \)) and Pasifika (\( OR = 2.22, \) 95% CI 0.98 to 5.00, \( P = 0.050 \)) groups. Being aged over 40 was significantly predictive of weekly alcohol consumption in the Vietnamese (\( OR = 2.07, \) 95% CI 1.07 to 4.01, \( P = 0.030 \)) and Italian (\( OR = 8.20, \) 95% CI 2.57 to 26.20, \( P = 0.001 \)) groups. Being born in Italy was also significantly predictive of weekly alcohol consumption in the Italian group (\( OR = 18.76, \) 95% CI 3.45 to 102.15, \( P = 0.001 \)).

Being male was predictive of usually drinking more than two standard drinks on drinking days in the Vietnamese (\( OR = 7.17, \) 95% CI 2.44 to 21.03, \( P < 0.001 \)) and Spanish-speaking (\( OR = 4.37, \) 95% CI 2.23 to 8.96, \( P < 0.001 \)) groups. In the Spanish-speaking group being aged under 40 was also predictive of drinking more than two standard drinks (\( OR = 4.07, \) 95% CI 1.82 to 9.11, \( P = 0.001 \)).

**Illicit drug use**

Illicit drug use was lower across all the six CALD groups compared with the NSW general population (see Table 1). In this study illicit drugs included cannabis, amphetamines, cocaine, hallucinogens, ecstasy, heroin and inhalants. The proportion who had tried an illicit drug ranged from 8% in the Chinese group to
30% in the Pasifika group. Cannabis was the illicit drug most commonly tried across all groups.

Being aged less than 40 years was predictive of having ever tried an illicit drug in the Spanish-speaking (OR = 15.60, 95% CI 7.15 to 34.01, \( P < 0.001 \)), Vietnamese (OR = 4.95, 95% CI 2.068 to 11.823, \( P < 0.001 \)) and Arabic-speaking groups (OR = 4.51, 95% CI 1.87 to 10.89, \( P = 0.001 \)). Being female was predictive of having tried an illicit drug in the Arabic-speaking (OR = 2.92, 95% CI 1.16 to 7.35, \( P = 0.023 \)) and Pasifika groups (OR = 2.34, 95% CI 1.09 to 5.03, \( P = 0.029 \)). In the Vietnamese group being male was predictive of having ever tried an illicit drug (OR = 2.74, 95% CI 1.287 to 5.810, \( P = 0.009 \)).

**Acculturation**

Acculturation was not found to be a significant predictor of any drug use.

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**Table 2. Drug use by sex, age and birthplace**

<table>
<thead>
<tr>
<th>Drug use by sex, age and birthplace</th>
<th>Arabic (%)</th>
<th>Chinese (%)</th>
<th>Italian (%)</th>
<th>Pasifika (%)</th>
<th>Spanish (%)</th>
<th>Vietnamese (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Daily smoking</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex—male</td>
<td>18</td>
<td>12</td>
<td>22</td>
<td>25</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td>Sex—female</td>
<td>15</td>
<td>2</td>
<td>11</td>
<td>25</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Age—14–39</td>
<td>16</td>
<td>4</td>
<td>11</td>
<td>22</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Age—over 40</td>
<td>16</td>
<td>10</td>
<td>19</td>
<td>30</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Birthplace—Australia</td>
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<td>2</td>
<td>13</td>
<td>10</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Birthplace—overseas</td>
<td>13</td>
<td>8</td>
<td>18</td>
<td>27</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>7</td>
<td>16</td>
<td>25</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td><strong>Daily—weekly alcohol use</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Sex—male</td>
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<td>17</td>
<td>59</td>
<td>36</td>
<td>40</td>
<td>32</td>
</tr>
<tr>
<td>Sex—female</td>
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<td>11</td>
<td>37</td>
<td>18</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>Age—14–39</td>
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<td>12</td>
<td>34</td>
<td>19</td>
<td>33</td>
<td>14</td>
</tr>
<tr>
<td>Age—over 40</td>
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<td>55</td>
<td>37</td>
<td>31</td>
<td>28</td>
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<td>Birthplace—Australia</td>
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<tr>
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<td>60</td>
<td>26</td>
<td>31</td>
<td>23</td>
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<tr>
<td>Total</td>
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<td>14</td>
<td>46</td>
<td>25</td>
<td>32</td>
<td>20</td>
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<tr>
<td><strong>Short-term risky drinking(^a)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex—male</td>
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<td>3</td>
<td>6</td>
<td>21</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Sex—female</td>
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<td>2</td>
<td>1</td>
<td>22</td>
<td>5</td>
<td>3</td>
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<tr>
<td>Age—14–39</td>
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<td>25</td>
<td>14</td>
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</tr>
<tr>
<td>Age—over 40</td>
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<td>5</td>
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<td>5</td>
</tr>
<tr>
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<td>5</td>
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<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
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<td>2</td>
<td>4</td>
<td>22</td>
<td>5</td>
<td>6</td>
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<tr>
<td><strong>Ever tried an illicit drug</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex—male</td>
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<td>8</td>
<td>12</td>
<td>22</td>
<td>21</td>
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</tr>
<tr>
<td>Sex—female</td>
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<td>9</td>
<td>17</td>
<td>36</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
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<td>10</td>
<td>20</td>
<td>32</td>
<td>49</td>
<td>15</td>
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<tr>
<td>Age—over 40</td>
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<td>6</td>
<td>11</td>
<td>26</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Birthplace—Australia</td>
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<td>12</td>
</tr>
<tr>
<td>Birthplace—overseas</td>
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<td>9</td>
<td>9</td>
<td>30</td>
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<td>10</td>
</tr>
<tr>
<td>Total</td>
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<td>8</td>
<td>14</td>
<td>30</td>
<td>20</td>
<td>11</td>
</tr>
</tbody>
</table>

\(^a\)For men, the consumption of seven or more standard drinks on any one day. For women, the consumption of five or more standard drinks on any one day.

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**Discussion**

**Changes in smoking since the 1990s**

The most notable changes in substance use since the 1990s occurred in relation to smoking. At that time being male was predictive of smoking in the Vietnamese, Chinese, Arabic-speaking and Spanish-speaking groups [6–9]. In this study, although more men than women smoked in five of the six CALD groups, being male was only found to be a significant predictor in the Vietnamese and Chinese groups. Despite declines in regular smoking among men in these groups since the 1990s, this did not offset being male as a predictive factor because of the very low rates of daily smoking among women. It would appear that, like Chinese and Vietnamese diasporas overseas [15,19,22,58–60], cultural norms continue to limit smoking among Chinese and Vietnamese women in Sydney (see also [11,61]).
Implications for smoking cessation

It is recommended that Australian smoking cessation programs prioritise communities where the proportion of daily smokers is higher than, or equal to, the proportion in the general NSW population, these being Vietnamese and Italian men, and men and women from Pasifika and Arabic-speaking communities. The foci for interventions should, however, vary between groups. Given lower proportions of quit attempts in the Vietnamese and Italian groups, it is recommended that smoking cessation programs in these communities focus on motivating decisions to quit. As higher proportions of smokers in the Pasifika and Arabic-speaking groups had made quit attempts, it is recommended that, for these communities, smoking cessation programs focus on preventing relapse. The limited proportion of smokers from Arabic-speaking communities who sought assistance when quitting highlights this as an additional focus area.

Implications for alcohol programs

Short-term risky drinking was not as frequent among the CALD communities studied as in the general community. While the Italian group drank alcohol more frequently than the other groups, the rate of short-term risky drinking was still eight times lower than that of the general population. This pattern of frequent yet low-quantity drinking follows results found in previous research among Italian Australians [7,16]. Out of the six groups studied, the Pasifika group had the highest proportion of short-term risky drinking, supporting research suggesting limited concept of moderate drinking among Pasifika people in New Zealand [62], and concerns over short-term risky drinking among Pasifika communities in Sydney [63]. These results demonstrate a need for targeted alcohol programs among Pasifika communities promoting low-risk drinking and the risks of short-term risky drinking even when infrequent. It is recommended that education be accompanied by appropriate treatment options.

Implications for other drugs programs

The substantially lower rates of illicit drug use among the CALD groups surveyed compared with the general population indicate that targeted alcohol and tobacco should be of higher priority for these communities.

Acculturation and substance use

Given substantive results from US studies [26,64–68], results from this research were expected to show significant relationships between acculturation and substance use; however, no significant relationships were observed. This could reflect a genuine absence of the hypothesised relationship, or could be an artefact of the predominantly language-based acculturation scale used or methodology used. Given these results, along with criticisms of the use of acculturation measures in health research [36], the application of acculturation scales requires further exploration in Australia.

Limitations

The following limitations should be considered when drawing population-level conclusions. Cluster sampling was chosen over ideal simple random sampling because of budget and logistical constraints. The complex sample plan did not account for those 39 CCDs not visited because of above mentioned practical considerations. The target of 500 surveys per community was not achieved; the Pasifika and Spanish-speaking communities were the most difficult to access because of their sparse populations.

As well as these specific limitations, the following limitations apply to substance use household surveys more generally. Although confidentiality and privacy were protected, substance use may have been under-reported because of concerns with disclosing drug use. Additional factors like literacy, questionnaire length and wariness of government-funded research are likely to have impacted the response rate. In this study the response rate was 45%, slightly lower than the 48% obtained in the drop-and-collect sample of the 2004 NDSHS [69]. Although self-reporting is favourable over face-to-face interviews [70], it is uncertain whether the selected householder completed the questionnaire themselves. Finally, the accuracy of prevalence estimates of illicit substance use obtained by household surveys has been questioned because of the high levels of non-responsiveness, consequent lack of power in examining data in detail [71] and difficulty in reaching marginalised illicit drug-using persons.

Conclusions

Compared with the general NSW population, there were lower levels of short-term risky drinking and illicit drug use across all the CALD groups studied, but higher or equal rates of daily smoking among Vietnamese and Italian men, and men and women in Pasifika and Arabic-speaking communities. Tobacco prevention and cessation programs should therefore remain a priority for these communities. Areas for focus would be further decreasing smoking rates, increasing the proportion of smokers seeking help to quit, and improving quitting success rates. It is also recommended that pro-
grams for Vietnamese men, and Pasifika men and women be prioritised given the higher proportion of daily smokers in these groups.

This research provides an analysis of substance use patterns among CALD populations often missed by English-language household surveys. Such research provides a crucial foundational component in developing culturally sensitive ATOD prevention and treatment programs [72]. Mixed results across the six CALD groups demonstrate the need for interventions and community programs to be targeted to the needs of particular CALD communities. Approaches should reflect the heterogeneity of CALD populations, acknowledging that universal approaches alone will not maximise the reduction of substance use-related harms across the Australian community.

Acknowledgements

This project was funded by The AER Foundation. The authors would especially like to thank the respondents for their participation. The authors would like to thank Ms Michelle Black, Dr Mark Cooper-Stanbury, Prof Richard Taylor, Mr Kelvin Chambers, Prof Chris Rissel, Mr Stuart Gilmour, A/Prof Mike Jones, Ms Sarina Afa, Dr Jael Wolk, Ms Helen Sowey, bilingual fieldworkers, members of the project steering committee and the cultural reference group for their contributions at various stages in the project.

Conflict of interest declaration

This project was wholly funded by the Alcohol Education & Rehabilitation Foundation Ltd (AER Foundation). None of the researchers have any connection with the tobacco, alcohol, pharmaceutical or gaming industries or any body substantially funded by one of these organisations.

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