Preventing alcohol and other drug related harm in multicultural communities

Joint Statement:
Ethnic Communities' Council of Victoria
& Victorian Alcohol and Drug Association

eccv
The Voice of Multicultural Victoria

vaada

Introduction

Migrant and refugee communities in Victoria experience barriers to accessing alcohol and other drug (AOD) treatment services. The AOD treatment system can be perceived as complex, difficult to access and may not have consistent levels of cultural safety necessary for optimal engagement with many diverse communities.

There is a need to capitalise on existing culturally specific AOD programs which, though many are unfunded, are currently in place. AOD agencies need to be supported to increase their cultural safety which includes working with communities in the co-design of tailored services. There is a need to increase the AOD specific health literacy among many community groups, increase access and uptake of interpreting services and seek to reduce stigma, which deters help seeking behaviour. The role of family and community leaders is vital and must be supported in progressing positive reform.

More broadly, there is a need to better ascertain the AOD related harms amongst migrant and refugee communities.

Issues and Evidence

Harmful use of alcohol and other drugs (AOD) is a problem that impacts all parts of Victoria's diverse population, including people from migrant and refugee backgrounds. Although there is some evidence to suggest that AOD use overall is lower amongst Victorians from migrant and refugee backgrounds, problematic AOD use is nonetheless an issue in many communities. Indeed, migrants and refugees can be particularly vulnerable to AOD harm because of experiences of torture, trauma, grief and loss, which can be exacerbated by other systemic issues and barriers, such as social exclusion, unemployment, language barriers, and a lack of culturally appropriate services and support.

These barriers can limit access to AOD services, resulting in increased risk of engaging with forensic and hospital systems.

Trauma experienced prior to migration, as well as the challenges of settlement, post migration social and economic marginalisation, and experiences of racial discrimination, have been linked to poor mental health and wellbeing[1], and the harmful use of alcohol or drugs by some community members[2]. It is therefore of vital importance that migrant and refugee communities are able to access AOD treatment and support services, and are educated about how to reduce AOD harms and aware of available supports for people engaging in harmful AOD use.

Members of migrant and refugee communities, however, are significantly underrepresented in use of AOD services. The most recent statistics show that 81% of users of AOD services were born in Australia, and that 95% reported speaking English as their first language[3], whereas 30% of Victorians were born overseas[4] and 27% speak a language other than English in the home[5].

It appears evident that underrepresentation is not a result of lower need, but is a result of systemic issues that lead to underutilisation of services by multicultural communities. Packaging the delivery of AOD services in a manner which minimises shame to both the individual and families, and providing clear information on confidentiality concerns may be a factor in increased service access.

The specialist program support afforded to migrant and refugee communities is sparse and sporadic, often contingent on unfunded (or short-term funded) yet innovative partnerships between multicultural and AOD agencies. While the anecdotal feedback for these arrangements is often positive, there is an absence of rigorous evaluation and at best a limited commitment from government to fund these endeavors.

1. Ziersch, A., Due, C. & Walsh, M. (2020) *Discrimination: a health hazard for people from refugee and asylum-seeking backgrounds resettled in Australia*, BMC Public Health 20 (108)
2. Horyniak D, Melo JS, Farrell RM, Ojeda VD, Strathdee SA (2016) *Epidemiology of Substance Use among Forced Migrants: A Global Systematic Review*, PLOS ONE 11 (7)
3. Australian Institute of Health and Welfare (2022) *Alcohol and other drug treatment services in Australia annual report, AIHW, Australian Government* [accessed 25 October 2022]
4. Australian Bureau of Statistics (20 September 2022), *Cultural diversity of Australia*, ABS Website [accessed 25 October 2022]
5. .idcommunityprofile, Australia- Community profile, *Victoria - Language spoken at home* [accessed 25 October 2022]

In 2016, VAADA conducted an analysis of the extent of AOD harms among culturally and linguistically diverse (CALD) populations in Victoria[6], which identified a number of challenges including:

- Inadequate data detailing the prevalence of AOD use within CALD communities
- Low treatment admission rates for individuals from CALD backgrounds (which does not reflect lower need but rather an underutilisation of services[7])
- The additional challenges associated with adjusting to a new culture, including feelings of dislocation and isolation, community shame and a lack of familiarity with Australian health systems and services
- For some, increased vulnerability to problematic AOD use due to experiences of torture, trauma, grief and loss. This can be exacerbated by factors associated with migration like unemployment, language barriers and a lack of culturally appropriate services
- Significant referrals to forensic services among some CALD cohorts, highlighting lost opportunities for preventative engagement and early intervention via the voluntary system.

Multicultural AOD support challenges – Redressing existing limitations

In December 2021, the Ethnic Communities' Council of Victoria (ECCV) surveyed its members about how AOD impact their communities, and how community members access treatment and services. Following this, ECCV and the Victorian Drug and Alcohol Association (VAADA) jointly hosted a round-table to discuss how AOD issues effect migrant and refugee communities, and how AOD services could better support them. Attendees at the round-table were a mixture of AOD service providers and multicultural and ethno-specific community organisations with an interest in reducing AOD harm in their communities. Key issues raised in the survey and round-table were:

1. Stigma

Stigma deters help-seeking behavior and impedes civil participation; these issues can be accentuated in migrant and refugee communities, necessitating a campaign to address stigma.

Stigma around AOD use comes in different forms – it can be self-inflicted, community based, or systemic stigma and discrimination from service providers. Stigma remains a significant issue in many communities and a strong deterrent to seeking help. It can be hard for people with AOD issues to feel accepted and subsequently disclose that they may need help. It may also be difficult for family members to acknowledge that a family member experiences substance dependence. There is a lack of education and experience of AOD issues in some migrant and refugee communities, particularly around co-occurring mental health and substance dependence issues. Remedying this is a priority, as the influence of both community leaders and families on supporting at risk people from migrant and refugee communities in seeking support is significant.

There is also a lack of education about rights. Due to stigma and systemic racism, migrants and refugees can be fearful that they will suffer consequences such as visa revocation or imprisonment if their AOD use is revealed. They may come from countries with punitive instead of recovery-based support

2. Seeking Support

Building up AOD specific health literacy is necessary to improve service access.

It can be hard to encourage members of multicultural communities to seek help. Unfortunately, many do not engage treatment services voluntarily; delaying treatment can exacerbate substance dependence issues, resulting in more severe health and social issues, such as an acute health issue or justice intervention. For many migrant and refugee communities, counselling is a foreign concept. There is a need to use language suitable to the communities at hand as well as enhance health literacy.

6. Victorian Alcohol and Drug Association (2019) *CALD AOD Project: Final Report*, VAADA, Collingwood [accessed 15 January 2020]
7. Beyer, L & Reid, G 2000, *Drugs in a Multicultural Community: An Assessment of Involvement, Department of Human Services*, Public Health Division, Melbourne

Health literacy can best be built through community engagement programs co-designed with the community and delivered by them. AOD staff need to be briefed on appropriate cultural norms, including how different communities perceive problematic substance use and what their particular help-seeking behaviours look like, and understand matters such as the importance of family support in treatment for many multicultural communities. There must be an accessible pool of interpreters skilled in working in therapeutic environments to support people to engage the AOD system.

A representative from an ethno-specific community organisation spoke about a young man who they have been trying to assist with his problem drinking. His reluctance to accept treatment stems partly from his concerns about lack of privacy and confidentiality if he seeks treatment. He thinks that government agencies and other members of his community will know about his issues and that he'll lose access to other support if he enters treatment. He therefore keeps attending the community organisation for support, but they are limited in how they can assist him as they receive no funding in this area.

3. Diversity and Cultural Safety

Bicultural workers are key to enhancing cultural safety and building the relations necessary for enduring change; however, agencies need to be resourced to maintain relations between AOD agencies and various communities.

The importance of diverse and culturally capable AOD workforces was a recurring theme in the survey and round-table. Such workforces will have an appreciation of the cultural norms applicable to different cultural groups, and can ensure that individuals presenting to services feel genuinely valued, welcomed and supported. Cultural safety can best be improved by the diversification of workforces at every level.

One participant noted how important it is that AOD services "have someone that looks like you and speaks the same language". Another gave an example of how a lack of cultural safety can manifest when a receptionist at an AOD service asking a client for their Christian name.

Bicultural workers can provide both cultural expertise and connections to communities. With appropriate funding, AOD organisations can employ bicultural workers both to build relationships with migrant and refugee communities, but also identify their needs and work collaboratively with them to develop community-led programs that support the development of AOD health literacy, reduce stigma and ultimately improve access to services. They can work effectively with their specific cultural/language group, and may be able to work cross-culturally in certain specific circumstances. However, it is important that bicultural workers should not be the sole solution to supporting migrant and refugee communities.

Bicultural workers would also play an important role in increasing the cultural capability of the AOD workforce. They would also play a role in building relationships with community leaders; however, these relationships and the broader notion of enhancing agency cultural capability should not fall solely to bi-cultural workers. AOD and migrant and refugee community agencies should be supported to build and maintain these relationships. Organisations that employ bicultural workers should receive training in how to effectively support them. Employee Assistance Programs and supervision must also be culturally responsive.

Culturally appropriate service delivery modes will also take a holistic approach and consider the range of social determinants of health that may be affecting people experiencing AOD harm, including but not limited to mental health, housing and employment. Staff will be able to determine if these issues are present and refer clients for support while they receive AOD treatment.

4. Improving Service Provision

Optimal AOD service delivery for people from migrant and refugee backgrounds have culturally appropriate intake systems, long term funding, a coordinated response, culturally appropriate means of service delivery and are evaluated.

There is a consensus view among migrant and refugee communities that effective AOD models would:

- Simplify complex intake processes
- Include more assertive outreach
- Take a holistic approach
- Deliver services in safe places that people from migrant and refugee backgrounds can access
- Maintain funding models that afford a level of flexibility to enable community-preferred treatment services.

While there are a range of pilots, short-term initiatives and unfunded programs, which profess strong anecdotal evidence, these are rarely evaluated. There is a need to identify a number of specific at-risk refugee and migrant communities and to pilot long-term service models using all the elements that have been shown to be effective, and use this to develop an evidence base. Evaluations should use a combination of statistical and qualitative analyses that gather evidence about treatment access, barriers, efficacy and recommended improvement strategies directly from community members and consumers.

Optimal outcomes are most common when AOD services work in conjunction with agencies that already work with at-risk refugee and migrant communities, who in return help to build their cultural capability. Facilitating this coordinated service response may involve a range of structures, including partnerships, co-located services and staff placements. These various collaborations should be supported by a lead coordinating role within the peaks. This role would support collaboration, facilitate enhanced culturally sensitive practice and provide a liaison point between the Department of Health and the broader sectors.

The most effective approaches are those which engage and enhance the health literacy of vulnerable people from migrant and refugee communities who face challenges navigating a new culture and institutions. Both online and paper-based endeavor should be considered.

Many community organisations lack resources for their AOD treatment programs, which makes it difficult to meet demand. It also inhibits any program evaluation.

There is a need for greater community input into the policy design of agencies. Some mainstream AOD agencies have peer networks and consult with service users, but these rarely include people from migrant and refugee backgrounds.

5. Funding Models

In alignment with Productivity Commission findings, models that adopt a longer contract period are vital for program sustainability and long-term community engagement.

Many participants in the round-table noted the important work being done by multicultural and ethno-specific organisations that are not funded for AOD work. Other multicultural organisations who have received funding noted that, unlike other AOD service funding, it was generally short-term (sometimes as part of a pilot program), making it difficult to achieve progress given the need for long-term support often required to address substance dependence issues.

Short-term programs make service planning difficult, reducing the agency of organisations to determine their own paths, and are difficult to recruit for. They often make progress but regress when the funding ends, thereby creating false expectations but ultimately being damaging to communities. It was also noted that the Productivity Commission has recommended that contracts for community services should be for seven years in order to be properly effective[8].

8. https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms.pdf p 263

Recommendations

ECCV and VAADA make the following recommendations to the Victorian Government:

1. Resourcing be provided to enable the establishment of interagency partnerships between multicultural and AOD services to support and develop more accessible and culturally safe services. This should include support for multicultural organisations to lead ongoing health promotion campaigns in their communities aimed at reducing the stigma attached to AOD use; it should include resourcing for the development of translated materials.

2. That people with limited English proficiency are supported to access AOD services through resourcing to increase the availability of qualified interpreters with enhanced capability in working with people experiencing AOD issues or suitably trained bicultural workers who can act as intermediaries, and ensuring that service users are aware of their right to access free interpreting. These interpreters and bicultural workers should be skilled in interpreting in therapeutic environments.

3. That funding is provided to establish a pilot program placing two bi-cultural liaison workers into AOD treatment services across four AOD catchment areas for five years. This should also provide for two capacity building project support officers to support the liaison workers, to increase migrant and refugee community access to AOD services and build the capacity of AOD services to cater for the needs of these communities.

4. That continued funding is provided to resource cultural safety training to staff working in the AOD service sector, which includes capacity to modify funded treatment programs in line with culturally sensitive practice.

5. That all AOD-related pilot programs to support multicultural communities are resourced and required to be properly monitored and evaluated, in order to build an evidence base about which methods of support are most effective in minimising AOD harm.

6. That funding is provided to enable the Department of Health, in collaboration with VAADA and multicultural community representatives, to explore avenues for a broader systemic approach to improving the capacity of AOD agencies to provide culturally responsive services, appointing a coordinating role to progress these activities. This should include a co-design process to develop culturally appropriate in-language materials and messaging relating to AOD harms, accessing services and harm reduction.

7. That culturally sensitive means of conducting intake and comprehensive assessment are determined, and funded, to increase service access among migrant and refugee communities.

8. That resourcing is provided for increased data collection, analysis and research. There is a need to ascertain AOD related harms within migrant and refugee communities and to analyse the longer-term outcomes in accessing AOD treatment and support services, in order to develop an evidence base about the most effective support models. Research should also be undertaken to ascertain the particular experiences and needs of international students experiencing AOD harm, and how these impact subsequence service access.

9. That there is an assurance of recurrent funding for all migrant and refugee-related AOD treatment programs for 5-year cycles with periodic reviews to ensure the service is meeting its objectives.

Appendix

Organisations engaging in innovative AOD work with multicultural communities

Several community organisations have been performing innovative work supporting members of multicultural communities who are experiencing AOD harm. The following profiles of four of these organisations demonstrate the successful outcomes that can result from partnerships and close work with communities, while also showing some of the issues that such programs can face, and the limitations resulting from short-term and insufficient funding.

Migrant Information Centre - Eastern Melbourne

The Migrant Information Centre (Eastern Melbourne) (MIC) began working in the AOD space after observing excessive alcohol consumption in public spaces by men from the local Burmese Chin communities. After being approached by the police to see how they could be supported, MIC formed partnerships with Turning Point addiction services and Link Health (later Latrobe Health), who took referrals, provided counselling, and with MIC provided community education to address the stigma and cycle of victim-blaming that stopped people from accessing services.

When funding for these partnerships ceased, MIC formed a new partnership with the EACH Substance Use Recovery (SURe) program, which employed a counsellor familiar with the Chin community who agreed to support MIC East's work with them. Now MIC refers clients to SURe to receive culturally appropriate support and treatment for substance dependence. MIC also provides information about AOD treatment and support at settlement services and family violence prevention sessions presented by SURe.

MIC works with Pastors from the Chin communities (which are predominantly Christian) who agree to help individuals exhibiting harmful AOD behaviours by removing them from the spaces in which they consume alcohol and helping them to recover.

Community education is provided through men's programs to teach about AOD and how to overcome the cycle of substance dependence. Further education about overcoming AOD harm is provided to community and faith leaders.

MIC staff also assist community members experiencing AOD harm to complete the intake and assessment process for AOD treatment. While assisting their clients to complete this, they witnessed the barriers that language can provide to accessing treatment. The first part of the form asks potential clients about their mental health, but there are no Chin words that translate for terms like "depression", "stress" and "anxiety". The second part of the form asks clients what they are taking and how often- many clients are reluctant to share this information due to shame and stigma. Therefore, partner AOD counsellors complete the forms with the client over a period of time, as trust is built.

Multicultural Drug and Alcohol Partnership led by the Centre for Culture, Ethnicity and Health

In response to growing concerns about harmful AOD use among young people from South Sudanese backgrounds in Melbourne, the Centre for Culture, Ethnicity and Health (CEH), a program of North Richmond Community Health, established the Multicultural Drug and Alcohol Partnership (MDAP) as a two-year pilot program in June 2019, with funding from the North Western Melbourne Primary Health Network (NWMPHN). MDAP aimed to support young people from the South Sudanese community in the City of Yarra who were experiencing AOD harm through engagement with them and their families, and by linking them to AOD treatment and support services, including detox and rehab services.

In addition, MDAP aimed to improve community understandings of harm reduction, available treatment and support options, and to equip AOD services to deliver more culturally responsive care. The program was built on an ongoing community partnership model that involved building relationships with other agencies working with South Sudanese youth on health promotion and harm reduction.

The COVID-19 pandemic made it difficult for the outreach model to be fully implemented, as much of it involved the bicultural outreach workers 'hanging out' on the estates and meeting young people where they were. Some of the outreach was replaced by online forums and education sessions. Although this meant the program could not reach the same groups of young people (who may not have been connected online) it arguably had some benefits in allowing more people to engage, greater flexibility, and anonymous participation.

Between lockdowns, MDAP outreach workers made regular visits to areas where South Sudanese young people lived, playing sport with them and organising social events. Once trust and rapport were built, young people began to feel comfortable speaking to outreach workers about their AOD-related concerns. Outreach workers used a holistic approach in engaging with dozens of young people about issues underlying their AOD use and referred them to services such as employment, housing, legal, mental health, and help to apply for citizenship. Sixteen young South Sudanese community members were recruited and trained as peer educators to run community education sessions.

MDAP also established a Community Reference Group to build partnerships with the local police, to run a South Sudanese women's gathering that talked about AOD issues in Dinka and to share information about MDAP, AOD issues and services available in the community. MDAP delivered twelve cultural safety training sessions to AOD treatment and support services, providing staff with new knowledge and skills to better work with South Sudanese community members.

Based on the two years of MDAP, it could be argued that the initial conceptualisation of the project – supporting young South Sudanese people to access AOD treatment options- was overly ambitious. It did not account for the considerable time needed to develop trusting relationships with young people and support them to make significant decisions to access treatment services whilst ensuring that the response is culturally appropriate.

The evaluation of MDAP by the Burnet Institute noted that:

> "Any future funding for programs targeting marginalised CALD communities must factor in the significant time required to build meaningful trust and rapport to achieve program objectives."

Multicultural Women Victoria

Multicultural Women Victoria (MWV) receives a small amount of funding from the Australian Drug Foundation (ADF) to provide AOD education and capacity building to women from multicultural backgrounds in Melbourne.

In the first year of this partnership, MWV provided community information and education sessions following a request from the women. The women they work with often do not have high levels of awareness about the risks of AOD harm, so MWV talked to them about different types of drugs, and about why alcohol consumption is so central to Australian culture. Often they provided support to mothers who were unsure how to help their children who used AOD. They worked to raise awareness of what services are available in particular neighbourhoods.

MWV used some of the ADF funding to build links with community AOD service providers and help them to understand the barriers that multicultural women face in accessing their services and to seek support for referrals and information. Due to the demand for services, this was not successful and although there was a willingness in most cases to talk through approaches about improving their cultural engagement, time and resources were not readily available.

In this, the second year of the partnership, MWV has decided to take advantage of its close community connections by changing its approach to focus on outreach work and capacity building.

This involves encouraging new migrant women to attend MWV's social support groups, where MWV provides a conversations-based learning module, which covers issues such as family violence, managing Centrelink, accessing My Aged Care, and personal health and wellbeing including AOD harms.

MWV also assists women who are prescribed medication by their GPs for mental health issues and trauma, usually without referral to any other service or follow up. In cases where there is follow up, they observed that this is rarely provided in a culturally comfortable manner. Without careful management, these prescriptions can easily lead to dependency, so MWV encourages women to be engaged in its activities to ensure they are supported if any signs of dependency arise.

The ADF's funding covers only a small proportion of MWV's AOD work. The rest is paid for through general funding from the Victorian Multicultural Commission, Department of Health, and various local governments.

Youth Support and Advocacy Service

The Transformer Program (CALD Youth AOD Outreach)

The Transformer program in the Southeast Metro growth corridor (Dandenong, Casey and Cardinia) targets disengaged young people (12-25 years) from predominantly African backgrounds who are experiencing emerging and problematic AOD use and who are at risk of enduring poor health and social outcomes. This includes young people who have experienced:

- Prolonged disengagement from positive community participation
- Adverse health and wellbeing impacts associated with serious substance use
- Involvement in the statutory service systems
- Early school disengagement
- Limited employability
- Dissonance with their family and community

YSAS has sustained CALD specific youth AOD services over a long period of time by utilising ad-hoc funding methods such as small government grants, philanthropy or drawing from organisational reserves. The Transformer program is presently funded by the Victorian Government in an arrangement that is reviewed annually.

The effort to ensure continuity of this service has resulted in our staff being highly trusted by the community and this has in turn ensured a high volume of young people are engaged and retained in support and treatment.

Background

The Transformer program is a location-based approach designed to assist marginalized young people with intense and complex needs. Innovative and resilience-based, Transformer targets a sub-population of predominately African-Australian young people who experience severe marginalization. This marginalization is highly correlated with:

- Individual jeopardy (alcohol and drug abuse; unemployment; statutory system involvement; incarceration; self-harm; being the victim of crime including family violence)
- Community jeopardy (criminal acts to person and property; social disintegration; endangered neighbourhood liveability; over-use of judicial and health resources).

Vulnerable young people targeted by Transformer do not tend to reach out and ask to become clients. They do not present saying *'please help. I have a problem.'* Because they are sensitive to feelings of shame and inferiority the traditional model of professional practice – the approach based on insightful, overtly motivated clients acknowledging they are not managing – does not work.

Action-based learning has taught Transformer staff that the first step towards engagement is to demonstrate usefulness. As is the case with any group who have experienced trauma and discrimination, potential Transformer clients tend to actively distrust officials whether these adult authority figures are white or ethno-specific. This means credibility has to be earned in practical ways.

This takes the form of broad-based practical wrap-around support to assist young people – and crucially, their families and carers – to navigate and negotiate a myriad of barriers to pro-social community participation.

Acting as youth and family worker and advocate, Transformer workers assist young people and families to attain education enrolment; employment services; Centrelink benefits; legal services; financial advice; primary and mental health support.

Transformer workers play a pivotal role in guiding and mentoring families with refugee backgrounds who have often suffered failed settlement experiences. Crossing such bridges entails a to-and-fro process. Repeat efforts, stops and starts, knowing when to back-off, but also sensing when it is timely to try again, are characteristic of this component of the program and is a non-linear process. Set-backs, as well as the occasional failure, need to be expected.

Within these demanding conditions advanced practice skills are called for. Enterprise and sensitivity are required. Non-procedural, and in a crucial way free-wheeling, casework in the Transformer program necessarily operates at the locus of intense uncertainty. For example, to be able to see opportunities where none are obvious requires both a practical kind of imagination and a tolerance for considerable uncertainty. Without this combination of highly developed professional competencies and personal attributes this balance is difficult to achieve but highly effective when it is.

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