A Narrative Literature Review of the Prevalence, Barriers and Facilitators to Treatment for Culturally and Linguistically Diverse Communities Accessing Alcohol and Other Drug Treatment Services in Australia

Dr Seraina Agramunt BSc (University of Geneva), MSc (University of Geneva), MAS (University of Geneva), PhD (Curtin University) &
Dr Robert Tait BSc Hons (UWA), PhD (UWA)
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EXECUTIVE SUMMARY

Introduction, aims and objectives

Australia is a multi-cultural society and includes a large number of individuals from Culturally and Linguistically Diverse (CaLD) backgrounds. Many people from CaLD backgrounds face numerous difficulties and stressors inherent to the acculturation process when settling in Australia. These may lead to increased mental health issues including problems relating to alcohol and other drug (AoD) use. With the increasing number of people belonging to CaLD populations in Australia, it is a necessity to ensure that AoD treatment services respond to their clients' needs, and are holistic and culturally sensitive in nature. Identifying the barriers and facilitators to treatment could highlight the areas that require further development, in order to improve client satisfaction, as well as the quality of services.

The aim of this narrative literature review was to summarise the literature available about the prevalence of AoD use by CaLD groups in Australia, and identify the barriers and drivers to treatment for these groups.

Methods

A comprehensive review of the literature published on the prevalence, barriers and facilitators to treatment for CaLD populations accessing AoD treatment services in Australia was undertaken for relevant documents published since 2000. Different databases were consulted, including the Cochrane Library, Google Scholar, Informit, Medline, Ovid, ProQuest, PsycInfo, PubMed, ResearchGate, ScienceDirect, Scopus, Taylor & Francis, SpringerLink, and Web of Science. Articles were reviewed if they included CaLD communities in Australia, and at least one of the following outcomes: prevalence, barriers, and facilitators to AoD treatment services. Articles were excluded if they were not written in English, were not available online, were specifically addressing tobacco use services, or were published as conference abstracts, factsheets, or editorials.

Results

There is limited information available about the prevalence of AoD use among CaLD populations in Australia. Studies have reported lower levels and prevalence of AoD use among people from CaLD backgrounds in comparison to the mainstream population. Limited access to appropriate cultural programs, language barriers, lack of awareness of support available, lack of trust in service providers, lack of mental health literacy, civil and religious factors,

stigma/shame/stereotypes associated with AoD use, financial difficulties, as well as a strong desire to be accepted by the welcoming country were recurrent factors identified as barriers to treatment. Emotional support from peers, their community, social media, the use of bilingual workers, and the perceived expertise of health workers were commonly perceived as facilitators to treatment. For some groups, cultural and religious beliefs support rather than impede engagement and treatment. The findings were contextualised with qualitative reports from consumers and health workers.

Conclusions

There is limited information available on the prevalence of AoD use among CaLD populations in Australia. Further research is required to identify whether the actual models of intervention offered to CaLD populations are culturally sensitive, holistic in nature and tailored to clients' needs and cultural groups. Initial findings suggest that treatment interventions should promote peer support, psycho-education programs and take into account clients' religious and cultural beliefs, as well as issues related to gender differences, and focus on reducing stigma associated with AoD use.

Keywords

Prevalence, illicit, drug, alcohol, substance use, AoD, barriers, challenges, facilitators, drivers, treatment, intervention, CaLD, migrants, refugees.

1 INTRODUCTION

1.1 Culturally and Linguistically Diverse (CaLD) communities in Australia

Australia is a multi-cultural society (AIHW, 2018) with nearly a third of its residents (32.3%) born overseas (Rowe, Gavriel Ansara, Jaworski, Higgs, & Clare, 2020; Australian Bureau of Statistics, 2017). People from Culturally and Linguistically Diverse (CaLD) backgrounds, defined as "*groups or individuals who differ according to religion, race, language or ethnicity, except those whose ancestry is Anglo Saxon, Anglo Celtic, Aboriginal or Torres Strait Islander*" (Office of Multicultural Interests, 2010) account for a large number of individuals residing in Australia (Australian Institute of Health and Welfare (AIHW), 2018). More than one-fifth of the Australian households (21%) speak a language other than English (Australian Bureau of Statistics, 2017), and the number of individuals who speak a language other than English at home is increasing continuously (Australian Bureau of Statistics, 2017). Table 1 lists the main ten languages spoken at home in Australia in 2011 and 2016.

Table 1. Main ten languages spoken at home in Australia in 2011 and 2016 (Source: Australian Bureau of Statistics, 2017)

	2011		**2016**	
Language spoken at home	**Number of people**	**Percentage of total population**	**Number of people**	**Percentage of total population**
Mandarin	336 410	1.6	596 711	2.5
Arabic	287 174	1.3	321 728	1.4
Cantonese	263 673	1.2	280 943	1.2
Vietnamese	233 390	1.1	277 400	1.2
Italian	299 833	1.4	271 597	1.2
Greek	252 217	1.2	237 588	1.0
Hindi	111 351	0.5	159 652	0.7
Spanish	117 498	0.5	140 817	0.6
Punjabi	71 229	0.3	132 496	0.6
English Only	16 509 291	76.8	17 020 417	72.7
Australia[1]	**21 507 717**	**100**	**23 401 892**	**100**

[1] Total includes all languages spoken at home and 'not stated'.

1.2 Alcohol and drug use among CALD communities

Overall, people from CaLD backgrounds have a lower prevalence of AoD use than the general population (AIHW, 2020). However, many people from CaLD backgrounds are faced by multiple difficulties and stressors inherent to the acculturation process when settling in Australia (e.g. Khawa & Milner, 2012; Milner & Khawa, 2010; Poppitt, & Frey, 2007; McCann, Mugavin, Renzaho, & Lubman, 2016; Smith & Reside, 2010). These acculturation stressors might include financial difficulties, language barriers, new cultural and social norms, racist behaviours, and loss of social network (McCann, Mugavin, Renzaho, & Lubman, 2016; Smith & Reside, 2010). Further, a desire for acceptance may increase substance use (Browne & Renzaho, 2010).

Overall, these may lead to increased mental health issues including AoD use (Foundation House, 2013; Reid, Aitken, Beyer, & Crofts, 2001). For example, a recent study aiming to analyse the risk factors and patterns of coexisting mental health and AoD issues among youth refugees in Australia found that pre-migration experience of torture and trauma, familial factors, adjustment difficulties to the new culture, maladaptive coping strategies, and lack of access to information were all common factors associated with the development of both substance use and mental health issues (Posselt, Procter, Galletly, & de Crespigny, 2015). Identifying the barriers and facilitators to treatment for CaLD populations accessing AoD treatment services in Australia, could contribute to improving the quality of services offered. This could also highlight various areas for intervention, as there is currently a lack of information in the literature on the efficacy of AoD treatment programs and services offered to these communities.

1.3 Aim

The aim of this narrative literature review was to review the literature on the prevalence of AoD use by CaLD groups in Australia, and identify the barriers and drivers to treatment for these groups. As such, it supplements an earlier systematic review of the treatment of AoD problems among CaLD groups.

1.4 Significance

The results of this general literature review will provide the Mental Health Commission (MHC) and other health agencies with relevant information about the prevalence of AoD use among CaLD communities in Australia. Identifying the barriers and facilitators to treatment could

highlight the areas that require further development, in order to improve client satisfaction and service quality.

2 METHODS

A comprehensive review of the literature on the prevalence of AoD use, as well as barriers and facilitators to accessing treatment in CaLD groups was undertaken in April 2020 for relevant documents published locally and nationally. Numerous sources of peer reviewed, and grey literature published in English were consulted. These included articles, theses, and government reports published since 2000.

Various databases were consulted, including the Cochrane Library, Google Scholar, Informit, Medline, Ovid, ProQuest, PsycInfo, PubMed, ResearchGate, ScienceDirect, Scopus, Taylor & Francis, SpringerLink, and Web of Science. Publications reference lists were also scanned, and relevant articles were selected from cited references included in the documents consulted.

Key words used individually and in combination in the search were as follows: '*alcohol*', '*drug*', '*substance*', '*misuse*', '*abuse*', '*illicit*', '*consumption*', '*cultural diversity*', '*CALD*', '*culturally and linguistically diverse communities*', '*non-English speakers*', '*ESL*', '*English as second language*', '*NESB*', '*Non-English Speaking Background*', '*migrants*', '*refugees*', '*asylum seekers*', '*prevalence*', '*trends*', '*treatment*', '*barriers*', '*challenges*', '*stressors*', '*drivers*', '*facilitators*', and '*experience*'.

Articles were reviewed if they included CaLD communities in Australia, and at least one of the following outcomes: prevalence, barriers, and facilitators to AoD services treatment. Consistent with the definition in the introduction, CaLD groups exclude Aboriginal or Torres Strait Islander people. Articles were then selected by the authors if they were relevant to the main themes and topics, in order to provide a general overview of the current literature on prevalence, barriers, and facilitators to AoD services treatment among CaLD populations in Australia. The findings were further illustrated with comments by CaLD consumers and health workers.

Search references were then merged using Endnote X8 Software.

3 RESULTS

3.1 Prevalence of alcohol and other drug among CaLD groups in Australia

There is a paucity of data available analysing the use of AoD among CaLD groups in Australia (AIHW, 2020; VAADA, 2016). Similarly, little is known about the prevalence of substance use among people with CaLD backgrounds (Rowe et al., 2020). Data from the 2020 National Drug Strategy Household Survey, which is the main source on AoD use amongst the CaLD population in Australia (AIHW, 2020) illustrate that overall, CaLD communities have a lower propensity to consume AoD than people who primarily speak English at home (AIHW, 2020. Table 2 illustrates the AoD use by main language spoken at home (AIHW, 2020, Table S3.53).

Table 2. AoD use by main language spoken at home, people aged 14 and over, 2013 to 2016

Drug/behaviour	**English**			**Language other than English**		
	2010	**2013**	**2016**	**2010**	**2013**	**2016**
Percentage speaking language	90.6	87.9	87.9	9.4	12.1	12.1
Tobacco						
Daily	15.5	12.9	12.8	8.6	11.3	5.9#
Weekly	1.5	1.4	1.4	*1.9	1.1	*0.9
Less than weekly	1.4	1.7	1.4	*1.1	1.2	0.9
Ex-smoker[(a)]	26.1	26.4	24.8#	8.0	9.5	9.7
Never smoked[(b)]	55.5	57.6	59.5#	80.4	76.9	82.6#
Mean number of cigarettes (current[(c)]smokers)	112.5	96.1	95.4	74.5	86.8	66.4#
Alcohol						
Abstainers/ex-drinkers[(d)]	16.4	17.5	18.9#	50.5	49.1	49.4
Lifetime risk: Low risk[(e)]	61.7	62.7	62.4	44.0	43.6	45.2
Lifetime risk: Risky[(f)]	22.0	19.8	18.6#	5.5	7.3	5.4#
Single occasion: Low risk[(g)]	40.4	42.0	40.9	34.0	30.2	33.1
Single occasion: At least yearly but not monthly[(h)]	12.4	12.1	12.6	5.4	7.3	7.2
Single occasion: At least monthly[(i)]	30.8	28.4	27.6	10.2	13.3	10.3#
Any illicit drug[(j)]						
Never used	58.0	55.6	54.1#	85.2	78.9	82.3#
Ex-user	26.9	28.7	29.5	7.4	12.3	10.1
Recent user	15.1	15.6	16.4	7.4	8.8	7.6
Cannabis						
Never used	61.9	62.4	61.6	91.1	85.0	90.4#
Ex-user	27.3	26.9	27.1	5.3	9.6	6.2#
Recent user	10.8	10.7	11.3	3.6	5.4	3.3#

Drug/behaviour	English			Language other than English		
	2010	2013	2016	2010	2013	2016
Ecstasy						
Never used	88.9	88.8	87.6#	97.9	97.1	98.0
Ex-user	8.0	8.5	10.0#	*1.1	2.2	1.7
Recent user	3.2	2.7	2.4	*1.0	*0.7	*0.4
Meth/amphetamine[k]						
Never used	92.5	93.1	93.1	98.8	97.4	98.9#
Ex-user	5.4	4.7	5.4#	*0.7	1.8	*0.7#
Recent user	2.2	2.2	1.5#	*0.5	*0.8	**0.3
Cocaine						
Never used	92.2	91.6	90.1#	98.4	97.6	98.0
Ex-user	5.5	6.1	7.1#	*1.2	1.6	1.4
Recent user	2.3	2.3	2.7	*0.4	*0.8	*0.6
Painkillers/analgesics and opioids						
Never used	n.a.	n.a.	90.3#	n.a.	n.a.	92.8#
Ex-user	n.a.	n.a.	6.2#	n.a.	n.a.	4.2#
Recent user	n.a.	n.a.	3.5#	n.a.	n.a.	3.0
Pharmaceuticals[k]						
Never used	n.a.	n.a.	86.9#	n.a.	n.a.	92.0
Ex-user	n.a.	n.a.	8.3#	n.a.	n.a.	4.6
Recent user	n.a.	n.a.	4.8	n.a.	n.a.	3.4

(Source: AIHW, 2020, Table S3.53)

* Estimate has a relative standard error of 25% to 50% and should be used with caution.
# Statistically significant change between 2013 and 2016.
(a) Smoked at least 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco in their life, and reported no longer smoking.
(b) Never smoked 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco.
(c) Includes people who reported smoking daily, weekly or less than weekly.
(d) Not consumed alcohol in the previous 12 months.
(e) On average, had no more than 2 standard drinks per day.
(f) On average, had more than 2 standard drinks per day.
(g) Never had more than 4 standard drinks on any occasion.
(h) Had more than 4 standard drinks at least once a year but not as often as monthly.
(i) Had more than 4 standard drinks at least once a month.
(j) Illicit use of at least 1 of 16 classes of drugs in the previous 12 months in 2016. The number and type of illicit drugs used has changed over time.
(k) For non-medical purposes.

3.1.1 Alcohol use

More specifically, it was found that approximately half of the CaLD sample did not consume any alcohol in the last 12 months (49.4%), while this occurred for 18.9 per cent of people whose main language spoken at home was English (AIHW, 2020). There were also some differences between the two groups, in terms of the numbers of standard drinks consumed. People whose first language spoken at home was English were more likely to have more than 2 standard drinks per day, on average (18.6%), in comparison to 5.4 per cent of individuals from CaLD

backgrounds (AIHW, 2020). In addition, a greater proportion of primary English speakers (27.6%) consumed more than 4 standard drinks on one occasion, and at least monthly, compared to 10.3 per cent of people from CaLD backgrounds (AIHW, 2020). There was also a significant reduction in the number of people from CaLD groups who consumed more than 4 standard drinks on one occasion, at least monthly, between 2016 (10.3%) and 2013 (13.3%), while this remained constant for primary English speakers (AIHW, 2020). Similar results were obtained in the 2013 National Drug Strategy Household Survey (Rowe et al., 2020) with individuals from CaLD groups more likely to report being ex-drinkers, and less likely to report use of alcohol in their lifetime than primary English speakers. People from CaLD groups were also more likely to report using harm reduction strategies (e.g. counting the number of drinks, eating while drinking alcohol) associated with drinking than English speakers (Rowe et al., 2020).

3.1.2 Illicit Drug use

In terms of illicit drug use, people from CaLD backgrounds (82.3%) were more likely to report that they had never used any illicit drugs in the last 12 months, compared to primary English speakers (54.1%) (AIHW, 2020). There was also a significant increase in the number of people from CaLD groups abstaining from illicit drug use, between 2016 (82.3%) and 2013 (78.9%), while there was a decrease in the frequency of primary English speakers doing so (55.6% in 2013; 54.1% in 2016) (AIHW, 2020). There were also more recent users of any illicit drugs in the last 12 months among the primary English speakers (16.4%) than among the CaLD groups (7.6%) (AIHW, 2020). However, primary English speakers were more likely to be ex-users (29.5%) than people belonging to the CaLD groups (10.1%) (AIHW, 2020). Similar results were found in the 2013 National Drug Strategy Household Survey (Rowe et al., 2020), with CaLD participants less likely to report any illicit drug use in their lifetime or in the last 12 months prior to the survey than primary English speakers (Rowe et al., 2020).

Data from the 2020 National Drug Strategy Household Survey revealed that non-medical pharmaceuticals were the most common illicit drugs used recently by the CaLD groups in the last 12 months (3.4%), followed by cannabis (3.3%), painkillers/analgesics/opioids (3%), cocaine (0.6%), ecstasy (0.4%), and meth/amphetamine (0.3%) (AIHW, 2020). In comparison, cannabis was the most common illicit drug used by the primary English speakers (11.3%), followed by pharmaceuticals (4.8%), painkillers/analgesics/opioids (3.5%), cocaine (2.7%), ecstasy (2.4%), and meth/amphetamine (1.5%) (AIHW, 2020).

Drug use amongst CaLD communities may not be homogeneous. For example, a study looking at the AoD use, attitudes and knowledge among six different CaLD groups in Sydney found that 30 per cent of people belonging to the Pasifika community reported having ever used any illegal drugs, followed by 20 per cent of Spanish speaking, 14 per cent of Italians, 11 per cent of Vietnamese, 10 per cent of Arabic speaking, and 8 per cent of Chinese (Donato-Hunt, Munot, & Copeland, 2012). Recent use of any illegal drugs in the last 12 months was reported by 9 per cent of Spanish speaking, 8 per cent of Pasifika, 4 per cent of Italians, 4 per cent of Vietnamese, 3 per cent of Chinese, and 2 per cent of Arabic speaking (Donato-Hunt et al., 2012). Cannabis was found to be the most frequent illicit drug used amongst the Chinese, Vietnamese, Italian, Pasifika, Arabic-speaking, and Spanish-speaking communities in Sydney (Donato-Hunt et al., 2012). More specifically, 28 per cent of participants belonging to the Pasifika community reported having ever used cannabis, followed by 20 per cent of Spanish speaking, 14 per cent of Italians, 9 per cent of Arabic speaking, 8 per cent of Vietnamese, and 5 per cent of Chinese (Donato-Hunt et al., 2012). Recent use of cannabis in the last 12 months was reported by 8 per cent of Spanish speaking, followed by 5 per cent of Pasifika, 3 per cent of Italians, and 1 per cent of Arabic speaking, Chinese, and Vietnamese (Donato-Hunt et al., 2012).

3.1.2.1 Cannabis

There was a higher proportion of people among the CaLD groups who reported having never used cannabis (90.4%) in comparison to primary English speakers (61.6%) (AIHW, 2020). There was also a statistically significant increase in the frequency of people who reported having never used cannabis between 2013 (85.0%) and 2016 (90.4%) amongst individuals from CaLD backgrounds (AIHW, 2020). No statistically significant differences between 2013 and 2016 were reported among the primary English speakers (AIHW, 2020). However, a higher number of primary English speakers were ex-users of cannabis (27.1%), compared to individuals from CaLD groups (6.2%) (AIHW, 2020).

3.1.2.2 Ecstasy

Similarly, individuals from CaLD backgrounds were more likely to have never used ecstasy (98.0%), compared to primary English speakers (87.6%) (AIHW, 2020). Less than 1 per cent of people from the CaLD groups (0.7%) reported being ex-users of ecstasy, while this occurred for 10 per cent of individuals whose main language spoken at home was English (AIHW, 2020).

3.1.2.3 Methamphetamine and amphetamine

A higher proportion of individuals from the CaLD groups reported having never used meth/amphetamine for non-medical purposes (98.9%), while this occurred for 93.1 per cent of primary English speakers (AIHW, 2020). There was also a statistically significant increase in the frequency of people who reported having never used meth/amphetamine between 2013 (97.4%) and 2016 (98.9%) amongst individuals from CaLD backgrounds (AIHW, 2020). No statistically significant differences were reported among the primary English speakers (AIHW, 2020). Ex-users of meth/amphetamine accounted for 0.3 per cent of the individuals from CaLD backgrounds and for 5.4 per cent of the people whose main language spoken at home was English (AIHW, 2020).

3.1.2.4 Cocaine

Similarly, there was a higher proportion of individuals from CaLD backgrounds (98.0%) who reported that they had never used cocaine, compared to 90.1 per cent of primary English speakers (AIHW, 2020). Primary English speakers (7.1%) reported more often being ex-users of cocaine than people among the CaLD groups (1.4%) (AIHW, 2020).

3.1.2.5 Pharmaceuticals for non-medical purposes

Similarly, a higher number of people from CaLD background reported having never used pharmaceuticals for non-medical purposes (92%), while this occurred for 86.9 per cent of the primary English speakers (AIHW, 2020). Pharmaceuticals for non-medical purposes have been defined as "*the consumption of a prescription or over-the-counter drug for non-therapeutic purposes or other than directed by a registered healthcare professional*" (Larance, Degenhardt, Lintzeris, Winstock, & Mattick, 2011; cited in AIHW, 2020). Pharmaceuticals included pain-killers/analgesics and opioids, tranquillisers/sleeping pills, methadone/buprenorphine and steroids. There was a higher frequency of individuals amongst the CaLD groups who reported having never used painkillers/analgesics/opioids (92.8%), compared to primary English speakers (90.3%). However, a higher number of people for whom English was the main language spoken at home (6.3%) reported being ex-users of pain-killers/analgesics/opioids, in comparison to people from CaLD backgrounds (4.2%) (AIHW, 2017).

3.1.2.6 Kava and khat

The National Drug Strategy Household Survey does not currently separately report the prevalence of kava or khat use in Australia, as the data are combined with other psychoactive substances (AIHW 2020). In 2004, the national prevalence of kava use was reported at 2 percent (AIHW, 2005). Kava is mainly used for ceremonial, medicinal and recreational purposes in Pacific Island communities. There are few data on the adverse effects of kava or detail of clinical features such as dependence: overall the risks appear to be low, but long-term, heavy use may cause liver damage and other health problems (Butt, 2019; Pantano et al. 2016)[1].

A recent report by the Alcohol and Drug Foundation (ADF 2020) found that there were currently no data on the prevalence of khat use in Australia. Khat has traditionally been used in countries in East Africa and the Arabian Peninsula (Jerah et al. 2017). Khat can have adverse effects on the cardo-vascular system, liver function and gastro-intestinal system (Jerah et al 2017); Pantano et al 2016). An Australian exploratory survey among African migrants found that just under half screened as positive for dependence on khat (Young et al, 2016). Notably, as a stimulant similar to amphetamine, stimulant induced psychosis, often with paranoia, following severe intoxication is possible (Kalix 1988).

3.2 Treatment

Some studies suggest that CaLD populations are underrepresented at AoD treatment services (AIHW 2017), as they have a reduced likelihood of seeking help than non-CaLD populations (Drug Policy Expert Committee, 2000). However, data from the 2013 National Drug Strategy Household Survey found that CaLD and non-CaLD participants who had ever used AoD did not differ in terms of access to online help and education, counselling, rehabilitation and withdrawal units, telephone helpline and peer support groups (Rowe et al., 2020). Recent Australian data from the Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW, 2019a) found that the majority of closed AoD treatment episodes delivered between 2017 and 2018 (n=208,935) were for users who were born in Australia (86%; n=180,721) (AIHW, 2019a). Only a small percentage of people who were born outside Australia received AoD treatment during this period of time, with the United Kingdom (2.5%; n=5320) and New Zealand (2.3%; n=4856) being the next most frequent countries of birth reported (AIHW, 2019a). Less than 1000 treatment episodes were recorded for people who

[1] The report by Butt (2019), also provides information on the use of kava among Aboriginal and Torres Strait Islander communities.

were born in Vietnam (n=951), South Africa (n=801), Sudan (n=782), India (n=730), Ireland (n=564), the United States of America (n=487), the Philippines (n=412), and Germany (n=387) (AIHW, 2019a). Treatment episodes recorded for people born in other countries accounted for 4.4 per cent (n=9246) of episodes (AIHW, 2019a). English was the most common preferred language reported by the clients (96%) (AIHW, 2019a). More specifically, similar trends were obtained in Western Australia, as 82 per cent of clients reported being born in Australia and having English as their most preferred language (98%) (AIHW, 2019a). These results are in line with national Australia data which suggests that people form CaLD backgrounds have a lower tendency to consume AoD than primary English speakers (AIHW, 2019a,b, 2017). However, they are in contrast to the 21 per cent who speak a language other than English at home (Australian Bureau of Statistics, 2017) and the approximate 25 per cent of the population from CaLD backgrounds [2] (ABS 2017).

Various studies have suggested that the data on substance abuse amongst people from CaLD backgrounds may be unreliable (Browne & Renzaho, 2010) and very difficult to identify, as there are significant limitations in the way data are collected (Rowe, 2020; DAMEC, 2019). This could be due to a variety of factors, such as low participation rates in research (Browne & Renzaho, 2010), the use of English-language household surveys (Donato-Hunt, et al., 2012), and the stigma and stereotypes associated with substance use in these communities (Browne & Renzaho, 2010; McCann et al., 2016).

Horyniak et al. (2014) identified various barriers that prevented a group of African youth based in Melbourne from taking part in their research study on drug injecting behaviours. These included: limited experiences in health research; being unaware of the difference between research and service provision; beliefs that participating in a research study would not result in changes; fearing that they would be reinforcing community stereotypes; and, community stigma (Horyniak et al., 2014). As a consequence, it has been suggested that some CaLD populations may in fact have higher rates or are more at risk of using AoD than people born in Australia (Department of Health, 2017; VAADA, 2016). For example, a cross-sectional study of CaLD populations in Sydney reported that some CaLD groups were more likely to engage in binge drinking than non-CaLD groups (Donato-Hunt et al., 2012). It has been suggested that extrinsic factors such as negative past experiences, grief, loss, torture, trauma, history of displacement,

[2] e.g. Approximated from those not born in Australia, UK, NZ, Canada or the USA

family stressors, intergenerational conflicts, English language problems, unemployment, financial difficulties, difficulties adjusting to the new cultural environment, poor knowledge of health education, as well as social and cultural discrimination, (AIHW, 2019a; Department of Health, 2017; Drug Policy Expert Committee, 2000; VAADA, 2016) might contribute to this vulnerability.

Furthermore, some cultural factors might also have an impact of on the use of AoD amongst certain CaLD populations (Department of Health, 2017). For instance, it has been suggested that some CaLD populations might have an increased risk of alcohol consumption when attempting to conform to 'Australia's more liberal drinking culture' (Department of Health, 2017; Lee, Sulaiman-Hill, & Thompson, 2014; Allan, Clifford, Ball, Alston, & Meister, 2012). Thus, an Australian study aiming to analyse the use of AoD amongst 268 migrant women who arrived in Perth, Western Australia, within the last 5 years, found that a third of women with CaLD backgrounds felt pressured to drink or drink more, in order to adapt to the host society's culture (Lee, et al., 2014). Furthermore, it has also been reported that some sub-sections of CaLD communities might be more at risk to AoD use than others. These high-risk groups include asylum seekers and refugee populations, CaLD pregnant women, injecting drug users, young individuals from African communities, men from the Pacific Islands, as well as Maori communities, Arabic and Turkish speaking men, some specific groups from the Middle East, as well as international students (VAADA, 2016).

Additionally, age might also have an impact on the use of AoD use amongst CaLD groups. For example, Mission Australia's Youth Survey which is the largest annual survey of young people in Australia found that there were higher levels of concern about AoD use amongst young individuals who were born overseas, and who spoke another language than English at home (Mission Australia, 2014) [3]. However, there is paucity of literature available on the effects of AOD consumption among both younger and older CALD communities. For example, it has been suggested that "*the needs from older people from culturally and linguistically diverse (CALD) backgrounds are not well understood*" (Nicholas, Roche, Lee, Bright, & Walsh, 2015).

To address their treatment needs and to help CaLD clients engage with services, treatment programs need therefore to be: culturally sensitive (Horniak, Higgs, Cogger, Dietze, Bofu, &

[3] A Mission Australia 'snapshot' report on CALD youth is scheduled for release in 2020

Seid, 2014); holistic in nature; individualised to respond to clients' needs (Gainsburry 2017; Roche, Kostadinov, Fischer, & Nicholas, 2015;VAADA, 2016) and age groups (Mission Australia, 2014); and, address the barriers that prevent people from seeking treatment (Horyniak, et al., 2014).

3.2.1 Barriers and challenges to treatment

Despite these vulnerability factors, people from CaLD backgrounds seem to be underrepresented at AoD treatment services (AIHW, 2017). This could be the result of some of the barriers and challenges that people from CaLD groups face when they seek treatment for their substance use (de Crespigny, et al., 2015), rather than lower necessity (Beyer & Reid, 2000; Reid, Crofts, & Beyer, 2001). For example: language barriers; limited access to culturally appropriate programs and services; lack of awareness of the support available; and, how they operate might be contributing factors (Department of Health, 2017; VAADA, 2016; Posselt, McDonald, Procter, de Crespigny, & Galletly, 2017; Reid et al., 2001). There may also be different mental models of illness in some cultures that will impact on help-seeking (Gopalkrishnan 2018; Wohler & Dantas 2017). It has also been suggested that people with CaLD backgrounds are often not informed about the availability of AoD treatment services (DAMEC, 2019; Posselt et al., 2017):

'*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?'* [Female Speaker] (DAMEC, 2019, p.50);

'*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.'* [Female Speaker] (DAMEC, 2019, p.50);

'*If the services are well known or better known in the migration agencies this could increase access. So if services worked with settlement support agencies they would know where people can get help and give advice.*' [Refugee youth] (Posselt et al., 2017, p.5);

‘*Do they [ethnic communities] really know of the service providers out there. They are not publicised ... no media advertises where you can get help.*’ [Vietnamese focus group] (Reid et al., 2001, p.20).

Providing treatments that are not culturally sensitive and which do not account for clients’ needs, personal history and background might also prevent people from seeking treatment (DAMEC, 2019; De Crespigny et al., 2015; McCann et al., 2016; Posselt et al., 2017):

‘*[…] 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]’ (DAMEC, 2019, p.35);

‘[…] even with counselling or any of those kind of health services, they are using Western point of view and that is different to what other cultures believe so, it’s totally different’ [refugee youth*]; ‘I would say to people, like a counsellor or a psychologist, to try to understand different cultures because you never know who you could be working with, so while they are doing their training and education… I’m sure they might do it but it’s still from a Western point of view and you really inhibit people from just accessing those kind of services and even if they do, they don’t feel satisfied’* [Refugee youth] (Posselt et al., 2017, p.8).

Language barriers might also prevent people from accessing AoD services (De Crespigny et al., 2015; Department of Health, 2017; VAADA, 2016; Posselt, et al., 2017; Reid et al., 2001; Rowe, 2014). Service providers might lack funding to get access to interpreters[4], which might have a negative impact on the delivery of services offered to their clients (Posselt et al., 2017). Clients might also become frustrated, as they might not be able to share their experiences appropriately:

[4] The use of interpreter services is further discussed in section 3.2.2

'They haven't seen that stuff, so it's hard to explain to them also. Some people who can't speak English so they don't know how to tell them, they don't know how to say some words in English.' [Refugee youth] (Posselt et al., 2017, p.8).

Language issues might also be an obstacle for the AoD counsellors themselves (Rowe, 2014), as they are unable to provide written resources to their clients, in order to deliver appropriate therapeutic treatments (e.g. CBT therapies) (Rowe, 2014). Evidence suggests that some mainstream Australian services do not have adequate procedures and policies in place for working with people from CaLD backgrounds (Donato-Hunt & Turay, 2009). For instance, a pilot study conducted among 14 AoD services in New South Wales found that the majority of staff members had not received any formal cross-cultural training, and there was an underuse of interpreters (Donato-Hunt & Turay, 2009). Further, some health workers highlighted the importance of using interpreters and written resources in their clients' language:

'Bilingual information, support and counselling is the most effective tool, and preferred option for counselling individuals and families from a CALD background.' [Health worker] (Donato-Hunt & Turay, 2009, p. 12).

However, others did not seem to acknowledge its benefits:

'*Because of the health provision nature of our services, it is essential that applicants be able to speak and understand English.'* [Health worker] (Donato-Hunt & Turay, 2009, p. 12).

Furthermore, due to the stigma and shame associated with AoD use (de Crespigny, et al., 2015; McCann, et al., 2016; VAADA, 2016) it could be seen inappropriate to address AoD issues with CaLD clients in a direct way (VAADA, 2016). Rather, it has been suggested that concerns relating to AoD use should be addressed while focusing on general health and wellbeing (VAADA, 2016). As there is often a clear separation between mental health and AoD treatment services in Australia (Flatau, Conroy, Clear, & Burns, 2010; Posselt, et al., 2017; VAADA, 2016), this might potentially also explain why CaLD communities are underrepresented at AoD services. The fragmented nature of the services provided in Australia (e.g. mental health services/ alcohol and drug services/ general mainstream services/ CaLD or refugee specific services) might increase the risk of treatment disengagement as clients might have to attend multiple services at the same time (Posselt, et al., 2017):

'Probably one of the biggest problems is the way in which services are funded to work in silos, there is that disconnection.' [Service provider] (Posselt et al., 2017, p.5).';

'*I think services need to work in partnership with one another; it needs to be a joint initiative.*' [Service provider] (Posselt et al., 2017, p.5).

Stigma and shame associated with AoD use, might also force individuals in certain CaLD communities to hide their substance use from family members, in order to protect them, which in turn might prevent them from seeking treatment (Horyniak et al., 2014; Posselt et al., 2017):

'[...]and they [young people] worry so much about what people are going to think of [their] family'. [Female Speaker] (DAMEC, 2019, p.51);

'They will not want to get help. [...]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] (DAMEC, 2019, p.51);

'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] (DAMEC, 2019, p.51).

AoD issues are often viewed as taboo topics within CaLD communities, and are therefore not openly discussed, which might further prevent treatment seeking:

‘*At the moment parents don’t wish to know if there is a problem. In fact they hope the child will not tell them if there is a problem. If they are aware their child has a problem they will always blame the child’s friends for the drug problem, or blame society. The community needs a lot of help to recognise they have a drug problem’*. [Focus group participant] (Reid et al., 2001, p.18).

AoD use could also be seen as a sign of personal weakness or defeat:

‘*The shame. The shame in this community again; being labelled a drunkard. It's like I failed myself; I had to go and seek extra help. So it's the shame; the disappointment would stop me; the embarrassment’.* [Sub-Saharan African speaker] (McCann et al., 2016, p.4).

As a consequence, this could lead to an attitude of stoicism and pride when dealing with AoD issues without having the need to seek help:

‘Why would I talk about something like that with someone? I just like keeping to myself’. [Sudanese speaker] (Horyniak, et al., 2016, p. 292)

‘I had a counsellor … It doesn’t work for me … . I just rolled with my own flow, you know? I just took it as a man … . I don’t need no counsellor [sic]. I don’t have to talk to no one to tell them my problem. [South Sudanese speaker] (Horyniak, et al., 2016, p. 292)

Furthermore, some CaLD communities might refrain themselves from seeking treatment, fearing that they would be reinforcing community stereotypes:

‘*The Indo-Chinese community are already heavily targeted by the media as being the source of the heroin, almost the cause of the heroin problem. To openly acknowledge the problem, it is almost to target yourself for further criticism, which is racially based and discriminatory*’. [Key informant] (Reid et al., 2001, p.19).

In addition, other barriers faced by CaLD populations might include: lack of trust in services provided; community perception's about service providers; confidentiality concerns; and, community reputation (DAMEC, 2019; Posselt et al., 2017; VAADA, 2016):

'No I couldn't find anyone, I couldn't trust anyone…I was embarrassed too but it's just that there was no one to trust.' [Refugee youth] (Posselt et al., 2017, p.7).

An Australian study aiming to describe how an AoD treatment service based in Sydney was culturally adapted, found that some structural barriers prevented their clients from seeking treatment (Rowe, 2014). More specifically, misconceptions, poor understanding and lack of awareness of counselling, as well as negative views about counselling were frequently reported by clients visiting the Sydney centre, as counselling was not a common practice in their own country of origin (Rowe, 2014). In addition, CaLD communities raised concern about intake procedures, as they feared that the information collected would be shared with other parties, which led to a sense of general distrust in health services (Rowe, 2014). Fear about information disclosure was highlighted by an AoD worker working with CaLD groups:

'[...] 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' [Health worker] (DAMEC, 2019, p. 61);

'*Vietnamese parents feel that if they go [to treatment services] Vietnamese workers may know the person or that their problems will not be kept confidential.*' [Vietnamese focus group] (Reid et al., 2001, p.22).

Fear of community disclosure may also prevent people from accessing services:

'*It is a stigma to have someone using drugs in the family. No way would they go to another Somalian for help.*' [Focus group participant] (Reid et al; 2001, p.19).

Other barriers inherent to civil and religious factors, as well as cultural divisions might also prevent people from seeking treatment (Rowe, 2014). For example, one client mentioned that it would be difficult for him to be assigned a counsellor from the place where he was brought up:

'*It would be harder for me if the counsellor was from East Timor*' [Male speaker] (Rowe, 2014, p.96).

Moreover, many people from CaLD backgrounds have a strong desire to be accepted by the wider community and might see AoD use as a form of betrayal for the welcoming country which might prevent them from seeking treatment:

'They [ethnic communities] try to hide the drug problem because it is almost like having to prove to the wider Australian community that we are a good community, you have let us in, we are settling in well, we are integrating. To say we have a [drug] problem in the community … it becomes a blotch on the record. It is almost that you have to keep this facade of a good community.' [Key informant] (Reid, 2001, p.19).

Lack of mental health literacy among CaLD communities has also been cited as one of the factors that might have a negative impact on treatment seeking (McCann et al., 2016). For example, it has been found that it was fairly frequent to dismiss early signs of AoD use:

'[…] the reason why [young] people who are mentally ill - or using drugs - the reason why they don't go to specialists I think is because they think they're not sick. They don't think they are sick themselves so there's no point of going to the specialists.' [Interviewee] (McCann et al., 2016, p.5).

Costs associated with access to certain types of services might also act as a deterrent for some people with CaLD backgrounds:

'[…] the costs, like health costs, medical expenses. If they can be reduced then more parents would be able to afford. Because some parents may not be able to take their children for much help because of the costs ….if it's too expensive, they'll not definitely go there; can't afford it.' [Interviewee] (McCann et al., 2016, p.5).

Furthermore, women from CaLD backgrounds might also be facing additional barriers than their male counterparts when accessing AoD treatment (Lee, 2008; Lee et al., 2014). For instance, women might be refraining from seeking treatment due to the unavailability of childcare services, domestic violence problems, and/ or fear of losing their children (Lee, 2008).

3.2.2 Protective factors, drivers and facilitators to treatment

Despite these barriers, it has also been found that CaLD communities possess a variety of resilience factors that protect them against AoD use (DAMEC, 2019). For example, it has been found that some CaLD groups have strong community support systems, large social community networks which have all been described as being protective factors against AoD use in various studies (e.g. Castro & Alarcon, 2002; DAMEC, 2019; McCann et al., 2016):

'*As a community, we have tried, since the time we arrived here, to be available for each other, to be a support group for each other, because no one understands us better than our own.'* [Sub-Saharan African participant] (McCann et al., 2016, p.6).

Community leaders also seem to play a major facilitator role for people with CaLD backgrounds:

> '*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 [...]*' [Female Speaker] (DAMEC, 2019, p.44).

Additionally, some CaLD communities might rely on a general sense of ethnic pride, as well as cultural and religious beliefs and practices which prevent them from using AoD (Castro & Alarcon, 2002; DAMEC, 2019; Lee, 2008):

'Cause religion plays a big part…in the PI [Pacific Islander] life, yeah?' [Female Speaker] (DAMEC, 2019, p.47);

'*One of cornerstones of Turkish culture is 'honour' ... If you break that honour it is very difficult to regain your place in the community. People are only accepted back if they have fixed themselves first ... this issue is more important than just helping the person overcome their addiction.*' [Turkish focus group participant] (Reid et al., 2001, p.18).

Emotional support from family members and friends also seem to facilitate access to AoD treatment services (McCann et al., 2016). More specifically, it has been found that role model behaviours might also prevent young people from using AoD in these communities (DAMEC, 2019). For example, some people with CaLD backgrounds highlighted the role that parents might play in preventing their children from using AoD:

'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". [Female Speaker] (DAMEC, 2019, p.39)*;*

'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'. [Male Speaker] (DAMEC, 2019, p.39)*;*

'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?' [Female Speaker] (DAMEC, 2019, p.39).

Others highlighted the role played by relatives or friends:

'*Actually, if it's a friend, a friend means a lot. If you're best friends, you talk a lot and you know a lot about each other. So if I go to my friend, I know they will understand how I feel and they will understand what is best for me.'* [Sub-Saharan African participant] (McCann et al., 2016, p.6).

‘*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] (DAMEC, 2019, p.44).

In addition, family involvement in some CaLD communities has also been seen as a facilitator to treatment (DAMEC, 2019). For instance, collectivists’ communities, such as Pacific Island groups, see problems as a group issue rather than an individual issue, and therefore, getting family support might influence clients’ engagement to AoD services (DAMEC, 2019):

‘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] (DAMEC, 2019, p.69-70).

Friends and peers also play an important role when preventing AoD use amongst CaLD communities (DAMEC, 2019; Horyniak et al., 2014):

‘*Interviewer: Have you ever seen anyone [of your friends] injecting drugs?*
Daniel[5]*: Nah never, never.... I’ve never seen anyone do any injections at all.*
Interviewer: OK, OK.
Daniel: ‘Cause if I did, I would have bashed them straightaway.
Interviewer: Really? Really, why do you say that?
Daniel: We’d bash our friends if they try other drugs than that, than weed. We tell them we’ll bash you and stuff.
Interviewer: Why? Why would you bash them?
Daniel: It’s no good for them; it’s not pretty good for them you know. One shot and it gets to you addicted straightaway, that’s what I think.’ [Male speaker] (Horyniak et al., 2014, p.413).

[5] Pseudonym

It has also be recommended that bi-lingual AoD counsellors act as facilitators to treatment (Rowe, 2014) as interpreters may paraphrase rather than translate what has been said, which could result in different treatment experiences when bi-lingual workers are not available (Rowe, 2014). For example, one client reported that:

'Straight away talking is better, I've found that translators change what I mean, so I'm not comfortable with a translator' [Female speaker] (Rowe, 2014, p.96).

Social media might also provide an educational support for some people with CaLD backgrounds, as reported by a female speaker:

' *[...]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.*' [Female speaker] (DAMEC, 2019, p.48).

Perceived expertise of formal professionals also seem to be a facilitator to treatment (McCann et al., 2016). For some CaLD groups, general practitioners seem to be a trusted from of support about AoD use (DAMEC, 2019; McCann et al., 2016; Posselt et al, 2017):

'Male Voice: Just not only hospital, he need some advice or someone trust. [Researcher asks who?]
Male Voice: Like Doctors.' [Male speaker] (DAMEC, 2019, p.48);

'*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] (DAMEC, 2019, p.49);

'*[...] but worried [it is] not confidential. I can trust doctors- they know better. But counselling- not really.'* [Female speaker] (Posselt et al; 2017, p.7)

4 DISCUSSION

The aim of this report was to provide a general review of the prevalence of AoD use by CaLD groups in Australia and identify the barriers and drivers to treatment for these groups.

4.1 Overall findings

4.1.1 Prevalence of alcohol and drug use

This review provides further evidence that there is limited information available on the prevalence of AoD use among CaLD populations in Australia. Even though the data available suggest that CaLD groups might have a lower propensity to use AoD than non-CaLD groups (AIHW, 2019, 2017), some caution needs to be taken when drawing these conclusions. Indeed, research suggests that the data on AoD use among CaLD groups might be unreliable (Browne & Renzaho, 2010), due to a variety of factors, such as low participation rates (Browne & Renzaho, 2010), language barriers (Donato-Hunt, et al., 2012), and the stigma and stereotypes associated with AoD use in these communities (Browne & Renzaho, 2010; McCann et al., 2016). Others suggest that some CaLD groups might in fact be at higher risk of substance use than non-CaLD groups (Department of Health, 2017; VAADA, 2016), due to the higher exposure to a variety of stressors, such as grief, loss, torture and trauma (AIHW, 2019a).

Further research is required, as the discrepancies between these studies might be in part due to methodological issues. For example, the National Drug Strategy Household Survey (AIHW, 2020, 2019b) was only conducted in English, which might have affected the response rate (Reichel & Morales, 2017). In addition, participants' friends and family members were used as "translators" when required, even though previous research suggests that some CaLD communities might expressively omit some words when interpreting for their peers, due to religious or cultural factors (Wolf, Zoucha, McFarland, Salman, & Dagne, 2016). Furthermore, previous research suggests that health statistics among CaLD populations should be disaggregated by ethnicity, gender, immigrant status, and country of birth (Baluja, Park, et Myers, 2003), which was not the case in the National Drug Strategy Household Survey (AIHW, 2020), as no information was provided about the ethnicity of the participants. Further research is required to address these methodological limitations.

4.1.2 Barriers to treatment

This review identified ten main factors that might prevent people from CaLD groups from seeking treatment. These include:

- Limited access to appropriate cultural programs and services;
- Language barriers;
- Civil and religious factors;
- Lack of awareness of support and services available;
- Lack of trust in service providers;
- Lack of mental health literacy;
- Stigma, shame and stereotypes associated with AoD use;
- Financial difficulties;
- Strong desire to be accepted by the welcoming country; and,
- Issues related to gender differences.

These findings indicate various areas for intervention. First of all, there is a clear need to identify whether the actual models of intervention that are offered to CaLD populations are culturally sensitive and holistic in nature. Previous research suggests that there is a shortage of guiding frameworks available to clinicians when conducting mental health interventions with these populations (Slobodin & de Jong, 2015). It is therefore important to ensure that AoD services provide culturally sensitive and holistic approaches to respond to their clients' specific needs, by taking into account their clients' history, cultural group, civil and religious factors, as well as language-literacy skills.

Additionally, these findings also suggest that there is a general lack of information provided to CaLD communities (e.g. what type of support is available? To what extent are support services required to retain the confidentiality of their clients? What are the signs of substance misuse? How to access free support?), which might be easily overcome by offering psycho-education programs. Psycho-education programs have indeed been found to be an effective way to improve mental health literacy among these communities (Guajardo, Kelly, Bond, Thomson, & Slewa-Younan, 2019). Similarly, it has also been suggested in the literature that community support programs aiming to increase awareness, and reducing the stigma and shame associated with AoD use should be offered to CaLD groups (Horyniak et al., 2016).

4.1.3 Facilitators to treatment

Despite these barriers, this review identified six different factors that might facilitate people from CaLD backgrounds in engaging with AoD treatment services and prevent them from using AoD. These include:

- Strong community support;
- Emotional support from family members and friends;
- Social media support;
- Cultural and religious beliefs;
- Use of bilingual workers; and,
- Perceived expertise of health workers.

The positive role played by social support has been found in various studies among CaLD populations. For example, previous research conducted in Australia among CaLD students suggests that social support and acculturation are both related to mental wellbeing. Both factors are also mediated by resilient factors (Khawaja, Ibrahim, & Schweitzer, 2017). It has also been found that social support acts as a buffer between some risk factors and wellbeing (Betancourt & Khan, 2008; Gaylord-Harden, Ragsdale, Mandara, Richards, & Petersen, 2007). It is therefore not surprising that people from CaLD groups might also benefit from social support in terms of their AoD use and service treatment, as a previous study conducted among the general population found that being socially supported can generally reduce stigma and shame associated with AoD use (Birtel, Wood, & Kempa, 2017). In terms of social media support, a recent Australian study suggests that peer-led social media campaigns could also contribute to harm reduction related to AoD use (Horyniak et al., 2016).

Previous research conducted among CaLD communities also suggests that some religious beliefs might function as protective factors against problematic use of AoD (De Kock et al., 2016; Lee, 2008). For example, the use of AoD is considered as "forbidden" in some communities and might therefore act as a direct deterrent (De Kock et al., 2016). Further research is required to determine to what extent cultural and religious beliefs mediate AoD use.

Matching clients with clinicians who speak their own language has been found to be a predictor of treatment outcomes among CaLD groups with AoD use problems (Gainsburry et al., 2017). Previous research conducted in Australia also suggests that bi-cultural workers and bilingual treatments should be provided when working with people from CaLD backgrounds (Rowe,

2014), even though there is currently a lack of bilingual health professionals working with CaLD populations in Australia (DAMEC, 2019). It also appears that translated materials are severely restricted (DAMEC, 2019), which could have a negative impact on treatment outcomes.

Clients' perception about the expertise of their health practitioners seems to be a facilitator to treatment. It is however unclear to what extent this could be attributed to their practitioners' multicultural competence. Indeed previous research conducted among CaLD populations suggests that the development of cultural competence is strongly associated with client satisfaction (Fuertes, Bartolomeo, & Nichols, 2001). Similarly, another study found that psychologists who possessed multicultural competence skills were perceived as more efficient by their clients (Wang & Kim, 2010).

5 CONCLUSION

This general review highlights that there is currently limited information available on the prevalence of AoD use among CaLD populations in Australia. Further research is required to identify whether the actual models of intervention offered to CaLD populations are culturally sensitive and tailored to the clients' needs and cultural group (Roche et al., 2015; Gainsburry et al., 2017). Psycho-education programs could increase awareness of AoD services for CaLD groups (Guajardo, et al., 2019; Rowe, 2014). Based on this literature review, our findings suggest that treatment interventions should promote peer support (Horyniak et al., 2016), and take into account clients' religious and cultural beliefs (Rowe, 2014), as well as issues related to gender differences (Lee, 2018; Lee et al., 2014), and focus on reducing stigma associated with AoD use (Horyniak et al., 2016).

5.1 Recommendations

- Clinicians dealing with CaLD populations should be encouraged to undertake a range of ongoing professional cultural competency courses delivered by specialised agencies.
- Interventions should be individualised and holistic in nature and take into account that not all CaLD communities would have similar needs and preferences. As a consequence, clinicians should ensure that a record of information provided about the clients' culture is kept (Rowe, 2014). Specific issues related to gender differences should also be taken into account (Lee, 2018; Lee et al., 2014).
- Mono-lingual clinicians should be encouraged to use interpreters when dealing with CaLD populations. Clients should have the choice to decide whether they would prefer to use phone interpreters, as some of them might fear that the interpreter might belong to the same community group for confidentiality reasons.
- More information about what type of services are available should be provided to CaLD populations.
- Free psycho-education programs should be offered to CaLD communities to ensure that they understand, for example, what counselling is, what confidentiality involves, but also to prevent stigma about AoD use, and to detect early signs.
- Peer-support, as well as family and community support (e.g. community and religious leaders) should be encouraged among CaLD populations.
- A longitudinal study with people from CaLD backgrounds who use AoD should be conducted in order to determine how treatments could be improved and tailored to their cultural needs.

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