

# Drug and Alcohol Multicultural Education Centre



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## Identifying Ethnicity

### Representation in Drug & Alcohol Treatment Services Data

### Full Report

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**Author: Karly van der Gaag**

**Supervisor: Connie Donato-Hunt**

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## DAMEC

The Drug and Alcohol Multicultural Education Centre's (DAMEC) mission is to reduce the harm associated with the use of alcohol and other drugs within culturally and linguistically diverse (CALD) communities in New South Wales.

The key objectives of the organisation are to:

- Increase the access by people from CALD communities in NSW to prevention, education treatment, and other harm minimisation programs and services;
- Increase the flexibility and cultural appropriateness of prevention, education treatment and other harm minimisation programs and services;
- Increase the access of CALD communities to information on alcohol and other drugs;
- Support community initiatives to reduce the harm associated with the use of alcohol and other drugs.

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## List of Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AODTS	Alcohol and Other Drug Treatment Services
AODTS–NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASCDC	Australian Standard Classification of Drugs of Concern
ASCL	Australian Standard Classification of Languages
ASGC	Australian Standard Geographical Classification
ATSI	Aboriginal or Torres Strait Islander
CALD	Culturally and Linguistically Diverse
CLDB	Culturally and Linguistically Diverse Background
DATS	Drug and Alcohol Treatment Services
LOTE	Language Other Than English
MERIT	Magistrates Early Referral into Treatment
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NMDS	National Minimum Data Set

## Executive Summary

The National Minimum Data Set (NMDS) for Alcohol and Drug Treatment Services reports on drug and alcohol service delivery and client characteristics. According to the data obtained from Drug and Alcohol Treatment Services (via the NSW MDS DATS) in 2004-2005, the percentage of people accessing services who were born in a non-English speaking country is approximately 6%. However, the state-wide figure of people born in a non-English speaking country is 17%.<sup>1</sup>

In order to verify whether the MDS was anomalous regarding the proportion of CALD clients, it was analysed in conjunction with three other data sets: Pharmacotherapy treatment data, Magistrates Early Referral Into Treatment data (MERIT), and the Emergency Department data collection. All data sets pertained to the financial year 2004-2005 and covered only NSW.

The percentages of clients from non-mainly English speaking countries ranged from 3.9% to 7.5% in comparison to the MDS's proportion of 5.5% (see table below). Despite significant variances, these figures were found to be relatively consistent since the specific contexts of each data set need to be taken into account. The proportion of clients using AOD treatment services who spoke a language other than English was 1.5% which was consistent with the figures of 1.6% and 1% pertaining to Pharmacotherapy and MERIT respectively. The percentage of people who presented to the Emergency Department with AOD related symptoms and spoke a LOTE was 5.5% however this was explained by incorrectly coded data and the context of the data set.

	Non-mainly English speaking Country	Languages Other Than English
MDS	5.5%	1.5%
Pharmacotherapy	7.5%	1.6%
MERIT	6.4%	1%
Emergency Admissions	3.9% <sup>2</sup>	5.5%

The analysis found that the proportion of CALD captured via the MDS using the ethnicity indicators of preferred language and country of birth is consistent with the proportions found in the data sets that were compared. Thus, the low proportion of clients from CALD backgrounds, as defined by the ethnicity items collected, was found to be an accurate reflection of client demographics.

Subsequently, the factors affecting the low proportion of clients from CALD backgrounds in the MDS were examined. The primary factors, as discussed in the report, are:

<sup>1</sup> ABS, Census of Population and Housing, 2006

<sup>2</sup> Country of Birth variable includes 38.6% incorrectly coded.

- Ethnicity Indicators: Both country of birth and preferred language are widely used and accessible indicators of ethnicity however their use may contribute to the low proportion of clients from CALD backgrounds in the MDS. This is due to a certain element of conceptual invisibility of ethnicity that is not captured by either of these indicators.
- Cultural Difference: Studies<sup>3</sup> have found that most ethnic groups find that services are inappropriate to their needs for several reasons. Services are often found to be culturally or logistically inaccessible because of a perceived lack of cultural sensitivity, the stigma associated with accessing services or due to preference of an alternate form of treatment that is culturally specific.
- Communication: There is generally a poor understanding by people from CALD backgrounds of how to access services and what the services do. This relates to a lack of appropriately placed publicity that is accessible to particular CALD backgrounds (multi-lingual).
- Location of services: The MDS covers all of NSW however ethnic minorities are mainly grouped around metropolitan areas.<sup>4</sup> If regional/rural areas are excluded, the percentage of clients from CALD backgrounds increases to 7.7%
- Clinician Reporting Methods: It is possible that clinicians conduct treatment and 'fill in the fields' marked preferred language according to the client's proficiency in English rather than their preferred language.

In conclusion, whilst the low proportion of clients from CALD backgrounds in the MDS is concurrent with other relevant data sets, it is essential to interrogate the factors contributing to the low proportion. This report documents several of these factors and aims to provide a basis upon which further analysis and research could be instigated.

DAMEC believes that repeating this process on a regular basis would be beneficial in informing key stakeholders and policy makers of the rate of access among CALD clients as recorded through the MDS in greater detail than is reported through MDS reports. Further, it would allow for the identification, documentation and interrogation of trends relating to CALD clients' access to AOD treatment services.

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<sup>3</sup> Reid, G. et al, Drug Treatment Services for Ethnic Communities in Victoria, Australia: an examination of cultural and institutional barriers, 2001

<sup>4</sup> NSW Government Community Relations Commission

[http://www.crc.nsw.gov.au/communities/the\\_people\\_of\\_nsw/nsw\\_overview](http://www.crc.nsw.gov.au/communities/the_people_of_nsw/nsw_overview), last updated 18 Sept 2007

## 1. Introduction

### 1.1 Background

The NSW MDS DATS was developed for the purpose of describing drug and alcohol service delivery and the characteristics of clients accessing these services.

The collection started in July 2000 among all government and funded non-government drug and alcohol service providers. The MDS collects data at a state level on 'closed treatment episodes', rather than total client registrations due to the repeat nature of treatment for drug and alcohol clients.<sup>5</sup> These refer to a period of contact, with defined start and end dates, between a client and a treatment agency. For example, a closed treatment episode may be for a specific treatment, such as information and education only, or it may be one part of a long-term treatment plan, such as withdrawal management.

### 1.2 Clients from Culturally and Linguistically Diverse Backgrounds

The MDS includes two items related to ethnicity and cultural background of closed episode clients. These are country of birth, and preferred language.

In the financial year of 2004-2005, reported characteristics for country of birth and preferred language spoken included the following:<sup>6</sup>

- 86% of clients were born in Australia
- Next most common countries were England, and New Zealand (2% each)
- English was the preferred language for 95%
- Other preferred languages were relatively uncommon, with each accounting for less than 1% of treatment episodes.

Therefore, according to the data obtained from drug and alcohol treatment services (via the MDS), the percentage of people accessing services that were born in a non-English speaking country was approximately 6%. In the 2006 Census, 17% of persons in NSW were born overseas in a non-English speaking country.<sup>7</sup> Thus, it would appear that the proportion of people from CALD backgrounds who are accessing AOD treatment services is substantially lower than the corresponding proportion in the general NSW population.

### 1.3 Purpose

The objective of this research project is to investigate whether this low proportion of CALD clients reported in the NSW MDS DATS is an accurate

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5 NSW Health, Drug and alcohol treatment services in NSW 2004-2005: Annual report on the NSW Minimum Data Set, 2005, p.1

6 Ibid, p.7

7 ABS, Census of Population and Housing, 2006

reflection of client demographics or whether it is due to limitations in data collection regarding indicators related to ethnicity.

Exploration involved basic comparisons of demographic information reported by the MDS and other data sets. The MDS was compared to pharmacotherapy data, MERIT (Magistrates Early Referral into Treatment) data and Emergency Admissions for AOD related diagnosis data. Conclusions were subsequently able to be made based on how the proportion of CALD clients accessing AOD treatment in MDS data compares with ethnicity reported in other datasets.

Dependent on the findings, the MDS was analysed to determine any possible factors for the low proportion of clients from CALD backgrounds.

A further goal of the project is to develop a format and process by which the rate of access amongst CALD clients (as recorded through the MDS) could be analysed in greater detail than what is currently reported. This would be valuable in regularly informing key stakeholders and policy makers. Moreover, it would allow for a more thorough examination and analysis of the MDS in relation to the client ethnicity indicators, with a view to interrogating the trends over time.

#### **1.4 Research Questions**

- 1) Is the low proportion of clients from CALD backgrounds, as captured in the MDS of Drug and Alcohol Treatment Services, an actual reflection of client demographics?
- 2) What are the factors contributing to the low proportion of clients from CALD backgrounds being captured in the MDS for Drug and Alcohol Treatment Services?

## 2. Methodology

### 2.1 Phases in the Study

- Analysis and evaluation of current literature on:
  - Drug and alcohol services in Australia (both qualitative and quantitative)
  - Cultural and linguistic barriers to access of services
  - Data collection
  - Conceptions of ethnicity
- Collate an annotated bibliography of relevant sources
- Familiarisation with the skills necessary to complete the data analysis using the Statistical Package for the Social Sciences (SPSS)
- Review the data from the MDS for Drug and Alcohol Treatment Services Drug and Alcohol Services in Australia
  - In-depth analysis of efficiency and accuracy of ethnicity indicators
  - Investigate scope and limitations of the data collection and collation processes
  - Compare processes with comparative literature on methodology
- Compare country of birth and language profile from:
  - Pharmacotherapy Treatment (not included in AODTS-NMDS reporting)
  - Magistrate's Early Referral Into Treatment Program (MERIT)
  - Emergency Department Data Collection
- Examine the population profile of drug and alcohol users through other data collection sources and research such as:
  - National Drug Strategy Household Survey (AIHW)
  - National Health Survey (ABS)
- The analysis gathered effectively answers the first research question which addresses the accuracy of the MDS figures on ethnicity.
- Explore the implications of the result. Examine possible factors for the low proportion of clients from CLDB in the MDS. Collate a report detailing findings and draw conclusions from those findings.
- Create a template by which this process of comparing data sets can be replicated on a regular basis.

### 2.2 Data Set Selection

An initial examination of the data sets in all three relevant fields (general population; health, welfare and AOD; and criminal justice) highlighted the inconsistent use of ethnicity indicators (see appendix 1 for a list of data

sources and ethnicity indicators collected). In-patient services often only include minimum mandatory variables which rendered them unsuitable. This limited the comparable data sets since a requirement for the study was the use of the two ethnicity indicators utilised by the MDS: country of birth and preferred language.

Whilst the NSW MDS consists of 49558 closed treatment episodes, the comparable data sets are all small select population studies. Therefore they all carry a bias from conception due to their limited scope being non-representative of the general population. However, that does not impose on the value in the study to the MDS since the aim is simply to do a peripheral comparison to determine whether the MDS figures regarding ethnicity were anomalous.

Each data set which is compared to the MDS is contextualised below.

All four data sets pertain to the financial year 2004-2005.

#### Pharmacotherapy Maintenance Treatment Data

The data set consists of 3644 clients. The data set documents closed treatment episodes of clients receiving pharmacotherapy treatment such as methadone or buprenorphine. Pharmacotherapy was chosen because essentially it is an extension of the AODTS-NMDS. Below is the reasoning behind it's exclusion from the AODTS-NMDS.

Services that provide pharmacotherapy maintenance treatment only are currently excluded because of the complexity of the service delivery structure and the range of agencies and practitioners in private and general practice settings. -*AODTS-NMDS 03-04 Specifications*<sup>8</sup>

Whilst the exclusion of Pharmacotherapy Maintenance Treatment Data from the MDS is justified, it is important to gauge the demographics of the clientele since they are in essence clients of AOD treatment services.

#### Magistrate's Early Referral Into Treatment

This database of clients of the NSW MERIT program listed 1470 clients for 04-05. To be eligible for the program the accused must have a demonstratable drug problem, be willing to participate in the program and reside in the catchment area. The scheme is voluntary and restricted to adult offenders. Defendants with serious violent or sexual offences or indictable drug offences are excluded from the scheme. Whilst MERIT is likely to capture only a small and select proportion of the population using illicit drugs, this does not undermine its use in comparing the surface demographics.

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<sup>8</sup> AIHW, Alcohol and other drug treatment services NMDS specifications 2003-04: data dictionary, collection guidelines and validation processes, 2003

## Emergency Admissions

The Emergency Department Data Collection is a collection of all presentations to Emergency Departments at public hospitals in NSW. The collection aims to show patterns in presentations by age, season and diagnostic groups to assist in the planning of services and improvement of care and outcomes for the NSW public. The data set used pertains only to those admitted to hospital via the Emergency Department with a recorded principal or first diagnosis as alcohol or drug related which amounts to 3127 patients.

The data is sourced from the Emergency Department Information System (EDIS), which currently includes data from 72 hospitals and represents more than 80 per cent of State total Emergency Department attendances.

### **2.3 Data Analysis**

The data sets were imported into SPSS from Excel and a thorough restructuring of the variables was required in addition to data cleaning and preparation. The Australian Standard Classification of Languages, the Australian Standard Classification for Drug of Concern, and the Australian Standard Geographical Classification were all applied as variables to facilitate accurate comparisons. The data was also grouped where required in order to ensure that no groups of five or less were featured. This allowed for an ethical and succinct analysis of captured ethnicity in each of the data sets. Data was cross-referenced using crosstabulations in order to identify any significant anomalies.

The MDS was analysed rigorously to account for possible factors of the low proportion of people from CLDBs. Further, the basic demographics of the population accessing treatment services was examined and contrasted with the general population of CALD people to determine whether there was a deviation.

### **2.4 Limitations of the Data**

- Due to the high percentage of incorrectly coded data in the Emergency Department data set, those findings are relatively defective in terms of ethnicity identifiers.
- The data sets account for select populations which restrict their generalisation to the wider population thus limiting the applicability of the findings.
- Regional grouping was required due to ethical constraints on the data. Groups of five or less were not specified to avoid any chance of identification and this subsequently resulted in data loss.

### 3. Findings

This section presents the findings from the analysis of the data sets.

#### 3.1 NSW Minimum Data Set for Alcohol and Drug Treatment Services

The majority of closed treatment episodes in 2004–05 involved clients born in Australia (86% of closed treatment episodes). Clients born in other countries were represented in only a small proportion of closed treatment episodes, with England and New Zealand (2.1% and 1.7% respectively) being the next most common countries of birth in 2004–05. Other significant minorities include Vietnam, Scotland, Republic of Ireland and Lebanon. Non-mainly English Speaking Countries constituted 5.5% of all countries of birth.

As in previous reporting periods, English was the most frequently reported preferred language with 96.5% of treatment episodes involving clients who indicated it as their preferred language. Other preferred languages were relatively uncommon, with each accounting for less than 1% of treatment episodes. Languages Other Than English constituted 1.5% of all preferred languages.

#### 3.2 Pharmacotherapy Maintenance Treatment Data

86.3% of closed treatment episodes involved clients born in Australia. The next most common countries of birth were Vietnam (1.8%), New Zealand (1.7%), and England (1.2%). Other significant minorities include Lebanon, Serbia & Montenegro, and Fiji. Non-mainly English Speaking Countries make up 7.5% of all countries of birth.

The majority of closed treatment episodes involved clients whose preferred language was English (96.7%) whilst the next most common was Vietnamese with less than 1%. It is important to note that 1.6% of closed treatment episodes did not state a preferred language. Languages Other Than English constituted 1.6% of all preferred languages.

#### 3.3 Magistrate's Early Referral Into Treatment

The majority of clients in the MERIT program listed Australia as their country of birth (89.6%). The next most common countries of birth were New Zealand and Viet Nam (2.2% and 1.3% respectively). Other significant minorities included England, Turkey and Scotland. Non-mainly English Speaking Countries constituted 6.4% of all countries of birth.

English was the most frequently reported preferred language for 98.5% of clients. The next most common preferred language was Vietnamese (0.6%). Languages Other Than English constitute 1% of all preferred languages.

#### 3.4 Emergency Department Data Collection

49.7% of patients listed Australia as their country of birth. The next most common countries of birth that were listed by patients were England (1.8%), Scotland (0.7%), and New Zealand (0.7%). Non-mainly English Speaking Countries make up 3.9% of all countries of birth. However it is essential to note that 38.6% of responses were incorrectly coded. Therefore, the data is likely to be highly misrepresentative of actual patient demographics.

English was reported as the preferred language for the majority of patients (92.5%). The next most common preferred languages were Welsh (2.5%) and Australian Aboriginal Languages (1.9%). Whilst it can not be concluded definitively, it is likely that the high proportion of patients listing Welsh as their preferred language was due to a code error. Languages Other Than English constitute 5.5% of all preferred languages.

### 3.5 Summary

	Non-mainly English speaking Country	Languages Other Than English
MDS	5.5%	1.5%
Pharmacotherapy	7.5%	1.6%
MERIT	6.4%	1%
Emergency Admissions	3.9% <sup>9</sup>	5.5%

From an overall comparison of the data sets it can be concluded that the MDS figures on ethnicity are not anomalous. The proportion of CALD captured via the MDS using the ethnicity indicators of preferred language and country of birth is consistent with the proportions found in the data sets that were compared.

<sup>9</sup> Country of Birth variable includes 38.6% incorrectly coded.

#### 4. Discussion of Factors Affecting Low Proportion of Clients from CLDB in MDS

In order to make any conclusions regarding factors affecting the low proportion of clients from CALD backgrounds in MDS, an image of actual levels of drug use among CALD populations must be obtained.

In reality, there is very little is known about the actual levels of drug use among different ethnic groups and there is a significant amount of conflicting literature on the issue. Some writers suggest that drug use within an ethnic group may be just as proportionally prevalent as in the general community<sup>10</sup> whilst others propose that the percentage of drug use is either higher or lower in these groups than in the general community<sup>11</sup>.

General population studies conducted within Australia suggest that less people from CALD backgrounds use alcohol, tobacco and other drugs problematically:

- National Drug Strategy Household Survey (AIHW)  
The National Drug Strategy 2001 Household Survey identified that people whose main language spoken at home was not English were less likely to drink alcohol, smoke tobacco or use illicit drugs than people who mainly spoke English at home.  
Australia-wide, a greater proportion of people whose main language spoken at home was not English had never used an illicit drug (89.2%) than those whose main language spoken at home was English (80.9%).<sup>12</sup>
- National Health Survey (ABS)  
THE 2004-2005 NHS reports on current smokers and risky alcohol drinking using the variables of birthplace, arrival year in Australia and language spoken at home. Overall, the proportions of current smokers and risky / high alcohol use appear to be lower amongst people born overseas. 15.3% of Australians drink with high risk to their health whilst only 8.2% of people born overseas do. The percentage of people born overseas who smoke was 19.2% whereas 22.3% of Australian born people smoke.<sup>13</sup>

While these general population studies support the position that there is a lower proportion of problematic drug and alcohol use among people of CALD

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10 Alcorso, The role of general practitioner in the delivery of drug and alcohol services to ethnic minority communities, Drug and Alcohol Review 1990; Johnson and Carroll, Dealing with diversity: Good practice in drug prevention work with racially and culturally diverse communities, 1995; Ezard, Trialling the new pharmacotherapies in the Vietnamese community: an appropriateness and possible options, 1997

11 Van de Wijngaart, 'Drug Problems among Immigrants and Refugees in the Netherlands and the Dutch Health Care and Treatment System' in Substance Use and Misuse, 1997

12 AIHW, 2001 National Drug Strategy Household Survey: First results, 2002

13 ABS 2006, National Health Survey: Summary of Results, 2004-05

backgrounds, differences are not as marked as what is found in MDS. Thus, there is still a gap between the reported proportion of people from CALD backgrounds with drug and alcohol issues and the proportion accessing drug and alcohol treatment services in NSW. This supports the assertion made by Reid et al that “under-representation of ethnic minorities at drug treatment services represents under-utilisation rather than a lower need.”<sup>14</sup>

The following discussion aims to address the second research question by examining factors that may further contribute to the low proportion of clients from a CLDB in the MDS. This is not a definitive list, simply an exploration of those factors which are most relevant.

#### **4.1 Ethnicity Indicators**

Country of Birth and Preferred Language were originally chosen to be included because the prerogative of the AODTS-NMDS is to inform and improve service delivery processes. These two variables enable service providers to cater to their clientele’s needs e.g. interpreters etc. A further goal of the MDS is to gauge the demographics of people accessing treatment services; it is for this reason that the choice of ethnicity indicators should be examined in order to capture an accurate picture of ethnicity.

It is acknowledged that it is difficult to capture ethnicity regardless of the indicators used due to a degree of indefinable cultural diversity. However, examining the suitability of ethnicity indicators is an invaluable process because it encourages continual improvement.

The two ethnicity indicators used in the MDS are examined below.

##### Country of birth

Country of birth is important in the study of access to services by different population sub-groups. Country of birth is the most easily collected and consistently reported of possible data items.  
*AODTS-NMDS 03-04 Specifications*<sup>15</sup>

Country of birth is a widely used variable in Australian and international data collection as a basic demographic indicator. In this context, it is used to indicate ethnicity since cultural and linguistic diversity often stems from overseas birth. Due to its relative user-friendliness, it is extremely useful in gaining an overview of the current migrant trends.

The principal weakness of country of birth is that it only captures first generation migrants. Those who identify with a CALD background due to parents’ birthplace and their families’ ethnicity are invisible. There appears to

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<sup>14</sup> Reid, G. et al, Drug Treatment Services for Ethnic Communities in Victoria, Australia: an examination of cultural and institutional barriers, 2001

<sup>15</sup> AIHW, AODTS-NMDS 03-04 Specifications, 2003

be no solution to this problem since birthplace of the mother and father is no more an in-depth indicator of ethnicity as there is no guarantee that there will be a continuum of cultural retention and practice. Country of birth implies that that country's cultural values and norms belong to that person<sup>16</sup>. Therefore, when used independently, the country of birth variable does not capture an accurate picture of ethnicity.

### Preferred Language

An important indicator of ethnicity, especially for persons born in non-English-speaking countries. Its collection will assist in the planning and provision of multilingual services and facilitate program and service delivery for migrants and other non-English speakers indicating the language most preferred by a client for communication.  
*AODTS-NMDS 03-04 Specifications*<sup>17</sup>

Preferred language is a beneficial demographic indicator in judging the degree of linguistic diversity and acculturation of any particular group. However it can be a misleading indicator of ethnicity since it represents preferred language for the purpose of the treatment. As mentioned above, this is often not the client's preferred language but the language of the clinician. Moreover, preferred language does not capture clients who speak a language other than English at home. The variable 'main language other than English spoken at home' allows for a more accurate picture of ethnicity. This variable is already in use within the AIHW and ABS.

The limitations of these two ethnicity indicators contribute to the low proportion of clients from CALD backgrounds identified in the MDS.

## **4.2 Cultural Difference**

Literature consistently found an overriding perception amongst ethnic groups that services were not appropriate to their needs. This arises from a variety of cultural and institutional barriers and results in an under-utilisation of AOD treatment services by CALD populations.

Drug use is not culturally acceptable amongst certain ethnic groups and carries a certain amount of shame and stigma<sup>18</sup>. This results in an unwillingness to gain help by accessing treatment services. Furthermore, AOD treatment services are often not the first point-of-call for people from CALD backgrounds who opt for a more culturally relevant and sensitive service e.g. Chinese medicine.

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16 Cheung, YW, Approaches to Ethnicity: Clearing the Roadblocks in the Study of Ethnicity and Substance Use. The International Journal of Addictions, 1993

17 AIHW, AODTS-NMDS Specifications 03-04, 2003

18 Smith J & Citta G. Identifying issues for young non-English speaking background peoples health service delivery, 1994

For some ethnic minorities, treatment services are inaccessible or inappropriate for several institutional reasons such as communication difficulties and culturally insensitive methods<sup>19</sup>. Drug treatment services have recognised that language and cultural differences are barriers stopping people from CALD backgrounds from accessing services however, there has been little push to implement more appropriate practices<sup>20</sup>.

### 4.3 Communication

Literature consistently found that there is generally a poor understanding by people from CALD backgrounds of how to access services and a poor understanding of what the services do. This is partly due to a lack of promotion of services in culturally accessible formats. Treatment services are not “communicating effectively or appropriately with ethnic communities, particularly those with poor English proficiency.”<sup>21</sup> This equates to inadvertent cultural biases that are built into service delivery. Ethnic communities need understandable (multi-lingual) information about available services. Treatment services also need to publicise in the right locations in order to reach their target audience.<sup>22</sup>

### 4.4 Location

The NSW MDS gathers information from all drug and alcohol treatment services across the state. In 2004-2005, 67.5% of closed treatment episodes took place in a metropolitan service provider whilst 32.2% took place in a rural setting<sup>23</sup> (see appendix). However, ethnic groups are concentrated in the metropolitan and suburban areas surrounding Sydney: of the 30 LGAs with the highest number of LOTE speakers all are in the greater Sydney area, and the same is true for highest proportion of LOTE speakers and those who speak English not well or at all.<sup>24</sup> Accordingly, the majority of closed treatment episodes of clients from CALD backgrounds took place in a metropolitan service provider (90.3%) (see table below). Only 1.7% of closed treatment episodes that took place in a rural service provider were for clients from CALD backgrounds. In effect, the inclusion of rural service providers dilutes the proportion of people from CALD backgrounds. If only metropolitan AOD service providers are taken into account, the percentage of people from a mainly Non-English Speaking Country jumps to 7.9% from the state-wide figure of 5.5%. Therefore, this is a factor in the low proportion of clients from CALD backgrounds. State-wide figures can be slightly misrepresentative since

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19 Reid, G. et al, 2001

20 Spathopoulos, E & Bertram, S. Drug and Alcohol Research amongst Non-English Speaking Background Communities in Australia: Literature Review, 1991

21 Reid et al. 2001

22 Romios, P. & Ross, J. Alcohol and Drug Utilisation by Non-English Speaking Background Communities, 1993

23 Metropolitan and rural classifications by AIHW. The figures of AOD service usage are consistent with the spread of AOD service providers, see appendices.

24 NSW Government Community Relations Commission

[http://www.crc.nsw.gov.au/communities/the\\_people\\_of\\_nsw/nsw\\_overview](http://www.crc.nsw.gov.au/communities/the_people_of_nsw/nsw_overview), last updated 18 Sept 2007

they suggest a low proportion of CALD people across the state. It would be advantageous to analyse these figures in conjunction with the figures derived from metropolitan service providers.

Use of Service Providers by clients from English-speaking/NES Countries.

Location of Service Providers	English Speaking Country	Non-English Speaking Country	Combined Total
Metropolitan/ Major Cities	65.8%	90.3%	67.2%
Rural/ Regional	33.9%	9.5%	32.5%
General (Non-specific location)	0.3%	0.2%	0.3%
Total	100%	100%	100%

#### 4.5 Clinician Reporting Methods

The quality of the reporting methods is manifestly crucial to the client's treatment in addition to the overall value of the reporting system. Whilst accurate client statistics allow for the best possible diagnosis and treatment, information on ethnicity is often not necessarily essential to service delivery. This is problematic because it results in an undervaluation of accurate reporting on ethnicity.

The lack of a synthesised method of data collection further adds to the problem. The possibility that the process of recording client information is completed separate to consultation with the client results in its contention as a contributing factor to the low proportion of CALD persons in the MDS. The onus placed on clinicians to 'fill in the fields' marked country of birth and preferred language can be problematic because the client may answer differently if given the opportunity. It is possible that since clinician-client relations are often conducted in English, from there assumptions can be made as to the client's preferred language. Interpreters are usually only utilised when it becomes apparent that the client cannot adequately communicate in English. Thus, a potential factor affecting the low proportion of clients from CALD backgrounds is that data often addresses the individual's capacity to converse in English rather than their preferred language. Furthermore, preferred language may not be same as language spoken at home (as discussed in section on ethnicity indicators).

## 5. Conclusion

### 5.1 Research Questions Revisited

The low proportion of clients from CALD backgrounds, as captured in the MDS of Drug and Alcohol Treatment Services, is an actual reflection of the country of birth and the preferred language spoken by clients. The primary factors contributing to this low proportion include the location of services, clinicians' reporting methods, the cultural inappropriateness of treatment services, the lack of promotion of services and the limitations of ethnicity indicators.

### 5.2 Insights Gained Directly from this Study

#### Pharmacotherapy Data Access

The AIHW should consider making the Pharmacotherapy data publicly available. The AODTS-NMDS interactive data cubes contain subsets of national information on alcohol and other drug treatment services. This allows anyone who has access to the Internet to view AODTS–NMDS data via the web interface. By extending this to Pharmacotherapy, users would be able to look up relevant figures and present them in a way meaningful to their needs. This would allow for a more comprehensive and accurate image of AOD treatment services clientele.

#### Emergency Department Data Integrity

EDIS has recognised that the Emergency Department Data Collection has problems with data integrity. The Health Department recently conducted an audit of the information system of EDIS. The audit found many problems in data quality and concluded that:

...the operation of EDIS is both inefficient and ineffective at the emergency department level, resulting in a material risk of data inaccuracy that is not countered by adequate data quality controls. Inaccurate data may cause processed information to be of questionable use for decision making and has implications for the quality of decisions.<sup>25</sup>

Whilst it is recognised that entering data is not the first priority for those in the Emergency Department, in terms of capturing ethnicity, the data set is ineffectual and there is no point accessing it until the data integrity is improved.

#### Ethnicity Indicators

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25 NSW Health, Performance audit report : hospital emergency departments : planning statewide services, The Audit Office of New South Wales, 1998

There is a certain degree of fallibility regarding the two variables relating to ethnicity that are currently in use by the AODTS-NMDS. It is acknowledged that the NMDS simply collects minimum data and a detailed view can be sought elsewhere. However, further empirical research should investigate the validity of other variables relating to ethnicity since there is an indication that they will give a more accurate representation of the characteristics of clients accessing AOD treatment services.

### **5.3 Where to from Here?**

Addressing the factors contributing to the low proportion of clients from CALD backgrounds being captured in the NSW MDS DATS is a complex issue which requires further scrutiny. It is clear that certain barriers need to be overcome by both CALD populations and AOD treatment services in order for improved access and equity to be achieved. By involving service providers in the reporting process, this creates a return investment which in turn encourages accurate reporting. A systemic focus on accurate measurement would result in increased quality and quantity.

DAMEC believes that repeating this process on a regular basis would be beneficial in informing key stakeholders and policy makers of the rate of access among CALD clients as recorded through the MDS in greater detail than is reported through MDS reports. Further, it would allow for the identification, documentation and interrogation of trends relating to CALD clients' access to AOD treatment services. This is an especially relevant process as advancements are made to increase access and equity, as well as improvements made to collection methods in order to maintain the rigour of the data sets.

## Appendices

### 1. Summary of Ethnicity Indicators

Data	Main language spoken at home	Preferred language	Country of birth	Parents' country of birth	Year of arrival
<b>General population studies:</b>					
AIHW National Drug Strategy Household survey 1. Statistics on Drug Use in Australia	√				
ABS National Health Survey	√		√		√
NSW Drug Trends 2005: IDRS (NDARC)					
<b>Health, Welfare and AOD Treatment Services</b>					
Clients of treatment service agencies: 2001 census (NDARC)	√				
Non-Fatal cocaine overdose and other adverse events among injecting and non-injecting cocaine users (NDARC)					
Cocaine related fatalities in NSW 1993-2002 (NDARC)			√		
Patient satisfaction in a NSW public opioid pharmacotherapy clinic (NDARC)					
Health services use and treatment costs over 12 months among heroin users: Findings from Australian Treatment (NDARC)					
Health service utilisation among regular methamphetamine users (NDARC)	√		√		
NSW Trends in Ecstasy and related drug markets – findings from the Party Drug Initiative	√				
Current smoking by Country of Birth 1997-1998			√		
Smoke free households 1997-1998					
Australian NSP survey: National Data Report 200-2004	√		√		
<b>Criminal Justice</b>					
Substance-use disorders and psychological distress among police arrests					
Drugs and crime: A study of incarcerated male offenders (AIC)					
Drug use monitoring in Australia: 2003 Annual Report on Drug Use Among Police Detainees (AIC)					
Drug use monitoring in Australia: 2004 Annual Report on Drug Use among police detainees (AIC)					
Drugs and Crime: A Study of incarcerated female offenders (AIC)					
MERIT	√		√		
Alcohol, drugs and crime: a study of juveniles in detention (AIC)					
Police Juvenile Justice Statistics NSW 1998	√			√	
Evaluation of the NSW Youth Drug Court Pilot Program			√		

## 2. MDS

<b>Area Health Service Location</b>	<b>Frequency of closed treatment episodes</b>	<b>% of closed treatment episodes</b>
Metropolitan/ Major cities	33474	67.5%
Rural/ Regional	15953	32.2%
General (non-specific location)	131	0.3%
Total	49558	100%

## 3. AIHW Spread of AOD Service Providers

	<b>Major cities</b>	<b>Inner regional</b>	<b>Outer regional</b>	<b>Remote</b>	<b>Very remote</b>
Government	55.14%	34.58%	10.28%	0.00%	0.00%
Non-Government	72.60%	26.03%	1.37%	0.00%	0.00%
Treatment Agencies	59.58%	32.40%	8.01%	0.00%	0.00%

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