# Working with culturally diverse clients in drug and alcohol services

## Worker perspectives

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# Executive summary

Currently in Australia there is limited substantive evidence on the extent to which cultural and linguistic diversity (CALD) impacts on the receipt of quality care in drug and alcohol (D&A) treatment settings. Consequently in 2007 DAMEC conducted a pilot research project that surveyed twenty-nine drug and alcohol workers from twelve agencies across western and south-western Sydney. The responses highlighted specific areas for further investigation. These included ethnicity data collection, the cultural diversity of clients, the existence of special provisions for working with CALD clients, the capacity of workers to work cross culturally, and how attitudes and perceptions influence actual client experiences and outcomes.

Evidence from the pilot study suggests that, on the whole, mainstream services do not see ensuring access for CALD clients as part of their role. While services encountered some cultural diversity among their client group, “low numbers” were often cited as the main reason for not giving this population group special consideration. The pilot results suggest that services lack specific policies and procedures for working with CALD clients and that workers are not formally trained in working cross culturally or linguistically. The most significant example of this is that across all of the services only two clients had used an interpreter in the last twelve months and only three out of twenty-nine workers had ever been trained in using interpreters (all in 2000).

Among workers in the pilot study there was disagreement regarding attitudes towards facilitating equity for CALD clients, with some not seeing special provisions for CALD as being applicable when numbers were low, and others seeing a need to proactively ensure provisions are in place in case a CALD client presents to the service. While further research is required to understand how staff attitudes impact the experiences and outcomes for clients, the pilot results suggest that if a service does not see working with CALD as being part of their service it is unlikely there will be adequate systems in place for ensuring equity of healthcare when people from this population group present to the service.

The limitations of this research related to the pilot nature of the project and budget constraints. Further research is required, with the inclusion of the perspective of clients, in order to understand attitudes across the sector, how these influence practice, and what the treatment experiences and outcomes are for CALD clients and their families accessing D&A services across New South Wales. Given the scope and complexity of such a project, it is recommended that such research only proceed once adequate funding has been allocated.

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# 1 Introduction

In 1997 the Drug and Alcohol Multicultural Education Centre (DAMEC) published research examining access and equity issues in the drug and alcohol (D&A) sector for clients from a culturally and linguistically diverse (CALD) background. The research focussed on the then South-East Area Health Service and was commissioned by the then Drug and Alcohol Directorate. Since this time there has been limited research investigating the barriers faced by people from a CALD background in accessing drug and alcohol treatment services, and much of what is available has come out of Victoria. Thus it was deemed timely for DAMEC to re-examine the current accessibility of D&A services and CALD client experiences in NSW, beginning with this pilot study.

The pilot study was an internally commissioned piece of research, focussing on access and equity issues from the perspective of workers in the non-government D&A sector.

## 1.1 RESEARCH PURPOSE, QUESTION AND AIMS

The primary research question that this pilot study endeavoured to answer is:

> *What are the experiences and barriers faced in the treatment of CALD clients in drug and alcohol treatment services in NSW?*

The rationale for this project is linked to the following two DAMEC organisational objectives:

- Increase the access by people from CALD communities in NSW to prevention, education, and treatment and other harm minimisation programs and services.
- Increase the flexibility and cultural appropriateness of treatment and other harm minimisation programs and services

As DAMEC has not conducted an access and equity scoping project since the late 1990s, the main motivation for this project was to begin to provide current evidence to further the above mentioned objectives by the following research aims:

- Identify any service gaps for CALD clients
- Identify the difficulties and barriers faced by CALD clients of D&A treatment services that are attributable to their cultural background
- Provide information on specific CALD needs in relation to D&A treatment
- Identify specific areas for change in services to improve CALD access and treatment
- Increase DAMEC's awareness of the capacity of mainstream D&A services to provide culturally appropriate treatment for D&A related issues

- Enable DAMEC to provide up-to-date informed advice on addressing service gaps and challenges at both a policy and agency level
- Continue to build and develop DAMEC's professional relationships with key agencies and D&A workers through interviewing and involving mainstream D&A services in this project.

# 2 Background

CALD clients represent only a small proportion of those who access drug and alcohol treatment services. According to the National Minimum Data Set (NMDS) for D&A treatment services in 2004-2005, nationally 86% of clients were born in Australia and English was the preferred language of 95% of clients[3]. While research has shown that problematic drug and alcohol use is lower among people from a CALD background than the general population [4-7], the low proportion of CALD captured in the NMDS is likely to be under representative. Preliminary research by DAMEC has found that this is due to a combination of actual under representation (i.e. access and equity issues preventing some people of CALD background from accessing services they need) and data collection not capturing the extent of the cultural diversity of clients in treatment, (i.e. the difficulty in quantifying cultural diversity, particularly in minimum data collection settings) [13].

People from a CALD background must overcome particular difficulties and hurdles before obtaining appropriate assistance. Concerns such as stigma surrounding an individual's inability to cope, fear of rejection, discrimination, loss of confidentiality, and shame all create barriers to accessing services or health workers. Accessing services often only occurs once crisis point has been reached within the family, or following a medical or legal intervention.[1] Language and cultural issues are widely recognised, at both a policy and service delivery level, as barriers to accessing adequate health services. Legislation, policies and guidelines have been put are in place to address these issues [14-19]. However, CALD clients continue to struggle when accessing treatment services, further exacerbating the stress and strain of their situation. Lack of culturally appropriate translated material, specialist interpreters and bilingual workers in treatment services, and Anglo-centric treatment practices (such as excluding the family) mean that CALD clients do not have access to the same level of treatment and communication with health professionals that other clients would have.

Increasing the capacity of treatment services to be responsive to the needs and circumstances of individuals is therefore pivotal, including the implementation of measures to improve access by individuals requiring treatment. It is important for treatment services to be aware of the particular cultural barriers and difficulties drug use presents to CALD clients and families. Further, the Western concepts of counselling and self-disclosure do not exist in many ethnic communities. This presents further challenges such as scepticism from clients and their families, and assumptions by workers in taking an individually centred approach excluding family. Culturally relevant approaches are needed to respond to differing life experiences and stresses to which many ethnic communities have been exposed, including pre- and post-migration experiences.

Currently there is no substantive evidence for the extent to which cultural background impacts on:

1. Clients' experiences of treatment in Australia
2. The capacity of D&A mainstream services to work with people from diverse backgrounds, and
3. The policies and procedures of mainstream D&A services when working with culturally and linguistically diverse clients.

It is therefore important to gain a clearer understanding of the picture across the sector in order to more strategically and effectively work towards sector development. This pilot project is the first stage in moving towards this aim.

# 3 Research design

The primary methodology was two self-completion questionnaires, one for workers in D&A treatments services in the area of Western Sydney, and another specifically for service managers. The purpose for surveying workers in the sector was to understand how they worked with clients from a CALD background, whether there were any particular policies or processes in their workplaces regarding CALD clients, whether workers felt their treatment of CALD clients was adequate, how many CALD clients they worked with, if outreach occurred to potential CALD clients, whether workers could identify any barriers for CALD clients and their families, and how workers saw such barriers could be addressed in their workplace.

The initial design for this project was for a larger study that also included in-depth interviews with former clients of treatment services and workers. The project was scaled down to only include self completion questionnaires with workers once it became evident that the recruitment process for former clients was not successful. The primary reasons for this are discussed in the limitations section of this report (see appendix 1 for the recruitment process for former clients of treatment services). As this project did not have an allocated budget the recruitment approach was limited, and alternative approaches to recruitment could not be employed primarily due to personnel resource constraints. The original larger scale project, of which the self completion workers survey was a part, received ethical approval from The NSW Population and Health Services Research Ethics Committee.

## 3.1 QUESTIONNAIRES

To identify workers, a list of alcohol and other drug treatment services in Western Sydney was obtained from the Network of Alcohol and Drug Agencies (NADA). Mangers or team leaders of these services were then contacted by telephone with an invitation to their agency to participate in the project. For those services that consented to being involved, an information sheet and the links to two online questionnaires were emailed to the manager with whom initial contact had been made with instruction for them to forward the email on to their staff so staff could opt to participate. The body of this initial email included information about the project scope and aims, methodology, how the information given would be used, and confidentiality. One service was not able to participate electronically, and as such hard copies of the questionnaire were posted to this manager for them to distribute to their staff. See appendix 3 for the process of recruitment and appendix 4 for a copy of the email, questionnaires and information sheet.

The results of the workers' questionnaires are outlined below. Following each sub heading is a box containing the implications for the findings. As this is a pilot study with a low number of participants, more comprehensive research is required to test the validity of these implications.

# 4 Results

## 4.1 PROFILE OF SERVICES

Fourteen services agreed to participate in the pilot study, with participants representing a total of 12 agencies located in the inner west, south west and western Sydney. A total of 29 D&A health professionals participated in this pilot study by completing an online questionnaire. The sample consisted of 14 managers, including service managers and program coordinators, and 15 workers, including counsellors, support workers, case managers, a program officer and a solicitor. The agencies ranged in size from seeing 14 to 230 clients during July 06 to June 07. They also ranged in type and included seven specialist drug and alcohol treatment services, two ethno-specific welfare services, one community health centre, one family service and one women's counselling service.

## 4.2 ETHNICITY DATA COLLECTION

When asked what ethnicity information services collected about their clients, 6 out of the 9 services responding to this question collected at least 4 ethnicity indicators, with the most common combination being country of birth, languages spoken at home, preferred language spoken and the need for an interpreter. Overall most of the agencies collected data on country of birth (8), languages spoken at home (7), preferred language spoken (7), and the need for an interpreter (6). All services collecting languages spoken at home also recorded preferred language. The responses show that very little data was collected on parent's country of birth (3) and English proficiency (3).

**IMPLICATIONS FOR DATA COLLECTION**

The NSW minimum data set (MDS) for alcohol and other drug treatment services requires services to collect data on country of birth and preferred language spoken. These results indicate that:

- Many services might be collecting more ethnicity information about their clients than required by the MDS
- At the same time, a small number of services may be failing to collect the minimum ethnicity data required.
- As this pilot only includes a small selection of services, further investigation would be required to determine the spread of ethnicity data collection across the sector.
- If services are collecting ethnicity information other than that required by the NMDS there is potential to compare how the different ethnicity indicators used impact upon the identification of CALD clients, and whether the number of CALD clients in treatment reported through NMDS changes according to the indicators used.

## 4.3 CALD REPRESENTATION IN SERVICES

Managers were asked to give actual figures of the total number of clients in treatment from July 2006 to June 2007, and the number of CALD clients[i] in treatment during the same period. Alongside this workers were asked to estimate the proportion of their clients from CALD backgrounds, with responses confirming that workers' estimates were accurate. Across the 12 agencies represented in the sample most (9) had less than one-quarter with three of these agencies indicating they had hardly had any CALD clients (less than 5%). Three agencies had most of their clients from CALD backgrounds, i.e. more than 50%, two of these being ethno-specific welfare services.

In terms of the demographic profile of CALD clients, managers reported that country of birth and language group representation among clients between July 2006 and June 2007 was diverse. The languages and birthplaces listed reflected the major CALD groups in services' catchment areas, as identified by workers. A total of 25 overseas countries of birth and 17 languages other than English were reported by managers[ii]. Six services had 3 or more languages represented in their client group, despite 4 of these services having less than 25% of their clients being from a CALD background. Managers reported that no clients had used an interpreter between July 2006 and June 2007. Across the 7 services who answered this question (not including the ethno-specific services) a total of only 2 clients had used an interpreter, with these clients coming from the 2 largest services (both had over 200 clients during the 12 month period). Therefore use of interpreters, at least among services in the pilot, is negligible.

**IMPLICATIONS FOR CALD REPRESENTATION IN SERVICES**

- Staff seem to be aware of the proportion of CALD clients in their services.
- According to the NMDS, 5% of clients preferred a language other than English. In this pilot study however 9 out of the 12 services said they had more than 5% of clients who were from a CALD background (born overseas in a NES country, or spoke a LOTE at home). While cultural diversity is difficult to quantify and identify through data items, this difference in results suggests that asking what languages are spoken at home may identify a higher proportion of CALD than current NMDS items.
- Nine out of 12 services had less than one-quarter of clients who were from a CALD background. However, even with the relatively low proportions, the CALD clients who were accessing these services were from a diverse range of backgrounds. This highlights the need for general cultural competence among all workers across the sector, not just training or resources in relation to specific cultural groups.
- The range of cultural backgrounds of clients who have accessed these services challenges the assumption that people of a CALD background do not want to access services, or that it is only the role of ethno-specific services to service CALD clients, particularly in areas such as western and south-western Sydney which have high proportions of cultural diversity.

[i] This was defined as being born overseas in a non-English speaking country or speaking a language other than English at home.
[ii] Overseas country of birth identified were New Zealand (4 services), Tonga (4), Samoa (4), Viet Nam (3), Fiji (3), Italy (2), Lebanon (2), Poland (1), England (1), Scotland (1), France (1), Turkey (1), Malta (1), Russia (1), Canada (1), Brazil (1), Philippines (1), Malaysia (1), Cyprus (1), India (1), Switzerland (1), Cambodia (1) and Iraq (1). Languages other English identified were Italian (3 services), Vietnamese (3), Tongan (3), Maori (2), Samoan (2), Turkish (2), Polish (2), Arabic (2), Greek (2), Korean (1), Spanish (1), Tagalog (1), Maltese (1), Chinese (1), Cambodian (1), Lebanese (1), and Iraqi (1).

### 4.4 REFERRAL AND TARGETTING CALD GROUPS

With regards to how CALD clients were usually referred to their respective agencies, the most common sources of referral were self referral, family members, alcohol or other drug treatment services and correctional services. Other referral sources identified included a GP or medical specialist, community health services, court diversion and CALD specific services. When asked if the sources of referral for CALD clients differed to those of other clients, managers unanimously reported that no differences existed.

During the last 12 months all services had briefed other agencies on the D&A services they offer and the work they do, but the most common agencies briefed were other related NGOs (8), Corrective Services (8), the Department of Community Services (DOCS) (7) and the Alcohol and Drug Information Service (ADIS) (7). Only 3 services had briefed CALD community groups, bilingual health workers or interpreter services about their agencies, and 2 of these were the ethno-specific services. Further, only 2 services had briefed migrant services about their agency. With regard to publicising services or programs only one service had utilised bilingual media, bilingual material and community liaison.

Only three services had ever run specific CALD funded projects or programs, with two of these being the ethno-specific welfare services. Among those who had not, the reasons given focussed on funding not being sought, or such programs not being seen as required.

Managers reported that their services became aware of the needs of CALD groups through networking and involvement in community activities, through interagencies, reports, clients accessing their agencies, referrals and community work. Eight managers indicated that the planning processes for their services addressed the needs of people from CALD backgrounds. The ways that the needs of CALD clients were addressed during planning were through networking with CALD groups in the community, recognising specific needs (e.g. language, diet, religious or cultural practices), seeking advice from other services, service promotion strategies, and the recruitment of bilingual staff. One manager commented that the low number of referrals from CALD clients was noted in all planning processes. One of the treatment services reported that given their very low referral rates, along with very high demand for their service, they put very little energy into increasing the agency's expertise for CALD clients.

**IMPLICATIONS FOR REFERRAL AND TARGETTING CALD CLIENTS**

- The results indicate that CALD specific programs, including those run in languages other than English, were not seen as a priority or within the scope of the mainstream services in the pilot study, despite their location in areas with high CALD populations.
- Services do not seem to be informing agencies which CALD clients might currently access of the range of services offered for D&A treatment.
- It would appear that while the majority of managers felt their services were aware of the needs of CALD groups and addressed the service delivery issues for people from CALD background, the methods of becoming aware and addressing needs were haphazard and not strategic, targeted or proactive

## 4.5 WORKING WITH CALD CLIENTS

With regards to the tools used in their work with CALD clients, the most commonly used tools as indicated by D&A workers were pamphlets in other languages (9), followed by interpreters (6) and bilingual or bicultural workers (6). Thus, while the use of interpreters was scarce during the 12 month period it would seem that most workers have had experience in working with interpreters in the past. When commenting on the experiences and effectiveness of each tool, it would seem that apart from ethno-specific workers, most of those workers who used pamphlets in other languages did so largely for the benefit of families, or commented that their clients still had English as a primary or preferred language. Interestingly, the workers who had utilised bilingual or bicultural workers stated that they had found this to be the most effective tool when working with clients from a CALD background, and spoke highly of their experiences with such workers. English language pamphlets and videos were reported to be of lower usage at treatment services when working with CALD clients.

Comments from workers regarding the effectiveness of tools indicated a range of attitudes towards working with CALD clients. These ranged from not having a need to use any such tools to more proactively seeking tools and engagement. The comments below reflect this spread:

> *Because of the health provision nature of our services, it is essential that applicants be able to speak and understand English*
>
> *[The] majority of our clients speak English as their primary language and therefore our resources are appropriate to use with our client group*
>
> *We have the tools in our resource library - to be used as needed*
>
> *The pamphlets have been predominantly for parents to receive information in their own first language. Although many of our clients are of a CALD background they are competent in speaking & reading English*
>
> *Context is lost in interpretation. It's really important to set up the process really well in order for it work and be effective!*
>
> *Bilingual information, support and counselling is the most effective tool, and preferred option for counselling individuals and families from a CALD background*

When asked if there were enough D&A tools available to workers to work with CALD clients and families, the responses indicated that a considerable number of workers felt they had enough tools available to them (9 out of 13). Additional resources required by the 4 remaining workers were pamphlets in other languages, and rights and responsibilities in other languages. One of these workers reported not having any of the listed tools at their workplace, and subsequently relied on their own CALD background and understanding when working with CALD clients.

In response to the special provisions offered to CALD clients by their services, one prominent special provision indicated by most workers was access to interpreters (6), or bilingual or bicultural workers (4). Other provisions listed included being culturally sensitive during treatment, telephone and face to face counselling, leaflets in other languages, referral to appropriate services, provision of alternate meal options to clients, supporting religious or cultural practices such as prayer, linking clients and/or their families into cultural community groups and staff attending culture specific training.

**IMPLICATIONS FOR WORKING WITH CALD CLIENTS**

- The most commonly used tools for working with CALD clients were pamphlets in other languages. Comments indicated however that not all workers have access to such resources on site due to an attitude that bilingual resources are not needed as the majority of clients speak English.
- Further research is needed to better understand the uptake of and experiences with different strategies specifically for working with CALD clients among workers across the sector.
- A range of attitudes towards working with CALD clients was expressed among workers, from excluding clients who could not speak English from services, to actively seeking tools and the most effective ways for working with individuals and families from CALD backgrounds. Further research is needed to understand the predominance of attitudes across the sector and how these influence practice and treatment outcomes and experiences for CALD clients and their families.

### 4.6 POLICIES, PROCEDURES AND PLANNING SPECIFIC TO CALD CLIENTS

Seven managers stated that their services currently had policies that related to CALD clients. Of these three did not appear to be specifically for CALD clients but generally related to respect and having the same rights and responsibilities for all clients. The remaining four services with specific policies related to the use of interpreters, and accessing appropriate community organisations or CALD services.

With regard to procedures to ensure that CALD clients were made aware of their rights as clients, 9 managers said that such procedures were in place in their services. However, as with the question on polices, although most managers responded in the affirmative, from their comments it does not appear that all of these are specifically for CALD clients. Most comments related to clients being told of their rights, confidentiality, and privacy more generally, i.e. the same protocols for all clients with no specific provisions for language or cultural difference. Only two made mention of making clients aware of interpreter services, with one commenting that: “All clients are made aware of their right to be given access to an interpreter if deemed necessary. There has not been a need to access interpreters at any stage to my knowledge”.

**IMPLICATIONS FOR POLICIES, PROCEDURES AND PLANNING**

- Most managers said they had specific policies and procedures for working with CALD clients, however, when looking at comments about these policies and procedures many were not actually specific for CALD clients but related to general rights and responsibilities.
- More investigation is required to ascertain the extent to which specific policies and procedures exist across the sector, and the extent to which non-government D&A services are aware of policies such as the NSW Health policy directive for Standard Procedures for Working with Health Care Interpreters, which is mandatory for all NGOs with 50% of more of their funding from NSW Health.

### 4.7 DIFFICULTIES AND STRENGTHS IN WORKING WITH CALD CLIENTS

Workers were asked about the difficulties they have encountered when working with CALD clients, and the difficulties or challenges in providing services to CALD clients. Overall the most common difficulties identified related to language and effective communication. Comments from two respondents were 'English not understood well' and 'difficulties understanding strong accents' Other difficulties relating to communication included the difficulty of counselling with an interpreter, and communicating concepts of treatment and counselling. The difficulties beyond language and communication that were identified included lack of services and long waiting periods, difficulty in referring clients to rehabilitation or detoxification units that are CALD equipped, the associated family shame due to the drug use of a family member, gaining trust, working closely with families, attending appointments and the difficulties in understanding different cultures and values.

Workers were specifically asked if CALD clients found it difficult to understand concepts that related to treatment, counselling and case management. It was reported that on occasions some CALD clients found these concepts difficult, for instance the distinction between case management and counselling, and language and cultural barriers to treatments such as therapeutic communities were also identified. It was acknowledged that such concepts need to be explained well and time taken to check all clients understand, not just those with a CALD background. One worker responded purely in terms of language stating that "If an applicant is unable to understand basic English we usually refer them to another program".

Workers were less able to identify the strengths or positive aspects in working with CALD clients than they were the difficulties or challenges. Only three workers identified strengths, responding that it was interesting and informative for them as workers, that CALD clients seemed to have an "extra bonus" of not only family support but support from their extended families and cultural communities. Also, many CALD clients had great respect for their religious leaders, their families, and community and this could be used to motivate them for change.

| IMPLICATIONS FOR DIFFICULTIES AND STRENGTHS | |
|---|---|
| | • That workers saw language and communication as the main difficulty in working with CALD clients suggests that increased utilisation of the Health Care Interpreter Service, and bilingual information, may assist workers in overcoming such difficulties.<br>• The responses on difficulties beyond language and communication identified areas where workers may be feeling ill-equipped, such as working with families and understanding different cultures and values. Further investigation is required to identify areas where confidence in working with CALD could be improved through training, resources and support.<br>• Family and community support was identified as a strength by several workers. This is perhaps a valuable avenue or entry point for promoting more inclusive service delivery and training for workers in engaging CALD families. |

## 4.8 BARRIERS TO ACCESSING SERVICES & THE COMMON CONCERNS OF CALD CLIENTS

When asked about the reasons that people from CALD backgrounds may not seek assistance for D&A related issues, most workers (6 of 9) identified shame, stigma, fear or denial. Specifically, the shame that seeking external assistance might bring to the family or community, the impact this might have on the client, and the result of living in denial of the problem. Other reasons for not seeking assistance were a lack of information or knowledge of available services, lack of staff, not being able to express their problem, and previous negative experiences with government agencies.

In regards to the common concerns of CALD clients who did access treatment, all client concerns identified by workers related to confidentiality or stigma in the family or community context. For example, their family or community finding out about personal issues, drug use or criminal behaviour, lack of family understanding, personal and legal issues being discussed with family without the client's consent, and being ostracised.

| IMPLICATIONS FOR BARRIERS AND CONCERNS | • There appeared to be an understanding amongst workers regarding some of the barriers people from CALD backgrounds face in accessing services, and the common concerns of CALD clients. Further investigation is required to ascertain the level of awareness and understanding across the sector, and how this impacts service delivery and approaches. |
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## 4.9 SKILLS AND TRAINING

None of the services included in the pilot used interpreters regularly, with one manager commenting that their service "…have had issues with translating in the past and therefore we are hesitant in using interpreter services". Further, not many of the front line D&A treatment workers in the sample had received training to work with interpreters and interpreting services. Only two managers said they had staff that had been trained, and the three workers who reported receiving training in working with interpreters all did so in 2000.

Half of the managers said their staff received cultural awareness training and seven of eleven workers said they had, this training included in house training during orientation and induction and training from senior staff. Specific training outlined was the half day workshop on working with people from Pasifika background delivered by Tedd Noffs and DAMEC (2006), NSW Health cultural diversity and aboriginal awareness training (2000), and bilingual health education training (1987).

Managers appeared to be aware of whether their staff were bicultural or bilingual, even where this was not specifically used in their roles. Of the five workers who identified as being bilingual or bicultural, two workers said they utilised their biculturalism in their current work, and another worker said they had utilised their bilingual/biculturalism in a previous role. One manager commented that their staff were "…not hired on the basis of languages or cultural background, although this is a bonus".

| IMPLICATIONS FOR SKILLS AND TRAINING | • A negligible number of workers had received training in using interpreters. The assumption in most services appeared to be that such training was not applicable as their client group did not need interpreter services.<br>• The negligible training in using interpreters, the difficulty of language when working with people from CALD backgrounds identified by workers, and the fact that interpreters were only being used for 2 clients across all the services in the last 12 months suggests that interpreters might be being underutilised. Further investigation is required to ascertain whether this is the case.<br>• As the NSW Health Care Interpreter Service would be available to most D&A treatment services it is suggested that training be made available to service staff on accessing and utilising this service. Training and policies should also include guidelines for establishing whether an interpreter is required.<br>• Further investigation is required to ascertain the proportion of staff in D&A treatment services in NSW who are bilingual and/or bicultural. By identifying this profile across the sector such staff and services could be utilised in improving treatment accessibility, experiences and outcomes for CALD clients. It is also important that utilising bilingual and/or bicultural staff is done in keeping with NSW Health guidelines with appropriate remuneration [iii]. |
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### 4.10 IMPROVING ACCESS BY CALD CLIENTS

Workers' suggestions for improving access to services by CALD clients included receiving more support from non English speaking communities and religious leaders, employing more bilingual workers, being aware of CALD services available and developing pamphlets in different languages. With regard to services becoming more culturally appropriate for CALD clients, workers suggested engaging specific assistance (such as spiritual), utilising bilingual educators and counsellors, having a network of bilingual counsellors for referral, workers understanding and being sensitive to cultural issues and traditions, training on CALD communities, and information provision in the required language. One worker commented that "the barrier is not only the language but it's also the cultural awareness".

[iii] NSW Health encourage bilingual staff to deliver their service directly in their other language, without using an interpreter, but state that the use of bilingual staff to interpret is inappropriate[20]. This is a slight but important distinction. Bilingual staff who work for NSW Area Health Services may be eligible for the community language allowance scheme (CLAS). The current base allowance is $1306 pa and the higher level rate is $1556.[21] Increased knowledge of this allowance may provide incentive for bilingual staff to sit for the Community Relations Commission (CRC) examination or obtain NAATI recognition, and further validate the use of staff's bilingualism in their service delivery where the opportunity arises.

# 5 Limitations and recommendations

The limitations of this research are primarily due to the pilot nature of the project and budget constraints. The identified limitations of this project are listed below.

- Given the small size of the pilot the results are not able to be generalised across the sector. Further investigation is needed sector wide to explore the implications of this research.
- The number of staff participating from each service was lower than expected (an average of 2.5 staff per service). It was thought that providing an online version of the questionnaire would have improved uptake, as it was judged to be easier for staff to follow a link to the questionnaire from an email sent by their managers. Further, no hard copies of the questionnaire were completed from the service that preferred this format. It is recommended that future research further explore which survey technique might yield the highest response rate among D&A workers, including interviewer administered telephone interviews.
- Eight participants did not fully complete the online questionnaire. Reasons for this could have been the length of the questionnaire and the online medium. Responses from this pilot study will assist in reducing the length of the survey to improve completion rates in future research.
- As this pilot project had no allocated budget, no incentive was able to be offered to staff to encourage participation. It is recommended that future research include funding for this, such as offering a chance for staff to win a CCWT training course, or another incentive deemed to be appropriate for a professional context. It is anticipated this would further increase staff participation and questionnaire completion.
- The pilot study includes no client perspective, which is a significant omission given this research is focussed on access and equity issues for CALD clients in D&A treatment services. Although ethics approval was granted to include interviewing former clients of services, recruitment for this stage was not successful. This is a difficult group to access and budget and time constraints did not allow for an adequate recruitment strategy. It is recommended that future research attempts to access clients that are currently linked with services (rather than former clients), includes a budget to provide resources for promotion and alternative recruitment strategies, and a budget to provide incentives for participation such as Woolworths gift vouchers or another incentive appropriate for this group.
- The pilot study only included services in western and south western Sydney, which are areas with high cultural and linguistic diversity. It is recommended that further research include services across New South Wales.

# 6 Conclusion

Currently across the sector drug and alcohol services are managing full client loads and waiting lists. Within this context managers expressed a reluctance to promote their programs and services to people from CALD backgrounds as this would potentially increase demand for their services. This is a tension between workload and equity that is difficult to navigate. However, the consequence is that CALD population groups do not have equal access to adequate specialist care in our health care system, and continue to be invisible to service providers. Evidence from the pilot study suggests that mainstream services do not see ensuring access for CALD clients as part of their role. CALD clients may be overtly excluded, with one manager stating that due to “the health provision nature of our services it is essential that applicants be able to speak and understand English”, or the exclusion may be less direct, such as services not including migrant services among those agencies they briefed on the D&A services they offer. For the sector as a whole to begin to engage with this tension between workload and equity, attitudinal shifts need to occur so that improving equity for CALD clients is not seen as peripheral to the business of mainstream services but as part of delivering universal healthcare in a culturally diverse society.

The diverse range of cultural backgrounds of clients who have accessed the services in this study, despite relatively low numbers, demonstrates that in a culturally diverse society services will encounter diversity to some extent, irrespective of the intentions or attitudes of service providers. While staff were aware of the proportion of CALD clients in their service, low numbers were cited as the main reason for not giving this population group special consideration. As long diversity is seen as irrelevant in service providers’ conceptualisation of their target population, services may be unprepared and ill-equipped to work with CALD clients when they present. The most fundamental provision to ensure equitable health care for CALD clients is accommodating language where a client is more proficient in, or would prefer, a language other than English. However, across all of the services only two clients had used an interpreter in the last twelve months, only three out of twenty-nine workers had ever been trained in using interpreters (all in 2000), and workers mostly identified language and communication as a difficulty when working with CALD clients. While English is the preferred language of most clients currently accessing services, these results suggest interpreters are being underutilised. If a service is not proactively anticipating or recognising a special population group then it is unlikely there will be adequate systems in place for ensuring equity of healthcare when people from this population group present to the service. While further research is required to ascertain whether this is the case, the pilot results suggest that services do lack specific policies and procedures and workers are not formally trained in working cross culturally or linguistically, with this having potential impacts on clients’ access to equitable healthcare.

Differences between services in attitudes towards access and equity, and in understandings of how these translate into service delivery, could mean significant differences between the experiences of clients across the D&A sector. The pilot results indicate there is great disparity between services, and between individual workers, in their attitudes and capacity for working with CALD clients. While some focussed on the profile of the majority, viewing special provisions for CALD as not applicable to settings where there were low numbers of CALD clients, and others focussed on the needs of individual clients, seeing a need

to be prepared if a client requires special provisions because they are from a CALD background. Fundamentally this is a difference in ideology surrounding the place of equity in health care delivery settings. Addressing such disparities could assist in improving equity of care sector wide, with the aim that sector wide CALD is seen as significant population group for mainstream service provision motivated by improving health care for CALD clients and their families, rather than numerical significance.

As this is a pilot study these results are merely suggestive of the situation across the sector. Further research is required, with the inclusion of the perspective of clients, in order to understand the dominant of attitudes across the sector, how these influence practice, and what the treatment experiences and outcomes are for CALD clients and their families accessing D&A services in New South Wales. Given the scope and complexity of such a project, it is recommended that such research only proceed once adequate funding has been allocated.

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# Appendix 1 – Former client recruitment

### 1.1 Inclusion criteria

- Either the participant or one of their parents is born overseas in a non-English speaking country
- Able to converse in English
- Previous contact with AOD mainstream treatment services
- No longer using AOD problematically
- 18 years old and over

The pilot project's aim is to assist in the development of culturally appropriate treatment for AOD related issues for CALD clients, therefore the project participant must be from a CALD background and have previously accessed mainstream AOD services. The participant should no longer be using AOD problematically so people are better positioned to retrospectively evaluate their experience in the treatment service, particularly any experiences attributable to cultural differences. Only people who are able to communicate verbally in English will be interviewed. Since there is no funding for the pilot bilingual researchers cannot be employed. Also, when interviewing someone it is important to help them feel comfortable describing their experiences, so difficult language barriers can cause distress due to communication frustrations.

### 1.2 Recruitment process

To identify CALD former clients an advertisement will be placed in the 'user's news' newsletter (appendix 2), briefly describing what the pilot project is about and providing contact details and names of the project facilitators at DAMEC. Potential participants for the CALD former clients group will then contact the principle researchers at DAMEC by telephone and/or e-mail if they are interested in participating. During this telephone conversation the researcher will further explain the project, and confirm that the participant fits the abovementioned inclusion criteria for the study.

During initial telephone contact made with potential participants, if it becomes clear that fluency in English will prevent the person from giving free and voluntary consent to the project, or mean they will not be able to adequately discuss their experiences then the will be excluded from this pilot study.

### 1.3 Consent process

In initial discussions with potential participates the following information about the project will be briefly outlined to them; the project scope and aims, methodology, time commitment should the person agree to participate, what will be involved in the interview, how the information given will be used, and confidentiality. The potential participant will then be asked if they are willing to be interviewed. When meeting with the interviewer participants will be provided with an information sheet for them to keep which the interviewer will talk them through. Following the participants having being read the information sheet, and after having had any of their questions answered regarding the information provided, if they are still in agreement to participate in the pilot project they will be asked the sign a consent form. The interviewer will also sign the form.

## Appendix 2 – Advertisement in 'User's News'

The following advertisement appeared in the Autumn 2007 edition of 'User's News' (issue no. 50). No participants were recruited through the advertisement.

- **Are you from a non-English speaking background?**
- **Have you stopped using?**
- **Have you ever been a client of a drug and alcohol treatment service in NSW?**

  If you said yes to all three we'd like to hear about your experiences

DAMEC is a NSW non-government organisation working to improve services for people from a non-English speaking background. If you answered yes to all three questions then we would like to talk to you about your experiences with drug and alcohol treatment services. Everything said will be kept confidential and anonymous. Your input will help us identify how services can better serve people from a non-English speaking background.

If you are interested in being interviewed we would love to hear from you. Contact Constanze or Connie on 0412247084 or email constanzed@damec.org.au for more information

# Appendix 3 – Worker recruitment

### 3.1 Inclusion criteria

ATOD workers in the area of Western Sydney, including service managers. Workers would either work for alcohol and other drug treatment services, or deal with issues related to problematic alcohol and drug use in their clients (such as counsellors, Reconnect workers etc). The purpose for including this group is in order to understand how services and workers work with clients from a CALD background, whether there are any particular policies or processes that are in place, whether workers feel their treatment of CALD clients is adequate, how many CALD clients they work with, if outreach occurs to potential CALD clients, whether there are any barriers for CALD clients and their families that workers can identify, ways workers see such barriers can be addressed in their workplace.

### 3.2 Recruitment process

To identify workers a list of alcohol and other drug treatment services in Western Sydney was obtained from NADA, and other workers who deal with AOD issues among their clients will be identified through industry and workplace contacts. Workers will then be contacted via telephone or email with an invitation to participate in the project by completing the questionnaire for workers and service managers. Questionnaires for workers will be emailed, or posted to their workplace if they do not have email access. Specific workers will also be identified who would be suitable for face-to-face interviews in order to further explore issues and experiences. They will be invited to participate in this way via telephone.

### 3.3 Consent process – Questionnaire

Workers will be emailed (or posted) a questionnaire to complete, with service managers being given a specific questionnaire. These will also be accompanied by the participant information sheet signed by Hamed Turay. The body of the initial email will also include the following information about the project scope and aims, methodology, how the information given will be used, and confidentiality. This will be extent of the consent process for the questionnaire. Participants will be asked to have their responses back to the researcher by a specified date.

# Appendix 4 – Email, information sheet and questions

Phone calls were made to service managers to inform them of the study. The email below was sent to managers, who agreed for their staff to participate, to forward onto workers in their services. Follow the links below for a copy of the information letter and questionnaires.

**From:** Connie Donato-Hunt
**Sent:** Thursday, 6 September 2007 11:37 AM
**Subject:** DAMEC research project

Dear Colleagues,

The Drug and Alcohol Multicultural Education Centre (DAMEC) is investigating the experiences of culturally and linguistically diverse clients in accessing drug and alcohol treatment services. The purpose of this research is to identify how services can better serve clients from CALD backgrounds. DAMEC has developed an online survey asking managers and front-line workers of ATOD treatment services for their perceptions and experiences in working with CALD clients.

Responses will be confidential, and not linked with the service you work for. Your input will be a valuable part of this research so please take the time to complete the survey online. If you would prefer to complete a hard copy please contact me. The survey period closes **Friday 14th September**, so it would be much appreciated if you could make time to do the survey before then. Please be informed that we are also interviewing workers and managers to discuss issues in greater depth, and you will be asked at the end of the online survey for your availability for a face to face in-depth interview.

Click here to complete the front-line workers survey
Click here to complete the manager's survey

Thank-you for your time,

Connie Donato-Hunt
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