HELPING ASYLUM SEEKER AND REFUGEE BACKGROUND COMMUNITIES WITH PROBLEMATIC ALCOHOL AND OTHER DRUG USE

A guide for community support and AOD workers

Helping asylum seeker and refugee background communities with problematic alcohol and other drug use: A guide for community support and AOD workers.

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Contents

Background

The motivation for creating this guide arose from conversations with staff from various health and community services around Queensland who were concerned about a perceived increase in problematic alcohol and other drug use amongst asylum seeker and refugee background communities. While this is what people were reporting on the ground, statistics on treatment for alcohol and other drug use told us that few people from these communities were seeking assistance from specialist alcohol and other drug treatment services.

Research most often finds rates of substance use in refugee communities are lower compared to the general population as well as for other migrant groups [(1)] [(2)]; although this is not always the case. [(3)] Both refugee communities and individuals possess a range of personal strengths and resilience [(2)] that may be protective factors against problematic alcohol and other drug use. However, there are particular risk factors relating to refugee experiences (displacement, trauma, resettlement) as well as the broader socio-economic-cultural environment in Australia that mean people from refugee backgrounds are not immune to problematic alcohol and other drug use issues. [(4)] [(5)]

With this in mind we organised a roundtable discussion with community services that work with asylum seeker and refugee background communities and interested alcohol and other drug services. We discussed what issues they saw regarding alcohol and drug use in the communities they interacted with and also what they saw as the barriers to their clients accessing alcohol and other drug treatment services. We also asked what information they felt they needed to know to better assist their clients with problematic alcohol and other drug use, as well as what information alcohol and other drug services needed to know to help them more effectively respond to people from these communities. The result of those discussions has informed the topic areas found in this guide.

How to use this guide

The guide is divided into two sections:

- The first part is for workers supporting people from refugee backgrounds across the general health and community services sector (including migrant and refugee organisations, mental health services, Centrelink, local government, etc) who may not have specific training or experience in alcohol and other drugs service provision.
- The second part is for those working in the alcohol and other drugs sector and discusses issues that are relevant across the range of treatment settings.

Both sections assume no previous knowledge of the topics discussed. Workers with greater familiarity with these issues may wish to skim over some of the content.

At the end of each section are links to organisations that can provide advice and support as well as additional resources that build on the guides content.

For Community Support Workers

What does that mean?

One of the things raised by roundtable participants was that there is sometimes misunderstanding regarding the terminology used in regards to alcohol and other drug use. The first part of this guide will sets out some common terminology and definitions.

Drugs

A drug is a chemical substance that changes one or more functions of your body [(6)]. This means that many substances that are used regularly are classified as a drug (coffee, Panadol, alcohol etc). It is how these substances are used and the short term or long term effects of them that make drug use problematic.

Drugs are usually considered to fit one of four categories:

- Depressants: drugs that decrease alertness by slowing down the activity of the central nervous system (e.g. heroin, alcohol).
- Stimulants: drugs that increase the body's state of arousal by increasing the activity of the brain (e.g. caffeine, nicotine, amphetamines (ice)).
- Hallucinogens: drugs that alter perception and can cause hallucinations, such as seeing or hearing something that is not there (e.g. LSD and 'magic mushrooms').
- Other: some drugs fall into the 'other' category, as they may have properties of more than one of the above categories (e.g. cannabis (marijuana, hash) has depressive, hallucinogenic and some stimulant properties).

Poly drug use

Poly drug use refers to the use of more than one drug (for instance alcohol and cannabis) either together or one after the other. For example, a person may use more than one substance to enhance the effects of one drug or to manage the symptoms of a drug. Poly drug use is extremely common. [(7)]

Problematic Substance Use

Not all alcohol or drug use will cause problems for the person or those around them. In the same way people can drink alcohol in moderation, illicit substances can be used without causing problems for the person or others, hence the term problematic substance use. It is when alcohol and other drug use causes problems for the person or those around them that they require treatment. This could be caused by problems associated with the person becoming dependent on the substance but problems can occur through recreational use as well.

Dependence/Addiction

Dependence occurs when a person has a strong desire to use alcohol or other drugs and finds it very difficult to control their use despite the harmful effects that using drugs is having on their life. Dependence on alcohol or other drugs may have physical and/or psychological elements as the body or mind adapt to the substance [(6)].

The latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM 5) which is a guide for diagnosing mental health conditions lists the following conditions for diagnosis of a Substance Use Disorder:

1. Taking the substance in larger amounts or for longer than the you meant to

2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts you in danger
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance. (8)

The DSM 5 allows clinicians to specify how severe the substance use disorder is, depending on how many symptoms are identified. The presence of two or three symptoms is indicative of a mild substance use disorder, four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder.

It is important to remember that a person can be both physically and/or psychologically dependent on a substance. A physical dependence is indicated where the body cannot function without the substance present and so goes into symptoms of withdrawal if the substance ceases to be present in the system. A psychological dependence occurs when a person feels that they cannot function properly without the substance or has overwhelming cravings for the effect the substance gives them. This might mean that they can go for a couple of days without using, but they have to use regularly otherwise they do not feel right or feel a very strong need to use the substance.

Dual-Diagnosis/Comorbidity

This term generally describes when a person has one or more substance use problems and one or more mental health problems at the same time. Dual Diagnosis is relatively common. Approximately one third of people seeking treatment for alcohol and other drug issues have a diagnosed mental health issue, while up to two thirds of people with mental health issues have an alcohol and other drug issue. (9)

Harm Minimisation

The principle of harm minimisation forms the basis of how Australia responds the impact of drugs on the community, whether they are legal drugs like alcohol, tobacco and pharmaceuticals or illicit drugs like cannabis, amphetamines (e.g. ice) and ecstasy. Harm minimisation is an umbrella term that includes strategies that:

- Reduce the supply of drugs to the community (such as policing, liquor licencing and regulating medicines),
- Reduce the demand for drugs (such as alcohol and other drug treatment, education and public health campaigns) and,
- Reduce the harms caused by alcohol and other drug usage (this is more fully explained later but includes strategies like needle and syringe programs and advice about safer use of substances).

Abstinence

Abstinence occurs where a person chooses to not use any substances and is sometimes also referred to as 'being sober'. While this is the goal of treatment for many people, it is not the goal for all. Some people may instead wish to reduce the amount that they use or the frequency of their use in order to minimise the problems that alcohol and other drugs have caused them. For many this is a realistic and beneficial goal. Others however may feel that they can't manage to moderate their use of alcohol or other drugs and so choose to be abstinent to avoid problems associated with alcohol or other drug use.

Relapse

Relapse (or lapse, as it is sometimes known) is to return to using a substance after a period of not using or reduced use of the substance. Alcohol and other drug dependence is often referred to as a relapsing condition because it is very common for people trying to achieve abstinence to experience several lapses or relapses during their journey. Each lapse or relapse is not a failure but a learning opportunity and highlights why it is important to provide harm reduction information to clients, such as information on safer using practices.

What is the "Harm Reduction" approach?

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use [(10)]. The goal of harm reduction is to reduce the negative consequences of alcohol and other drug use (such as contracting infectious diseases, overdosing), not to eliminate the use of licit or illicit drugs [(11)].

Strategies may include changing the way a person consumes drugs or ensuring that the environment in which they use minimises the risks of negative consequences to their health or quality of life (legal problems, social and familial issues, etc.).

Harm reduction is not in opposition to prevention or treatment approaches to reducing drug use. Rather, it works in collaboration with these other approaches to meet the health needs of the client based on how the person understands the place of substance use in their life and their readiness for change. By taking a harm reduction approach you are not necessarily encouraging the use of substances, but simply focussing on the current health needs of the client to minimise the potential long term impact of their substance use on themselves and those around them.

What are the potential harms from alcohol and other drug use?

Each drug will interact with the body and the person's life in a different way. A simple way of thinking about the adverse consequences of alcohol and other drug use is using the "4 L's" coined by Roizen and Weisner [(12)]:

1. Liver: problems related to the user's physical or psychological health such as cirrhosis; cancer; overdose; psychiatric, psychological, or emotional problems (amnesia, depression, paranoia, etc.); accidents or other injuries while intoxicated; etc.
2. Lover: problems related to relationships, family, friends, intimate partner, and children.
3. Livelihood: problems related to the user's professional life (e.g., lack of concentration at work or school) and other non-professional activities such as hobbies.
4. Law: Legal problems related to illegal drug use, drug acquisition, and/or trafficking, including driving under the influence of drugs.

What are the important principles to remember when trying to reduce these harms?

- Have a non-judgemental attitude
- Emphasise the person's ability to care for himself or herself
- Provide information about the transmission of HIV, its prevention and its connection with risk behaviours (For more information see the Handy Hints resource)
- Provide different options for reducing risks of use
- Provide a supportive environment
- Be informed about harm reduction programmes and strategies
- Referral to alcohol and other drug treatment programs as requested. [(13)]

General Harm Reduction strategies

Education

The first step is to provide the person with accurate information about the risks of alcohol and other drug use and promote behaviours that reduce risk This information needs to be factual and provided with in a non-judgemental way; trying to scare the person or exaggerate the risks means the client is not likely to believe you. This requires that you inform yourself about the potential risks of alcohol and other drug use. Remember that you do not have to be an expert,

indeed it might be beneficial to seek out the information together with the client. For some good information and resources go to the Resources chapter of this guide.

Needle/syringe exchange programs

For clients who are injecting substances, it is important to provide information on where they can access and dispose of injecting equipment safely. If clients do not feel they can access clean injecting equipment, they may share or reuse old equipment leading to the contraction of blood borne viruses (such as HIV or Hepatitis C) and vein injury. They can also safely dispose of their equipment at these locations so that they reduce the potential harm to the community. Information on locations of Needle and Syringe Programs can be found at http://www.health.qld.gov.au/qnsp/. In Australia, it has been estimated that between 2000-2009 needle/syringe exchange programs have directly prevented 32,050 new HIV infections, 96,667 new Hepatitis C infections and saved $1.28 billion in health care costs. [14]

Emphasising and providing information about less risky methods of use

Sometimes people choose high risk methods of use because they are not aware of other methods of using or do not understand the risks. For example, you could provide someone who is injecting or smoking a substance with information about methods of use that are less harmful, such as swallowing. Advice about choosing safe surroundings for drug use can also be helpful such as:

- Try not to inject or consume drugs alone, have another person around or a support network to contact in case of emergencies
- Where possible first try a small quantity of a substance to test for strength or adverse reactions,
- Avoid using multiple substances at once.

Encourage clients who use regularly to take a break

Suggesting a person take a break from their alcohol or drug use might assist with breaking their cycle of use, or help with preventing their use becoming more problematic. Encourage them to include healthy behaviours into their routine, particularly when they are having a break, like eating nutritious food, sleeping regularly, consuming plenty of water and being involved in other activities that give them enjoyment.

Raising the issue of alcohol and other drug use

For many people talking about alcohol and other drugs with clients and the community is challenging. You may be concerned that raising the topic may adversely impact your relationship with the client or the community, you may feel that the client will think you are judging them, or you might feel that you don't know how to start the conversation. This section of the guide provides some ideas to give you more confidence in talking about the issue of alcohol and other drug use.

AOD use is a health issue, not a moral or legal issue

The first thing is to make sure that the client understands that you are approaching the issue of alcohol and other drug use from the perspective of it being a health concern, not a moral or legal concern. By clearly framing your interest in the issue of alcohol and other drug use as it impacts or potentially impacts your client's health, you reduce any worries the client might have about you judging them for their use.

It is also important to make it clear that you do not view this as a legal issue. If a person is using an illicit substance it is important that you make it clear that you will not be reporting their use to the authorities. This is a common barrier to seeking help or addressing the issue, particularly where a person is being assessed for a permanent protection visa. The client may be concerned that disclosing their illicit (or what they deem to be socially inappropriate) behaviour might lead to that behaviour being reported to the authorities. It is therefore very important that you let the client know that this is a health issue and that they are free to talk to you about it without fear of being reported.

However, if your client is aged under 18 and they provide you with information that suggests that are at risk of harm to themselves or others, through either suicidal thoughts or through very high risk substance use (such as injecting), the worker may need to take steps to protect them from these risks of harm. This could include informing parents or child protection authorities. However, if a young person aged under 18 is considered competent to consent to treatment without parental involvement (sometimes referred to as "Gillick Competent") they may have the right to refuse family involvement in the treatment. Decision making in this regard should be undertaken in consultation with service management, with the knowledge and involvement of the young person. Further consideration of legal and ethical considerations of drug and alcohol issues and young people can be found in the Dovetail good practice guide on legal and ethical dimensions of practice.

No community is immune to problematic AOD use

Some communities that include people from refugee backgrounds have religious or social customs that prohibit the use of alcohol or other drugs. This can lead to the erroneous assumption that there can't be any people who have a problem with alcohol and other drugs in that community, as well as a strong reluctance to talk about the issue. It is estimated that across Australia, 28% of males and 11% of females drink alcohol at levels that put them at risk of harm. It is also estimated that 8% of people in Australia currently have, or have previously had a drug use disorder [(15)]. While there may be protective factors within refugee background communities, it is unlikely that they are immune from the issues of the wider Australian community. Simply having information available on alcohol and other drug use as part of general interactions with the community about health matters will help to de-stigmatise and promote conversations about alcohol and other drug issues.

Patterns of AOD use

When talking to someone about their alcohol and other drug use it is important to understand their pattern of use. Do they use occasionally in small amounts? Do they use often/daily or in large quantities? How does the amount and regularity of their use impact on their life? Do they use in a particular pattern e.g use on every payday then not in-between?

Not all alcohol and other drug use will cause problems for an individual. Using caffeine as an example, you might have one coffee a day, sometimes a few more, but this does not have any impact on your ability to fulfil your duties at work or home and it does not have any ill effects on your health. However if you were to increase that intake to daily use of 4 or more coffees you might find that your anxiety levels increase, you start to notice that you don't function well without coffee and you become agitated easily if you have not had a coffee. You are still using the same substance, but the quantity and frequency of your use has changed, the impact on your life has also changed.

It is the same with other illicit and legal substances. Some people can use a substance like alcohol, or cannabis or even amphetamines (e.g. ice) in small quantities every now and then and not experience problems or become dependent. When that use becomes more regular, and/or larger quantities are used, this is when problems can start to occur.

By gaining an understanding of how often and how much a person is using and how it impacts on their life, you can better address the health needs of the client where they are at. If they are only using occasionally or in small quantities and it does not impact their life, giving them information about the possible longer term impacts of use, or talking about how to ensure they are using the substance safely might be what you focus on. If they are starting to see impacts on their life, or are feeling that they are starting to use more frequently or in larger quantities then what they would like, then this would be the time to talk to them about reducing their use and considering treatment options if the client expresses a desire for specialist support (See treatment options section of this guide).

Risk and Protective Factors

When working with a community or individual it is helpful to look at both the risk and protective factors for problematic alcohol and other drug use. These are things in a person's life or in a community that might help them to avoid developing a problem with alcohol and other drug use, or alternatively might contribute to developing a problem with alcohol and other drug use. When talking with a community this can be a helpful way to broach the topic of alcohol and other drug issues, particularly where the community is reluctant to acknowledge any potential for problems. Start by looking at what are the factors in the community or culture that protect from alcohol and other drug problems, then move onto looking at what might be risk factors.

Some potential risk and protective factors:

- **Protective Factors**
  - strong support networks in the community
  - close relationships with friends and family
  - if a young person, open communication with parents
  - feeling that they belong in a community
  - friends who don't drink alcohol or use drugs
  - good role models
  - a culture or religion that discourages alcohol and drug use

- **Risk factors**
  - isolation
  - exposure to alcohol and other drugs not previously experienced
  - difficulty with a new language
  - difficulty finding their place in a new community
  - conflict between their first country's culture and the Australian culture
  - money problems
  - racism
  - friends using alcohol or other drugs
  - someone in the family using alcohol or other drugs
  - Trauma
  - Family and relationship issues

What are the different types of alcohol and other drug treatment?

A common misconception regarding treatment for alcohol and drug problems is that everyone requires detoxification, followed by residential rehabilitation, and that these are the only treatments that work. Problems associated with alcohol and other drug use comes in varying degrees and affects people in many different ways. This means that treatment needs will be different for each individual.

A range of treatment types and settings are effective for problematic alcohol and drug use. Some people find that using more than one form of treatment can be helpful. All Government provided or funded treatments are provided by qualified staff and abide by privacy and confidentiality laws.

Most forms of treatment seek to address alcohol and other drug use in the context of the client's life experiences, with a focus on the areas of their life that are impacted by substance use.

This section of the guide provides an overview of the different forms of treatment, as well as an indication of who the treatment is most suitable for.

Out-Client Counselling

As the name suggests this form of treatment is conducted in the community with the client staying in their normal residence. Clients will be provided with an appointment, usually 1-2 hours in length, and they attend a service for that appointment. Sometimes counsellors will also provide outreach services to other services that the client is already accessing or provide the session in another safe and private place where the client feels comfortable.

This form of treatment will usually include:

- Assessment – where the counsellor will ask questions about the client's alcohol or other drug use and general health and social issues to gain a picture of the problems associated with the substance usage and what they want to achieve from treatment.
- Treatment planning –the client and the counsellor will set goals for the treatment and discuss strategies for achieving those goals
- Treatment – this could be Cognitive Behavioural Therapy, or Mindfulness Based Therapies or other psychological interventions. Treatment may also include the counsellor helping the client look at other areas of their life that may be impacted by, or impacting on their choice to use alcohol or other drugs.
- Treatment review –the counsellor and the client will periodically look at the client's progress in achieving their treatment goals and decide on next steps. This may include continuing treatment, referring the client on to other forms of treatment or social support, or ceasing treatment.

In Queensland there are a range of services in different areas that provide out-client counselling including publicly funded non-government organisations (NGOs), as well as Queensland Health operated alcohol and other drug services. Government operated or funded services will provide counselling free of charge. Clients can also receive counselling from private psychologists, however this would involve a fee. If a client is eligible for Medicare then they can attend their GP for a referral for 6 subsidised sessions with a psychologist. These may have no fee or a reduced fee associated with them.

As this form of treatment does not require a client to be away from their everyday life for an extended period of time this form of treatment is suitable for clients who have family or work responsibilities. Like many specialist health services, most out-client treatment is operated only during business hours.

A person does not need to be abstinent (stopped using alcohol or other drugs) prior to attending these services. The treatment goal of these services may include safer use, reduced use or abstinence.

All Queensland Health funded or operated services have access to interpreter services, making this a good option for clients with limited English.

Withdrawal/Detoxification

If a person uses alcohol or drugs regularly or for a long time, this can lead to a dependence on these substances. Suddenly stopping the use of alcohol and some other drugs can cause a person to feel sick, sad, angry or anxious and can in some circumstances result in death.

When a client is physically dependent on a substance they may need to seek the assistance of a withdrawal or "detox" service to stop using or reduce the use of the substance safely, and to alleviate some of the symptoms of the withdrawal process.

There are two types of withdrawal:

Inpatient withdrawal: This occurs in a hospital or a residential withdrawal facility. The client will attend the service before they start to withdraw and be admitted for a period of 5 to 15 days, depending on the substance and the client's response to withdrawal. In the facility they will receive medical care and monitoring, medication to alleviate symptoms and psychological interventions to help the client prepare for the next steps of treatment. This form of withdrawal is most suited for people who have had a history of seizures or other complications with withdrawal, do not have an appropriately safe and comfortable place to stay while withdrawing or do not have appropriate supports and care while withdrawing. Medicare ineligible asylum seekers can access hospital detox services however for NGO-operated services a Centrelink benefit is required, otherwise a fee will be involved.

Outpatient withdrawal: A general practitioner (GP) or alcohol and other drug service can provide assistance to a client during their withdrawal, while the client stays in their home or other appropriately safe and comfortable place. This will usually include a client attending the GP or alcohol and other drug service for an initial assessment and to receive advice about the withdrawal process. They may also be prescribed medication, or given a small supply of medication to alleviate the symptoms of withdrawal. The client will then generally go back to their GP or alcohol and other drug service each day during withdrawal to assess how they are progressing through withdrawal and for medication adjustments if required. For GP services a Medicare card will be required otherwise full fee will be charged, for Queensland Health outpatient withdrawal services no Medicare card is required.

Withdrawal/'detox' is not considered treatment on its own and should be considered as the start of an ongoing treatment program, with follow-up counselling and support. [(7)]

Residential Treatment Services (Rehab)

Residential treatment services allow for a person to remove themselves from their current situation and stay in supported accommodation whilst receiving treatment for their alcohol and other drug problems with other people going through the same experience. Most 'rehab' services require clients to have ceased their use of alcohol and other drugs (for some this includes tobacco) and completed withdrawal prior to coming into 'rehab'. Some services will have a withdrawal service onsite as part of their service.

Most residential programs will have a staged approach to treatment that will run over 2-12 months with gradually increasing levels of responsibility and freedom to leave the rehab facility or have people visit.

The initial stages are more intensive and focused on alcohol and other drug use and identifying the reasons for use. The later stages are focussed on assisting the person with living a healthy life without using substances and relapse prevention. Most programs include individual and group work, meaning this is not generally considered a good option for people with limited English.

Some services also have an after care stage where the clients live in more independent, but still supported accommodation to assist with reintegration back into everyday life.

Residential rehabilitation services generally have a state wide intake and there are usually waiting periods to get access, either due to capacity or because the service is making sure that the right therapeutic mix of people are in each group. Some services will have a support program for those that are on their waiting list, or you could also connect the client with an out-client counselling service.

Most residential treatment services are geared for clients on Centrelink benefits and take a portion of the benefit to cover living expenses while in the service.

There are some services that will take clients who do not receive Centrelink benefits, but charge a fee (around $400 a fortnight).

Opioid Substitution Treatment (Methadone Treatment)

People can become dependent on opioids through the use of prescription medication such as codeine, morphine or oxycodone, or through the use of illicit substances like heroin.

Approved Doctors or specialist clinics provide the individual with a substitute opioid based medication to alleviate withdrawal symptoms of opioids. The two main forms of substitute medicine are Methadone and Buprenorphine.

Substitute medications support the individual to have a stabilising dose of the medicine that does not impact their ability to function normally but prevents withdrawal and has been proven to reduce cravings for opioids and are generally administered daily.

Some clients may choose to gradually reduce the dose until they stop using all together, while others may stay on the medication, as it helps them to continue to live a normal life.

Studies in many countries of opioid substitution treatment have repeatedly shown it has positive effects on reducing heroin use, overdose, HIV transmission, and crime. Additional

treatment and support is also beneficial whilst a person is using opioid substitution treatment. (16)

Only some doctors are registered to prescribe this medication.

For people without access to Medicare the normal Doctor's fee will apply if seeing a private GP. For Queensland Health services there is no payment required and can be accessed by those that are not Medicare eligible.

Peer Support/self-help groups (eg Alcoholics Anonymous or Narcotics Anonymous)

These groups are generally volunteer run and involve people coming together to talk about their problems associated with using alcohol and other drugs. In these groups people share what has worked to help them change their substance use. Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and SMART Recovery are examples of such groups. While not strictly treatment, many people find a benefit from these types of group and may use these groups in combination with other treatment mentioned above.

These groups are generally focussed on abstinence being the goal for every person in the group and may include references to Christian concepts of a higher power.

Help for Family and Friends

Sometimes the friends and family of those that are using substances need support to deal with the issues regarding their loved one's alcohol or other drug use. Family support or family counselling services help families think about the best ways that they can help a person who is using alcohol or other drugs.

This support can be in the form of one-on-one counselling, group counselling or the provision of information and education.

Government alcohol and other drug services can provide this type of counselling, as well as NGO services such as Family Drug Support (www.fds.org.au) Lives Lived Well (www.liveslivedwell.org.au) and Drug Arm (www.drugarm.com.au).

How can I find out what services are available in my area?

The Alcohol and Drug Information Service (ADIS) is a 24 hour 7 day a week phone service that can provide advice about what services could assist an individual, what services are available in your area and how to contact them. They can be reached on 1800 177 833.

Tips for making a referral to an AOD service

A client does not need a referral from a GP to be assessed by most alcohol and other drug treatment services. The only exception to this is if they wish to access Medicare subsidised private counselling services.

It is best to talk to the client about what they want to get from treatment before thinking about what service you will refer them to. Some things to consider might be:

- Does the person want to stop their alcohol or drug use? If the answer is no, then perhaps providing them with information about safer use, or referring them to a harm reduction service might be the best option. Also, talking to them about what they like and don't like about their use might help them see more clearly any problems associated with their alcohol or drug use.
- If they want to change their alcohol and drug use do they want to stop completely? If they don't want to completely stop then referring them to an out-client counselling service that is not abstinence based might be a good option.
- How motivated are they to change? You may wish to find a service that can see the client immediately or that has a short waiting list such as out-client counselling to take advantage of their motivation for change.
- Are they physically dependent on a substance or experiencing problems associated with alcohol and drug use? This will affect whether they will need to be assisted with withdrawal as well as receiving psychological interventions. Not all clients will need detox.
- Does the client require an interpreter? If they do then the best option would be an out-client counselling service for assistance where they can use interpreters for each session.
- Is the client eligible for Medicare or Centrelink payments? This can influence whether they can receive fee free treatment at some forms of service. There are still plenty of options that are free for clients if they are not eligible for these Government payments (See treatment type section).

Through building connections with local AOD services (see next section of this guide) you will get a better idea of what these services provide and how they prefer to receive referrals.

Talk to your client about what services are available and then ask them which ones they might be interested in being referred to. While most services will take a client without any referral, assisting the client to make a phone call to introduce themselves to the service can be very helpful for both the client and the service.

Some things you might wish to discuss with the client prior to making a referral include:

- Reassuring the client about privacy and confidentiality when talking to Government or non-Government services about their problems with alcohol and other drug issues. This has been identified as a major barrier for clients seeking treatment as they feel that identifying as someone who has a problem with alcohol and other drug use could negatively impact their application for asylum, or could impact their protection status. For adults, the information provided to an alcohol and other drug service is not shared with anyone unless the client agrees, if the information is subpoenaed by a court, or if

the information needs to be shared in instances of threats of harm to themselves or someone else.

- Explain what the services are. Many countries do not have the range or type of services that we have in Australia for problematic alcohol and other drug use. In some countries alcohol and other drug treatment facilities are more like prison facilities than the health facilities we have in Australia.
- Explain what is expected of them e.g. trying to turn up on time to appointments, what they need to do if they have to cancel an appointment, how to ask for an interpreter.
- Talk to them (and family if they allow) about the expectations for treatment. Changing alcohol and drug use is sometimes very hard and takes a lot of commitment and time. It may not happen overnight. Sometimes it takes a few attempts to stop using alcohol and other drugs. A relapse is not a failure but an experience to learn from next time they try to address their alcohol and drug use. A person may also need to try a few different forms of treatment or services before they find the one that works for them.
- Make sure they understand any potential costs involved. As stated above some services cannot provide a free service to people who are not eligible for Centrelink or Medicare. Be aware of these limitations and make them clear to the client.

How can my service build connections with an AOD service?

It is always much easier for a client, and a worker, to seek help from a service that they already have some idea about. One way we can increase the accessibility of alcohol and other drug services for people from refugee backgrounds is by building connections between those services refugee communities already use. This section of the guide provides some tips on how to build those connections.

Find out what services are available in your area

To find out what is available in your region you can call the Alcohol and Drug Information Service on 1800 177 833 or call the peak body for alcohol and other drug services in Queensland (QNADA) on 3023 5050. Both of these services should be able to give you contact details of the services that are available in your area and what they offer. The QNADA website also offers a service finder function (www.qnada.org.au)

Invite the local services to events or network or team meetings

A good way to make a connection is to personally invite a representative from a local alcohol and other drug service to an event you are holding in the community. You may be part of a health information event, a sports day or something that brings the community together with local services. These events would be a great opportunity to not only meet the service yourself but also to get community members to meet service providers., This can help build the communities' understanding about treatment services available, as well as alcohol and drugs more generally, and could act as a 'soft entry' point to treatment if necessary.

Some services participate in network meetings with other services on a semi-regular basis. Inviting an AOD service to present at these meetings would assist with cross-sector communication and building an understanding of how different services can work together to holistically support clients. The same applies for inviting a service to come and meet your team. This could be an opportunity for your team to ask any questions they have about AOD treatment and start to build a stronger connection between services.

Ask if you can come and visit the service

Sometimes the best way to get to know about a service is to go and visit it. If you can make contact with the service manager and organise for a visit to meet the team and see what the service is like, this is a great way of getting an idea as to who and what you are referring clients to. Many people are surprised at what an AOD service is like, particularly residential rehabilitation services.

How can I help reduce stigma in the communities I work with?

Why is Stigma a problem?

It has been estimated that only 10% of those who have a problem with alcohol or other drugs seek help; with stigma surrounding alcohol and other drug use being the main reason for not seeking help [17]. One study has listed illicit drug dependence as the most stigmatised health condition in the world, followed in fourth place by alcohol dependence [18].

Alcohol and other drug treatment statistics show very low rates of treatment for people born overseas, including those from refugee communities, with 92% of alcohol and other drug clients in 2012-13 born in English-speaking countries. [19] This may mean that that these communities have less of a problem with alcohol and other drug use, but it is also likely that social norms and stigma create a barrier for people from some communities identifying as having a problem and seeking assistance.

Wider than just accessing help, stigma can impact an individual in ways such as:

- Low self-esteem and self-worth
- Feelings of isolation
- Development of self-hate
- Feelings of helplessness
- Disempowerment
- Exclusion from community life
- Physical and psychological distress
- Compromised quality of life
- Chronic stress
- Depression
- Unemployment
- Difficulty obtaining housing
- Problems accessing education
- Limited social opportunity
- Bring shame to one's family and community [20]

"Stigma and discrimination deny the individual their human rights and their right to fully participate in family, community and public life." [21]

What can I do?

Start with yourself. One factor that is easy to change and can make an impact on an individual and the communities you interact with is being mindful of your views and the language you use about people who use alcohol and other drugs.

One of the biggest hurdles to overcome in reducing stigma is to move the discussion of alcohol and other drug problems out of the legal and moral realm and into the health realm. For many years the media and public figures have demonised drugs and drug users. This attitude further increases stigma.

Addressing problematic drug use as a health issue is particularly important with communities that have strong religious beliefs against the use of substances. Talking about the health

impacts of problematic alcohol and other drug use does not diminish the religious beliefs of the community.

Language can also play an important part in how people view an issue. Here are some examples of ways that the language about alcohol and drug users can increase stigma:

- Junkie – This automatically labels the person as 'other', that is, someone who is different to you and of less value. Instead of using junkie you can use terms like "drug dependent" or "person who uses drugs".
- Addict – This term, although used by some people who have had problems with alcohol and other drugs, creates the idea that the person is defined by their substance use. Instead of using 'addict' you can use terms like "person experiencing problems associated with alcohol and drug use". This is sometimes called person-first language, because it puts the focus on the person, not any issues they have.
- Describing someone as being 'clean' – Some people who have stopped using drugs describe the length of time since their last use as being 'clean', the problem with this is that it implies that those that continue to use drugs must therefore be 'dirty'. Instead of using 'clean' you can talk about how long it has been since someone stopped using a substance.
- Drug Abuse or Alcohol Abuse – Abuse conjures ideas of a perpetrator harming a victim (child abuse, sexual abuse, physical abuse etc). This portrays the person who has a problem with alcohol and other drugs as being at fault for their own issues and therefore not 'worthy' of assistance, or the person is seen as inflicting harm on others because of their use. Instead of using drug abuse you can use problematic drug use or problematic alcohol use.
- Drug misuse – although slightly better than abuse, it once again labels the behaviour as something the person is doing wrong, when in fact most drugs have been designed to be used the way that the person is using them and for the purpose they are using them. Drug use is more nuanced than just a question of right and wrong. Instead of using drug misuse use "drug use" if you need to.

Finally, regularly talking about alcohol and other drug use when assessing the wellbeing of clients will assist in reducing stigma around these issues. If you demonstrate to the individual and to the community that you are open to talking about the issues associated with alcohol and other drug use and that you will do so in a non-judgemental way, then these attitudes may be adopted by those that you interact with.

Training and other resources available

Drug and Alcohol Multicultural Education Centre

http://www.damec.org.au/resources/links - Provides links to resources about drugs and alcohol in different languages and for different cultures.

QNADA

www.qnada.org.au – QNADA is the peak body for the AOD sector in Queensland. It provides a range of information about available services, upcoming training and conferences.

Dovetail

http://dovetail.org.au – provides information to support people working with youth alcohol and other drug issues, including videos.

Queensland Injectors Health Network

http://www.quihn.org/ - QuIHN offers a range of information and training about harm reduction. They also provide support for people who use substances.

DrugInfo

http://druginfo.adf.org.au/ - provides information on different types of substances including free printable handouts. They also have a section dedicated to culturally and linguistically diverse communities that can be found here

Headspace

http://www.headspace.org.au/ - provides a range of youth and mental health focussed fact sheets

Youth Beyond Blue

http://www.youthbeyondblue.com/ - youth focused site providing information about alcohol and other drugs and how to minimise harms.

Qld Needle and Syringe Program

http://www.health.qld.gov.au/qnsp/ - provides a list of Needle and Syringe Program outlets across the state.

Queensland Multicultural Health (Interpreters)

http://www.health.qld.gov.au/multicultural/health_workers/refugee_hlth.asp - provides instructions for how Queensland Government funded services can receive access to free interpreters.

For Alcohol and Other Drug Workers

What should I consider when working with people from a refugee background?

People from refugee backgrounds share many client care needs in common with those from non-refugee backgrounds, but also have additional needs due to exposure to traumatic experiences, interrupted access to health care prior to arrival, language and cultural differences. [22]

Barriers to receiving treatment

Whilst there is some evidence to suggest that rates of AOD use may be lower amongst refugee communities than in the Australian-born community [1]; low presence in AOD treatment among people from diverse backgrounds is believed to reflect an under-utilisation of services. [23] Barriers to accessing AOD treatment include lack of awareness and understanding of services. [24] Newly arrived persons in particular may be unfamiliar with not only AOD treatment services but the health system more generally in Australia.

Make time to explain to your clients on more than one occasion fundamental aspects of your service, including:

- Treatment options and rationale, including that AOD treatment in Australia is part of the health system;
- Appointment systems;
- Costs;
- Privacy, confidentiality and consent, including procedures to address these (such as secure storage of personal information)
- Rights to and processes for making a complaint. [22] [25] [26]

Other reasons people from refugee backgrounds may have difficulty seeking assistance for AOD problems include lack of trust in or concerns about the confidentiality of services, including the fears about the impact of disclosing problematic AOD use on immigration applications. [27] For some diverse communities where the family is the traditional source of social support and assistance, seeking help and assistance outside the family unit may be an unfamiliar concept. [27] [28] AOD use behaviours may be concealed due to stigma and the wish to protect the family from feeling shame, scrutiny, and judgment from the wider community; support may only be sought if there is a crisis. [23] [24] Lack of service capacity to cater for persons who speak languages other than English or offer services that are culturally appropriate also impedes treatment access and retention. [23] This is discussed further in the Cultural Competency section.

To address access and treatment retention barriers, AOD services should consider flexible and innovative strategies, such as the following, which have been proven to be effective:

- Partnering with a community agency to deliver services in a less stigmatised setting; [29]
- Relaxing age cut-off criteria in order to engage with a group of disengaged youth as one peer group; [24]
- Using a co-therapist team to overcome shortages in trained bilingual workers; [29]

- Using recreational activities (e.g. BBQs, camp) to build rapport with participants and facilitate treatment engagement; [24]
- Being able to change or add to activities to respond to participant preferences and needs (for instance changing formats of information delivery and seeing clients in a non-formal environment); [30]
- Focussing on relationship building and assisting with life issues (including refugee and immigration issues) rather than maintaining an exclusive focus on problematic AOD use. [24] [29]

Many evidence-based practices were developed for and tested in Western (European/ American) populations. [31] Cultural adaptation of evidence-based interventions (i.e. modifying standard interventions to be culturally responsive) may be considered when an intervention is not effective at engaging a cultural group or enabling that group to achieve positive outcomes, or where there are unique risks or resilience factors in a particular group, or unique symptoms. [32] An example of this is integrating elements of cultural philosophy, practices and communication preferences into AOD treatment. In one program, Vietnamese AOD counsellors explained the concept of 'goals' to clients through the use of metaphors for journeying, visual mapping and outlining step-by-step processes. [33] Another service integrated traditional values of respect for family and community to increase motivation in AOD treatment with Cambodian refugees. [34] Culturally adapted interventions can range from making a few changes to an existing program to address engagement or risk factors, to the creation of a new approach in collaboration with and grounded in the views and perspectives of a particular cultural group. [32] The limited evidence available for cultural adaptation is mixed but promising, and cultural adaptations appear to be comparable in effectiveness to unadapted interventions. [32] [35]

Providing wrap-around support

Of the utmost importance to refugees and their families is rebuilding their lives. Practitioners should facilitate opportunities for retraining, employment, establishing social connections, regaining physical health (also as pathway to mental wellbeing), such as by linking the person with appropriate services. [35]

When making a referral explain clearly to the client the outcome of that referral including: the type of service they're being referred to, how to travel there and a contact person; special procedures for referral and/or eligibility; the type of intervention they will receive (e.g. one-to-one, group); what outcome can realistically been achieved (e.g. if the client is referred for counselling, explain that this may not provide a 'quick fix' for problems); if there is a waiting list; how and when the service will contact them. Refer to public and bulk-billed services where possible as some visa categories do not provide for Medicare eligibility or work rights; but remember that allied health, private psychologists and dental practitioners are not funded to provide interpreters. [22] [26]

Avoid making assumptions about how much support a refugee gets from their ethnic community: people with problematic AOD use may feel excluded from their community and families [35]; or small and emerging refugee communities may have little resources or infrastructure available in general. [26] For instance if your client needs social support, explore ethnic-specific and mainstream services, including places of worship, volunteer programs or other local community groups. [26]

Families may be a particularly important source of advice and support for people with AOD use issues in diverse communities, with some research arguing that lack of provision for family involvement in AOD treatment is a barrier to service access and retention. [23] [27] However others have noted that those who identify as coming from diverse backgrounds do not always want to involve their family in AOD treatment, [36] or some refugees may not have the support of family living in Australia. [37] Where family or caregivers are willing and able to support the person, and with client consent, involving the family in discussions about treatment and family inclusive sessions can help support the client. [25] As intergenerational conflict is an important risk factor in the development of AOD problems in refugees [28] [37] referrals to programs that can build stronger family networks and improve communication processes can be beneficial.

Communication

Newly arrived refugees may have low levels of written and spoken English, and may also have experienced interrupted or no schooling and not be literate in their first language. [38] Information provided to refugees should suit language ability and communication preferences (e.g., oral versus written information) and ideally would be matched with age and gender. [25] [39]

Whilst access to interpreters may not always be easy and may require more resources (e.g. longer session time), using trained interpreters is particularly important when discussing confidential issues, when clients and/or caregivers are distressed, at discharge, when providing referral information, and when working with children and young people. Asking family to interpret for clients is often inappropriate, particularly if discussing sensitive or potentially traumatic information. Family members may also not have the knowledge to translate health/technical terms accurately or withhold information. [22] [25]

Queensland Health funded NGOs are able to book an interpreter at no cost through the Queensland Health Interpreter Service.

More information is available from: http://www.health.qld.gov.au/multicultural/interpreters/QHIS_NGO.asp

Some tips for working with interpreters: [22] [26] [40] [41]

- Ask if the client has any preferences for an interpreter, such as a particular ethnicity, religion or gender. This is particularly important for small/emerging communities where members may be more likely to know each other, and where interpreters are often educated community members/community leaders. Clients may feel that confidentiality is affected if they have to disclose experiences through known persons.
- Book the interpreter as early as possible to allow time to organise a suitable person. Some communities have a shortage of interpreters.
- Contact the interpreter beforehand to discuss the interview. Brief them on the type of discussion, how you would like the interpretation done, and any special needs the client has that could affect how information is received and conveyed.
- Explain your and the interpreter's role to the client. Clarify the interpreter's obligations to keep information confidential. Professional interpreters are bound by a code of ethics which

includes confidentiality.

- Speak directly to the client, using the first person.
- Explain to the client that you may meet with the interpreter after the session for a joint discussion. Debriefing with the interpreter, particularly when distressing or traumatic issues are discussed, is important.

Seek advice on what non-verbal aspects of communication are appropriate, including: touch, closeness of contact (e.g. where staying away could indicate disinterest), handshakes, silence (e.g. may show reflection and respect), eye contact (e.g. between men and women or older/younger people). [42]

Torture/ Trauma

The impact of torture and trauma experiences on mental health is well documented, although estimates of the extent of this vary widely. [43] Post migration stressors can impact more on refugee mental health outcomes than pre-migration exposure to traumatic events. [44] These stressors include separation/loss of family and friends, concern about safety of relatives/friends in conflict areas, settlement difficulties, loss of status, social isolation, loss of culture and traditions, discrimination, racism. [22] [32] [45] In addition for asylum seekers, Government policies relating to detention and visa regulations can have a detrimental impact on mental health and wellbeing. [46] [47]

Australian Guidelines for the Treatment of Acute Stress and Post Traumatic Stress Disorder [40]

For people with comorbid PTSD and AOD use practitioners should consider integrated treatment of both conditions as the two interact to maintain each other and treatment is likely to be less effective if AOD use remains untreated. Where decision is made to treat AOD use disorders first, PTSD symptoms may worsen due to acute AOD withdrawal or loss of AOD use as a coping mechanism. Treatment should include information on PTSD and strategies to deal with PTSD symptoms as the person controls their AOD use. AOD use should be controlled before the trauma-focused component of PTSD begins.

Trauma symptoms and strategies developed for coping with traumatic events can impact on the effectiveness of health treatment: [22] [40]

- Shattered core assumptions leading to distrust/loss of faith in people, loss of sense of self and future;
- Feelings of powerlessness and lack of connection to others can impede ability to carry out everyday tasks and attend to basic needs;
- Feelings of anxiety, distress from intrusive memories, sleep disturbance, and helplessness is associated with poor concentration, confusion, memory impairment, impaired learning ability and interferes with ability to 'hear' and understand questions and instructions;
- Brain damage inflicted during torture can interfere with memory and concentration;
- Anger, hostility (as a manifestation of fear and uncertainty) and lack of trust in 'authority figures' can interfere with obtaining information;

- Survivor guilt may undermine a person's capacity to follow through with self-care strategies and can maintain health problems;
- Means of dealing with anxiety and depression (e.g. excessive tobacco consumption) can interfere with the person's capacity to adopt health promotion practices.

However people with PTSD symptoms also demonstrate resilience and post-traumatic growth. It is important for workers to identify and build on these strengths where possible. [40] Exploration of ways clients have been able manage the challenges of trauma, flight from homeland and resettlement in a new country could be used as part of relapse management and addressing other client issues (mental ill-health, intergenerational conflict). [34]

The extent to which a worker inquires about and responds to experiences of torture or trauma will depend on the person's professional role and whether rapport has been established with the client. [22] Nevertheless, strategies that are useful in a range of settings include: [22] [25] [26] [40]

- Collection of information about reasons for leaving the country of origin, means of arrival, transit countries and conditions experienced in those countries in order to identify potential need for trauma informed care;
- Aspects of treatment may be reminders of past trauma (e.g. being made to wait, sudden movements, seating arrangements, rooms with closed-in spaces or barred windows). Encourage reception to explain cause of any appointment delay and likely length of wait. Consider allowing trusted persons to be present at intake and assessment, or holding sessions outside an office.
- It may be necessary to hold a longer first time appointment or conduct an assessment over several sessions to build trust/rapport;
- Provide information on the purpose and use of assessments, what information will be recorded and what duty of care means. Encouraging the person to ask questions can help promote a sense of control; although bear in mind that in some cultures this practice may be unfamiliar and require extra encouragement/multiple checks;
- Avoid inquisitorial questioning, overly officious and authoritarian behaviour since this can reinforce feelings of powerlessness and trigger memories of interrogation;
- Survivors of torture and trauma may not realise their symptoms are common responses to extremely distressing events and fear they are 'going mad'. Explain that symptoms are normal reactions to extreme stress. Listening and responding sensitively to experiences can help reduce feelings of isolation and counter destructive messages;
- Gender of the AOD worker is likely to be important for survivors of sexual assault;
- Make reminder calls and repeat instructions if the client has memory problems;
- Set small achievable goals that accommodate the client's coping style and any relevant cultural practices;
- Reduce anxiety by planning the client's management in consultation with the client
- Where possible allow for flexibility in follow up appointments (due to transport difficulties, memory problems, anxiety, mistrust);
- Encourage the person to seek appropriate support. If the client has disclosed experiences of torture or trauma make thorough case notes and with client consent, inform referral services so the person does not have to repeat traumatic stories to each service or worker;
- To manage stress and prevent burnout, workers must be aware of their own needs and find appropriate ways of coping with feelings and responses to a client's situation.

These are general recommendations and it is important to seek further advice from or refer to specialist service for survivors of torture and trauma:

The Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)

Phone: 07 3391 6677
Fax: 07 3391 6388
Email for all offices: admin@qpastt.org.au

General Cultural competency tips

Culture shapes the way in which we see the world and ourselves, our preferences, norms and beliefs, the opportunities open to us and how solutions to problems are presented. [48] [49] [50] Cultural competence is a set of behaviours, attitudes, and policies that enable people, organisations and systems to work effectively in cross-cultural situations. [51] The benefits of delivering culturally competent service include:

- Improved access and equity for all groups in the population;
- Improved consumer 'health literacy' and reduced delays in seeking treatment;
- Improved communication and understanding of meanings between service users and service providers, resulting in: better compliance with recommended treatment; clearer expectations; reduced medication errors and adverse events; improved attendance at 'follow-up' appointments; and improved client satisfaction. [52] [53]

Culturally competence is an ongoing process that involves continuous valuation/assessment and reflection. [53]

Individual cultural competency

Cultural competence goes beyond being able to demonstrate empathy, tolerance and respect when working with people from other cultures. Skills of a culturally competent worker also include flexibility, the ability to listen carefully, being able to privilege the client's perspectives about how they define their own needs and problems, and the capacity to recognise that issues that arise are likely the result of misunderstandings, rather than rushing to make judgments. [39] [54]

General knowledge of the culture of refugee groups that make up the population in your local area is important, [42] however as a range of sub-cultures and diversity exist in any cultural group, this knowledge is not likely to be representative of all members of a particular community. [23] For instance, among second generation migrants (i.e. children born in Australia), people may identify with several ethnicities. [55] It is also important not to overstate the influence of culture. For some people, cultural background will not be important to their identity. [56]

Exploring the following with each client can help provide treatment that is responsive to cultural background and avoids stereotyping: [22] [34] [42]

- Countries of origin, migration patterns, ethnic identification and languages spoken;
- Religious affiliation and practices;
- Beliefs, moral values and norms of conduct. For instance, cultural notions of a "good family" mean that family problems are never discussed with outsiders, or in some cultures talking about certain subjects with a member of the opposite sex or a younger person may be inappropriate [25];
- Composition of nuclear and extended family, living arrangements, the use of family, other informal and formal networks for support (including decision making in healthcare matters).
- Perceptions of problematic AOD use, the cause of and ways such problems should be managed. For example, in religious or cultural communities that prohibit the use of alcohol, low risk drinking messages may be seen as inappropriate. [57] Alternatively

> service providers may present minority group experiences as 'problematic' (e.g. a coping strategy to deal with the stresses of migration), whilst community members see AOD use as acting as a mechanism of social integration or affirmation of group identity. (58)

For example, sensitive exploration of refugee and resettlement experiences can help workers forge bonds with clients. (34) Understanding religious and social practices, community and familial networks, and living arrangements for each client is useful in the implementation of cognitive behavioural therapy and brief solutions focused therapy. (33) For example, knowing religious beliefs allowed one program to integrate Buddhist tenets in interventions to re-establish self-purpose, self-respect and to maintain treatment goals. (34)

Reflective practice

Central to working in a culturally competent manner is the ability of workers to be aware of their own cultural background, attitudes, expectations and values. Self-reflection can be used to explore the influence of one's own cultural identity on behaviour and beliefs about what is 'normal' or 'natural'. (25) (38) (42) Workers should also consider how their culture intersects with both the client's culture and the culture of the AOD organisation/ system (including mission/goals/philosophy, view of authority, community attachment). (59)

Geert Hofstede's (49) (50) widely-used work highlights different dimensions to consider when thinking about broader differences between cultures:

1. Individualism – collectivism: Individualistic cultures place value on the freedom of person, individuality, independence, respect for human rights, high value for human life and personal initiative. Individual aims are more important than aims of the group. Ties between individuals are loose, people are expected to look after him/ herself and their immediate family, and relationships are characterised by independence and equality, e.g. children start to leave the parental household earlier. Whereas in collectivistic cultures from birth onwards people are integrated into strong cohesive groups and the interests of the family/tribe/clan are placed above those of individuals. Values emphasise respect for elders and observing hierarchical relationships. When working with collectivist cultures, it is important to: build relationships with community leaders, conduct activities as a group with other professionals, and recognise the effect that age of the professional may have when working with the target group. (42) For instance, one Australian project (60) found that when attempting to arrange an opportunity to speak to an African refugee community group that operated with a hierarchical structure it was necessary to ensure that permission was obtained from committee elders, before an invitation to speak at the group's meeting was extended.
2. Power distance: the extent to which less powerful members accept and expect that power is distributed unequally. Cultures with a greater power distance have a larger gap in status between authority figures and those in a less powerful position. Relations are based on reverence towards elders and obedience; subordinates expect to be told what to do. Cultures with lesser power distance place greater emphasis on level of education, personal merits and initiative, rather than the person's status. Use of power should be legitimate and is judged according values of good and evil. Subordinates expect to be consulted. High power distance is associated with collectivist cultures, low power distance with individualistic cultures. When working with community with a high

power distance culture it is useful to recognise that some members may feel reluctant to disagree with those with status or authority. [48]

3. Uncertainty avoidance: this dimension is about need for clarity and structure, the level of stress in society in the face of an unknown future, the extent to which unknown, surprising and different situations make members feel comfortable or uncomfortable. Strong uncertainty avoiding cultures try to minimise such situations through strict behavioural codes, laws and rules, disapproval of deviant options, belief in absolute truths. Even when people may not stick to rules themselves they wish to see others following these rules. Certainty and stability are valued, whilst unforeseen circumstances (such as migration) cause inconvenience and generate anxiety. Greater efforts may need to be made to engage with people from these groups, who may demonstrate more reserve and formality towards strangers. [42]
4. Masculinity – femininity: Masculine culture is oriented towards material success, achievements, willpower, competitiveness and ambition. Feminine culture aims at the quality of life, interpersonal relations, equity and empathy for the disempowered (for both men and women). Masculine cultures are associated with greater discrimination and difference between gender roles. For instance, it may be necessary to provide same-gender workers when discussing sensitive issues. [42]
5. Short term orientation - Long term orientation: In long term orientated societies the focus on the future, thrift and perseverance are important goals. A good person adapts to the circumstances, what works is more important than what is right, traditions are adaptable to change. In short term orientated societies people's efforts are focussed on the present and past, social norms emphasise immediate need gratification, spending, and sensitivity to social trends in consumption. There is a concern with respecting social codes about what is good and evil, personal steadiness and stability are valued.
6. Indulgence – Restraint: refers to the gratification or control of basic human desires related to enjoying life. Indulgence societies have a perception of personal life control, are more likely to focus on positive emotions, place higher importance on leisure, and have lenient sexual norms. In restrained societies there is a perception of helplessness, members are less likely to remember positive emotions, leisure has lower importance and societies have stricter sexual norms.

Organisational cultural competency

Worker cultural competence should be supported by organisational cultural competence. Organisational cultural competence operates across a range of domains: organisational aims and objectives; Governance and management; service delivery; infrastructure; planning, monitoring and evaluation; partnerships; staff development and performance. [27] [61]

Examples of these include:

- Establish referral relationships with refugee and resettlement services to allow for early intervention pathways. [62]
- Collecting more detailed information on cultural background, including ancestry and length of time in Australia, to enable the service to identify gaps and plan for future client needs. [25]
- Invite cultural leaders or community representatives to team meetings to educate staff about key aspects of particular cultures. [36]

- Developing systems for engaging and consulting with local communities to guide service development. [27]

How to engage with refugee background communities and support services on AOD issues

Input from refugee communities into the promotion, development and improvement of services is an essential element of organisational cultural competence. [23] [53]

It may be useful to hold initial discussions with community leaders/representatives (refugee community leaders, bilingual general practitioners and ethnic or refugee agencies) to seek advice on appropriate strategies, formats, questions and logistics before attempting to engage more broadly with community members. In some communities projects will not get support if the community leaders have not been involved. Key community members and organisations can assist with language and cultural competence factors, are likely have credibility with and the trust of refugee community members, and can help reshape public opinion and influence behaviours. [27] [39] [42] The hierarchical nature of some communities may mean it is necessary to engage with community leaders before approaching a wider community audience. [60]

For a variety of reasons, some community gatekeepers may state that no one in that community uses alcohol or other drugs. Emphasising the importance of prevention and improving knowledge across the whole community may assist here. [30]

Some agencies or community members may be hesitant to work with mainstream organisations because of disappointing prior experiences. Strategies to address this include:

- Be aware of the power imbalance that can exist between mainstream organisations and smaller community agencies. Make efforts to involve these groups as equal partners, such as by learning about and adapting to their level of resources available and methods of working and looking for ways to incorporate your goals into the current work of community organisations. [63]
- Be willing to resource and implement solutions that are perceived as beneficial by community members. [64]
- Following through on actions that have been agreed to demonstrate accountability and build trust. For instance, consulting community members about a new strategy for future service engagement, and then inviting those consulted to assist with the implementation of that strategy. [65]
- Key community members are often extremely busy juggling multiple roles. “Piggy-backing” on to existing consultations could be a way to minimise consultation fatigue. [65] For instance, incorporating AOD with discussions on other general health issues, which could also diffuse some of the sensitivities around AOD. [66]

When seeking assistance from community leaders and agencies, be aware there may be significant levels of diversity within refugee communities along ethnic, linguistic, religious and political lines which may have an impact on the ability of community leaders and agencies to gather community support and involvement. [26] [39] In some communities leadership roles may be more likely to be taken on by particular groups (e.g. men with higher levels of English language ability), so women’s and youth issues may not be adequately communicated to service providers. [26] Looking to engage beyond community leaders also promotes communication flows and connections with a wider community base.

Organisations could consider:

- Drawing on the support of individuals across social/ethnic/geographic groups who are effective peer recruiters. [67]
- Tapping into pre-existing community groups such as women's support groups [67] [68]
- Informal engagement to allow potential participants to become familiar with the project and workers before formal consultations. [68]
- Using feedback methods that do not require a high degree of literacy as some groups in the community are less likely to have attended school compared to others. [69]
- Engaging through age-based or separate gender small groups. [39]

Addressing AOD use sensitively with refugee communities

Attitudes towards AOD use vary in any community. However, particular sensitivity may be needed when discussing problematic AOD as in some cultural communities there is intense shame and stigma attached to AOD use, and acknowledgement of AOD use problems leads to social ostracism and loss of face for both the person and their family. [23] [57]

Previous research has shown that fact-based information delivered by professional workers with experience and knowledge of the needs of refugees, where people have the opportunity to share their concerns and have their questions addressed, is highly valued and perceived positively by community members even when the issue is sensitive or rarely discussed formally. [70] Using evidence-based data, such as to show what programs can achieve, can be used to make discussion and acceptance of controversial issues easier, such as by clarifying misconceptions and diffusing strong emotions associated with culturally sensitive issues. [42]

It has been suggested that using community based venues that are familiar to the target community and that have bilingual and culturally competent staff that can assist can help with 'silence' and stigma about discussing drug use. [27]

A recent study with African refugee communities [71] recommended that due to limited research into what is effective in responding to AOD stigma in diverse communities; approaches could use effective components identified in other health areas (e.g. HIV) such as: involving affected groups, community representatives and health workers in the development and delivery of messages; including both information provision and skill-building components; focusing on the detrimental effects of stigma and discrimination and explaining how individuals can contribute to open discussion and reducing stigma.

Training and other resources available

Queensland Multicultural Resource Directory

https://www.qld.gov.au/community/your-home-community/multicultural-resource-directory/ The Queensland Multicultural Resource Directory lists organisations that offer information, advice, support and networking opportunities and are culturally and linguistically diverse.

Ethnic Community Council Queensland

http://www.eccq.com.au/ This site contains information about ECCQ and their work as well as information about training and services that they provide and resources in different languages.

World Health Organisation

http://www.who.int/substance_abuse/publications/atlas_report/profiles/en/ Substance use profiles for different areas and nations around the world.

Drug and Alcohol Multicultural Education Centre (DAMEC)

www.damec.org.au This organisation provides information and education to promote access for culturally and linguistically diverse clients to alcohol and other drug service. They have two parts to their website, one for clients and one for workers. An example of documents that you can access is:

Respect: Best practice approaches for working with culturally diverse clients in AOD treatment settings

Queensland Program of Assistance to Survivors of Torture and Trauma

www.qpastt.org.au provides flexible and culturally sensitive services to promote the health and well being of people who have been tortured or who have suffered refugee related trauma prior to migrating to Australia. They also provide training and professional development opportunities and a range of resources for health professionals.

NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)

Working with Refugees: A guide for social workers

Foundation House – The Victorian Foundation for Survivors of Torture Inc.

Promoting Refugee Health: A guide for doctors, nurses and other health care providers caring for people from refugee backgrounds 3rd edition

Centre for Multicultural Youth

Culturally-Competent Intake and Assessment

Centre for Culture, Ethnicity and Health

Cultural competence series

Cultural Competence Organisational Review Tool

Interpreters

Queensland Health Interpreters Service

http://www.health.qld.gov.au/multicultural/interpreters/QHIS_home.asp This site provides information about how to access free interpreter services for all Queensland Health funded services. It has a section specifically for NGO funded services as well as information and guidelines for the use of interpreters.

NSW Refugee Health Service, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), NSW Health Care Interpreter Services.

Guidelines for working with interpreters for counselling & health care staff working with refugees a helpful guide specifically focussed on Refugee background populations.

Sexual Assault

http://www.health.qld.gov.au/sexualassault/html/contact.asp Information about support services across Queensland

Trauma

Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder Phoenix Australia - Centre for Posttraumatic Mental Health

http://www.phoenixaustralia.org/resources/ptsd-guidelines/

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