


# FINDING THE RIGHT HELP: Pathways for culturally diverse clients with cannabis use and mental health issues

**SUMMARY REPORT** Email [research@damec.org.au](mailto:research@damec.org.au) for further information or a copy of the full report.



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Flaherty I, Donato-Hunt C, Arcuri A & Howard J. 2010. Finding the right help: Pathways for culturally diverse clients with cannabis use and mental health issues – Summary report. Sydney: DAMEC & NCPIC.

ISBN: 978-0-9805584-7-0

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This project was funded by the NSW Health Department and supported by NADA. DAMEC is funded by the NSW Health Department.

NCPIC is supported by the Department of Health and Ageing.

Design: Pro Bono Publico

Project period October 2008 to June 2010.

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## Introduction and aims

Currently in Australia there is limited evidence on the extent to which cultural and linguistic diversity (CALD) affects the receipt of quality care in drug and alcohol (D&A) and mental health service settings. This project investigated the experiences of people from CALD backgrounds who have experienced both drug use (including cannabis) and mental health issues. Specifically, this research sought to investigate the experiences and pathways to specialist mental health and drug and alcohol services for CALD clients with these co-existing issues.

## Methods

The research methodology was qualitative, involving in-depth interviews with 56 current clients of mental health or drug and alcohol services in the greater Sydney and Wollongong regions. Twenty-two workers from either mental health or drug and alcohol services were also interviewed. A total of 22 services were involved in the project, 8 government and 14 non-government services. Interviews were transcribed and thematic based analysis was conducted in order to identify themes and analyse narratives to discover semantic information and patterns. Key results are presented below.

## Part I: Background to service access

Prior to examining experiences of service access it is important to first understand the situation and contexts of clients accessing services. The results below present some of the key themes that emerged as participants discussed background issues to their service access. Specifically these include the issues they have sought help for, and the cultural and familial contexts within which they have accessed help.

### Cannabis and co-existing mental health issues

All clients spoke of experiencing both substance use and mental health issues, with mental health issues often being depression, anxiety or psychotic symptoms. For many, the primary drug of concern was cannabis, reflective of the target sample. For those who reported experiencing symptoms of psychosis, such as auditory hallucinations, or feeling paranoid, connections were often made between these and their cannabis use.

... last year I had a psychotic episode... I have been smoking a lot of weed for the last 10 years and then I just lost the plot one day, and I thought people were trying to kill me and like usually when you smoke and you wake up the next morning the feeling's gone... you're like, "Oh, it was just the weed" but this time it didn't go away, so I was really scared.

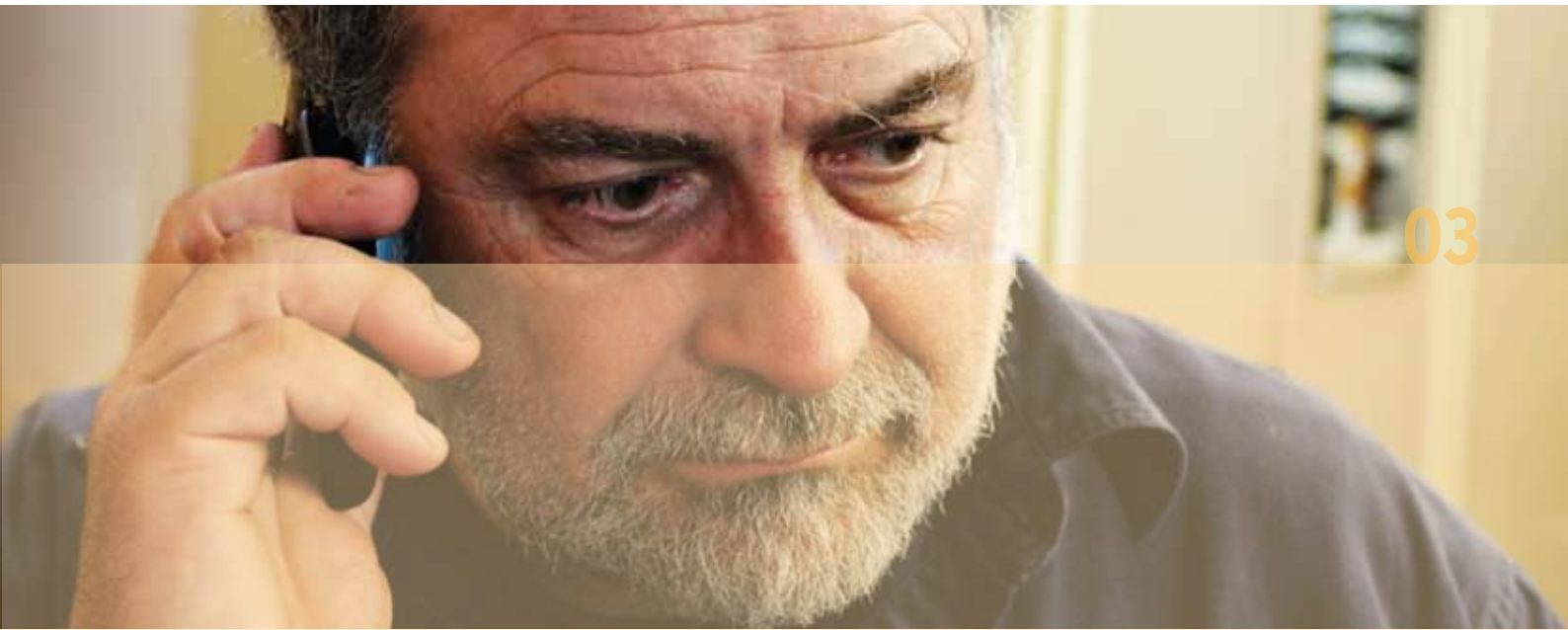
**(DD, 2009)**

Some clients spoke of a causal relationship between their drug and alcohol use and mental health issues, particularly the onset of psychotic symptoms following cannabis use, yet for others their experience of co-existing drug use and mental health issues was seen as cyclical, not related, or unable to be disentangled. Among participants no clear pattern emerged of whether it was a mental health or substance use issue that brought clients to a range of services, with many drug and alcohol clients articulating that their pathway to help for mental health issues was facilitated by their attendance at a drug and alcohol service.

### Aetiological issues

The majority of clients had experienced adverse childhood events, including sexual and emotional abuse, abandonment and the death of close relatives. Several of the overseas born clients spoke of difficulties related to migration as a child, such as social isolation due to language, or adverse childhood events due to living in a country where violent civil unrest was present.

I'm from a third world country, different, a lot of drug use, pretty violent. Lot of civil war, lot of terrorist attacks. I came here when I was about ten so it was a big cultural change and all the shit I've seen, I used weed to numb it out, or forget about it. **(TM, 2009)**



It was often in response to how clients came to be at a service (What were you there for? What were you receiving treatment for?), that descriptions of adverse childhood experiences arose, overshadowing recent experiences such as problematic drug use or involvement with the criminal justice system.

### Cultural and family contexts and attitudes

When discussing cultural attitudes and contexts, it appeared as though cultural background was inseparable from family background. For the CALD participants, narratives of family featured prominently in relation to attitudes towards seeking help for drug and alcohol or mental health issues, more so than for clients of Anglo-Australian background only. There were divergences however among the CALD clients regarding those attitudes and, consequently, as to whether or not they wanted their families, or certain family members, involved in their help seeking. For some this was mixed, for example, involving their mother but not their extended family or father of the same cultural background. For those who wanted to hide their current service access from family members, these decisions were motivated by fear of disownment, shame, not wanting to disrespect parents' act of migrating for a "better life", and protecting family members from service environments.

I've cut them [family] off because I don't want to bring them into this world and plus they can't, they don't know how to act in that world...I don't want to bring any more trouble to my parents, let them live their life and just get this over with.  
**(TM, 2009)**

For others maintaining contact with their families was seen as integral to their process of getting better, mostly through the connections and support family offered.

When I first moved in here they kind of kept me from my family for a little bit because they wanted me to live more independently but my family, because it's such a big part of my life, I really struggled without my family.  
**(LH, 2009)**

## Part II: Service access and referral

It is amongst this background that the client participants successfully engaged with specialist drug and alcohol or mental health services. As many experienced often long term co-existing issues and preceding adverse childhood experiences, examining the motivating reason or catalyst for initial service engagement was of interest. Further, given the challenges associated with accessing services, it was also seen as important to identify the referral pathways and services accessed for those who had successfully engaged with the health care system, as well as what participants found helpful. The results below present some of the key themes that emerged as participants discussed their service access.

### Catalysts for service access

The catalyst for seeking help for drug and alcohol and mental health issues was often characterised by crisis situations. Such crisis moments included: requiring medical intervention (due to seizures, self harm or suicidality); police intervention; and for many parents who participated in this study, intervention by the New South Wales Department of Community Services (DoCS).

I was ordered by DOCS to go to a psychologist due to having my children removed from me to see if I was fit enough to be able to have them back... May this year I gave birth to my seventh baby. DOCS removed him the minute he was born. It killed me. I needed help. **(SJ, 2009)**

For others, the catalyst for seeking or getting help was articulated as having a "breakdown" or "hitting rock-bottom".

Then one day, I think I was probably coming down and everything was just going to shit and so I went to the doctor and I said, "You've got to help me, I lie, cheat and steal for this shit, what do I do, give me a number of a rehab, I've got to escape". **(FW, 2009)**

### Referral pathways and service access

About half the clients interviewed had accessed both drug and alcohol and mental health services. The vast majority had experience with multiple services, with only three clients accessing a service for the first time. While service use history was largely fragmented and disjointed across the participant group, it appeared even more so for the CALD clients. The experiences of the CALD client group were largely either a case of lower service engagement, where more of the CALD clients had only ever accessed one service or were accessing services for the first time, or lower instances of continuous referral, where less of those who had accessed multiple services had had any experience of one service referring them onto another.

I had my doctor give me an antidepressant, but I ended up taking myself to casualty, freaking out...a couple of years before that I went and saw a doctor about depression... And I've seen counsellors. I've seen psychologists... I just felt like I was going around in circles and I wasn't getting anywhere. (NP, 2009)

The role of hospitals appeared more significant for CALD clients throughout their service use history, whereas residential drug and alcohol rehabilitation was less accessed by those from CALD backgrounds compared to clients of Anglo-Australian background (seven to twenty-three). Twenty-nine participants spoke of having contact with a general practitioner in relation to accessing help for their drug use or mental health issues. A diversity of experiences and functions were presented, more so than any other service provider. These results demonstrated the important role a GP can have in facilitating service access, and the impact GPs' knowledge and attitudes have on whether or not clients access effective help.

Agency and motivation were significant themes as clients discussed their process of service engagement, articulating their individual agency regardless of the referral source. Although still strongly present, this appeared less apparent among the CALD clients. Self-referral was the most common referral source. Family played a significant role in first service

contacts, particularly for the CALD clients, whereas for current service contacts family referrals were minimal, with referrals from other services increasing. More often than not the experience of referral from workers was "cold" referral, where workers gave clients the number of a service for them to call and make appointments themselves.

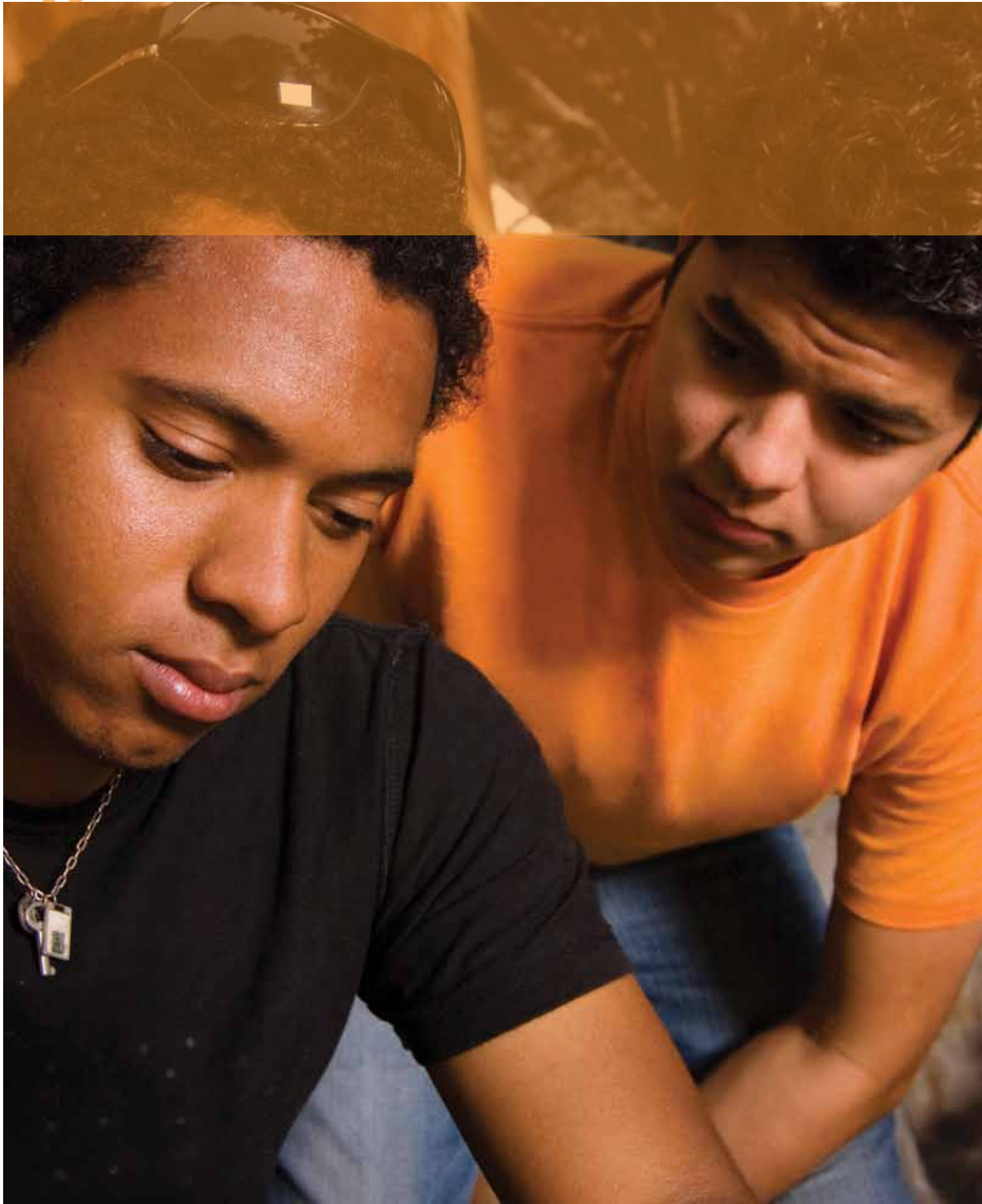
### Effective approaches

In discussing what was helpful, clients spoke of the roles of both pharmacological and non-pharmacological approaches. For those clients who had been prescribed medication to assist in addressing their mental health issues medication was seen as largely helpful, yet not without challenges such as finding the most appropriate medication, adherence, consequences of non-adherence and side-effects. Both clients and workers saw that it was important to combine medication with counselling or other therapy based approaches and continuing care.

Both workers and clients attributed positive experiences of therapy to flexible, individualised and personal service delivery. Many of the clients described how, in their experiences, feeling that the workers understood them and their experiences was an important aspect of effective approaches. Empathy featured prominently, as well as positive communication, a caring approach and workers not being judgemental. Some clients also spoke of worker knowledge attached to commonality of experience as pivotal to helpful worker approaches; this included similar life experiences and shared cultural and linguistic diversity.

Well, just be understanding, try, and be empathetic. Put yourself in their shoes and just relax, because like, [chuckle] it's such a stressful job... they're here because they care you know, it's not, it doesn't pay that much, you know. (FW: 2009)

Groups and training courses also featured prominently in positive narratives around therapy experiences. This included staying busy and having a diversion from substance use, as well as opportunities for learning, skills development and planning for the future. In one service many of the clients spoke about their experience of being members of a cohesive group, and how important this was in the outcomes of attending that service.



## Part III: Structural issues

In speaking about experiences of service access both clients and workers identified broader structural issues that affected the receipt of specialist care for CALD clients experiencing co-existing issues. Key themes included the capacity of the health services sector to effectively help people with co-existing issues and to accommodate the particular needs of some CALD clients. These results are summarised below.

### Organisational structures

Clients and workers spoke of the services sector struggling to effectively help people with substance use and mental health issues. This was in relation to under resourcing, the separation of drug and alcohol and mental health services and service access. Alongside this, among the client narratives were discussions of the valued work of individual workers, where, while the system itself was seen by many as struggling to meet need, clients spoken of the interpersonal processes that took place between themselves and individual workers that had beneficial outcomes in addressing their co-existing issues.

I think on the ground that there's people that are in the too hard basket, you're mad or you're a drug addict and no one's seems to want to match them up. I'm sure if you've got language issues on top of that you just sort of beaten from pillar to post and I think that's appalling. (W:EM, 2009)

### Perceived implications of accommodating CALD

Many of the perceived implications identified by both workers and clients for working with CALD clients centred on language issues, particularly in relation to the capacity for organisations and individuals to provide services to people whose preferred language is other than English. Some workers spoke of difficulties with both the availability and quality of multilingual resources. Participants also spoke of the importance of not making assumptions about individuals' language preference or English proficiency, and being aware of issues around stigma, shame, visibility and confidentiality as they relate to those from CALD backgrounds.

While formulated in several different ways, the theme remained the same: whether due to language or other reasons, it is very difficult for people from CALD backgrounds to engage with drug and alcohol and mental health services. Among the reasons given by workers, unfamiliarity with the Australian healthcare system was key.

Cause they don't know where to go. I mean they might have been here for 20 years, they might have been here for three but you know they, they might not and they might have no conception that they would be entitled to some of the things that they might be entitled to. (W:DV, 2009)

Insufficient resources, including time, money and staff competencies were identified as the primary challenges for accommodating cultural and linguistic diversity. From both client and worker comments it became apparent that, in many ways, individual workers were able to overcome the perceived deficits of the system by offering often creative solutions within structural confines.

## Recommendations

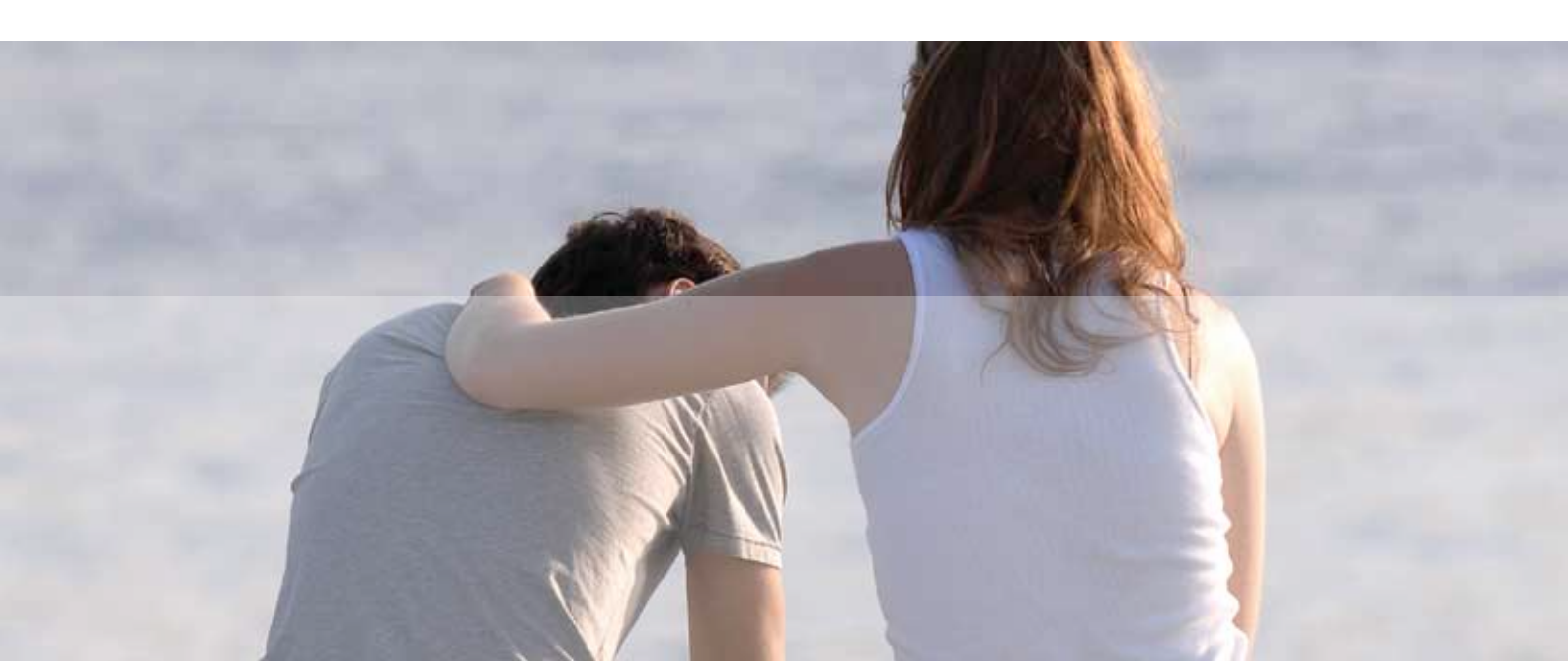
Recommendations made by the participants in this study include those listed below.

### When working with clients who have co-existing issues:

- Understand where people are coming from and how they see their drug use and mental health.
- Treat people with respect and care.
- Build relationships and trust for when people are ready to seek help.
- Structure services to reflect the occurrence of co-existing drug use and mental health issues.
- Improve services for people with less visible symptoms.
- Help to prevent relapse through fostering support networks.
- Address people's needs and situations in a holistic way.
- Promote services and improve knowledge of where to go for help and support.
- Continue training and education for workers.
- Increase the evidence base.

### When working with clients from a CALD background:

- Make interpreter services readily available to clients.
- Understand where people are coming from and find out about their culture.
- Invest more time in explaining things and relationship building.
- Provide holistic services, particularly addressing issues related to refugee or migrant experiences.
- Liaise with CALD communities.
- Continue to develop cultural competency and knowledge.
- Have a culturally diverse workforce with bilingual / bicultural workers.
- Increase service engagement by reducing language barriers.



## Conclusion

The results from this study highlight the difficulties faced by those with co-existing drug use and mental health issues in accessing specialist care, particularly when those clients face additional cultural and language barriers. The results also highlight the importance of understanding people's individual contexts and backgrounds, rather than making assumptions or treating those from a CALD background as a homogenous group, particularly as CALD background may or may not be a critical factor in people's substance use, mental health issues or help seeking experiences. For those who had successfully engaged with services, service use history was largely fragmented and disjointed, particularly for the CALD clients. Both clients and workers spoke of the services sector struggling to firstly effectively help people with co-existing substance use and mental health issues, and secondly adequately accommodate cultural and linguistic diversity. Alongside these comments among clients, however, were discussions of the valued work of individual workers facilitating beneficial outcomes despite the systematic deficits within which they may work. It is concerning that for those who successfully engaged with specialist drug and alcohol or mental health services, their engagement appeared largely contingent on their capacity to engage with services and navigate the system themselves, regardless of the referral source, sometimes persisting after many unsuccessful attempts. This is particularly concerning for a client group with complex needs related to substance use and mental health issues, particularly when language barriers and a limited understanding of the Australian healthcare system are added. There is therefore some way to go in building clear and navigable pathways to service access for people with co-existing drug use and mental health issues, particularly those from CALD backgrounds.

## Acknowledgements

This project was funded by NSW Health, through the NGO Mental Health and Drug and Alcohol Research Grant Program, with this grant being administered by the Network of Alcohol and Drug Agencies (NADA). The authors would especially like to thank the respondents and collaborating organisations for their participation. The authors would also like to thank the following: Feona Cowlin for her valuable assistance in recruitment and interviewing; the members of the project advisory group; NADA and the Mental Health Coordinating Council (MHCC); Prof Jan Copeland and Kelvin Chambers; the New South Wales Population and Health Services Research Ethics Committee; Area Health Services' Research Governance Officers; and other management and staff who assisted in the project administration and recruitment processes.



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