Understanding the factors facilitating or hindering utilisation of drug and alcohol services for the Muslim and Arabic speaking community in Sydney

Research Report

June 2020

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ISBN 978-1-74210-528-4

Contents

Executive summary

Australia is considered one of the most culturally diverse countries in the world (Markus, 2018). People from an Arabic cultural background make up 1.4% of the Australian population, and 4.0% of the residents in Greater Sydney (ABS, 2017). Such cultural diversity requires health services to provide accessible and culturally competent care to respond to the varying health needs with which people present, including in the drug and alcohol sector. However, the impact of culture on substance use and ways to adapt drug and alcohol services to achieve effective outcomes with Muslim and Arabic speaking (MaAS) populations continues to be an under-researched area.

During 2019, a research project was conducted in Sydney Local Health District (SLHD), South Western Sydney Local Health District (SWSLHD) and Western Sydney Local Health District (WSLHD), to ascertain drug and alcohol workers' perspectives and understanding of the unique factors, concerns, priorities and barriers that exist for MaAS consumers in Sydney with substance use issues.

Following a review of the literature to identify evidence for a culturally sensitive approach to drug and alcohol services for members of the MaAS community, semi-structured interviews with 32 stakeholders were conducted. The study gathered data from a range of stakeholders, including key informants from peak organisations, health professionals and managers across three Sydney local health districts and community organisations working with substance-using members of the MaAS community.

Key findings of this study:

Contextual factors and community constraints:

Culturally sensitive issues related to being a migrant and a member of the MaAS community impact upon willingness to seek help outside the immediate family. The use of alcohol and other drugs in MaAS communities is strictly prohibited and often associated with shame, stigma, denial and loss of face within the community (this excludes tobacco use, which is widely used in this community). This issue is confounded by widespread community denial regarding substance use issues and reliance on alternative sources of help, for instance, religious and community leaders. Several community constraints were identified:

- Community stigma and denial; concerns about shame and family honour; fear of community exclusion.
- Negative community attitudes towards mainstream help-seeking.
- Crisis-driven help-seeking behaviours undermining early intervention efforts.

Culture as both a protective factor and a hindrance to drug and alcohol service engagement:

The participants conveyed that the MaAS community, in general, express a deep-seated sense of commitment and connection to the worldview of their ethnic community. This community belonging is both a protective factor and hindrance for substance use recovery, as shame and denial merged with limited understanding about substance use, addiction and recovery. Culture was found to impact drug and alcohol services engagement in several ways:

- Strong cultural, familial, collectivist and religious factors as supportive elements in drug recovery.
- Different explanatory models – substance use and addiction largely viewed as a spiritual crisis for which medical or psychological treatment has limited use.
- Cultural beliefs favouring abstinence over harm minimisation.
- Punitive approach to substance use.

Structural barriers:

Significant barriers exist for disadvantaged groups in accessing health services, such as the complexity of the health system, service fragmentation and language barriers. Other barriers identified were:

- Centralised drug health entry pathways as distinct from multiple (less stigmatising) entry points.
- Limited partnership between mainstream services and community NGOs.
- Complicated health system, limited linkage and service navigation support.
- Limited capacity to provide culturally responsive services.

Consumer-clinician cultural concordance:

Many participants suggested that for some consumers, having workers with shared ethnic backgrounds would be an advantage. For others, however, ethnic similarity would be an additional reason to avoid health services, especially given the small community and concerns that privacy may be compromised. Although specialised local services targeting the MaAS community were considered culturally safe, others highlighted the need for services to not be directly associated with religion as this may add further stigma. In particular:

- Ethnic matching of staff to the community was not universally perceived as an effective engagement strategy.
- Fear of violation of confidentiality created a preference for treatment from mainstream services.
- Others MaAS designated services, citing fear that the advice given at mainstream services might be incongruent with religious beliefs.

Culturally responsive strategies:

Factors that might assist in achieving a culturally competent health system included the use of culturally appropriate and responsive language, promoting bi-lingual and bi-cultural workforce development and training for service providers to provide person-centred care. Increased awareness by health practitioners regarding the characteristics of Muslim and Arabic minority communities including those tied to gender, family and family-community relations as well as cultural and religious perspectives and habits were suggested. Several strategies to increase the cultural appropriateness of services were identified:

- Person-centred practice combined with strengthened cultural competence of service providers.
- Incorporating elements of religious and philosophical beliefs, communication styles and cultural points of views.
- Acknowledging collectivist orientation of consumers, offering family inclusiveness in treatment.
- Bilingual and bi-cultural services.

Recommendations

Participants stressed the need for better collaboration between MaAS designated service and mainstream services in acknowledgment that substance use recovery and rehabilitation for MaAS consumers often required engagement with both mainstream and cultural services. Areas thought to strengthen engagement with the community included forming reciprocal relationships and working in partnership with communities, building on and sharing existing knowledge within the community, the inclusion of expertise and contributions from different community organisations, and strengthening the communities' capacities to provide drug and alcohol services and liaise with the health sector. Building stronger bridges between community-based MaAS designated services and mainstream services were identified as a key area of priority.

Specific recommendations included:

- Emphasis on providing universal, person-centred care that is culturally responsive.
- Increasing partnership across health and MaAS designated community organisations.
- Greater outreach and education of general practitioners (GPs) who serve the MaAS community.
- Drug and alcohol educational and de-stigmatisation campaigns targeted towards religious leaders, the MaAS community and families.
- Support bilingual and bi-cultural staff (across both community and mainstream services) to maintain professional boundaries when dealing with culturally similar consumers.
- Building the bi-lingual and bi-cultural workforce.
- Additional family support and health system navigation support workers for the MaAS community.
- Better education for MaAS community partners on harm minimisation frameworks.

Introduction

It is widely recognised that cultural factors play an important role in the use of drugs and alcohol, the evolution of problematic use and in the process of recovering from such problems (Jarusiewicz, 2008; Unlu & Sahin, 2016). Illicit substance use is highly stigmatised within mainstream Australian culture. Such stigma may be heightened for individuals from a Muslim background, which compound the barriers and difficulties experienced by Australian Muslims with substance use issues and their families. Additionally, people from Culturally and Linguistically Diverse (CALD) populations, especially those from newly arrived communities who use illicit substances, are likely to be unfamiliar with drug and alcohol services (DAMEC, 2014) and tend to be under-represented in treatment service settings (NADA, 2014).

Following submission of a proposal from Ausrelief to NSW Ministry of Health, three local health districts (Sydney Local Health District, South Western Sydney Local Health District and Western Sydney Local Health District) agreed to fund research to identify the requirement for a culturally sensitive drug and alcohol program for the Muslim and Arabic speaking (MaAS) community in Sydney.

Aim of project

The aim of the project was to identify key issues influencing access to drug and alcohol services among members of the MaAS community and investigate the requirement for a culturally sensitive drug and alcohol service model to better meet the needs of MaAS individuals. Specifically, the research objectives were to:

- Develop a better understanding of the unique factors, priorities and barriers that exist for the MaAS community in Sydney in accessing drug and alcohol services.
- Inform the development of a service delivery model able to increase access to drug and alcohol services and reduce the harms associated with substance use disorders among members of the MaAS community.

Methodology

Two data sources informed this study development: a literature review and semi-structured in-depth interviews with key informants.

Literature review

A review was conducted focussing on issues relating to cultural competent drug and alcohol health services specifically targeting individuals with a Muslim and Arabic speaking background. This review included both peer-reviewed and grey literature from Australia and overseas. In particular, the review focused on:

- Critically examining the evidence around the need for a culturally sensitive drug and alcohol service for members of the MaAS community;
- Summarising the evidence and their contributions to our understanding of the barriers and facilitators of an effective culturally appropriate drug and alcohol service delivery model for members of the MaAS community.

Interviews with key informants

To develop an understanding of the unique priorities and barriers that exists for individuals from a Muslim and Arabic speaking background with drug and alcohol issues, semi-structured interviews were undertaken with key stakeholders including: health service providers (clinicians, managers, and health promotion workers) from health and multicultural community services providing care to members of the MaAS community, representatives of non-government organisations, peak bodies and academics with expertise in these issues. A purposive sampling frame was chosen where participants were recruited based on pre-selected criteria such as their work role, place of work and clinical discipline (Coyne, 1997). Respondent-driven sampling (also known as snowballing) was also used as a recruitment strategy (Decker et al., 2014). Research participants suggested other staff or services whose views should be included in the study. This study was limited to consultation with key stakeholders and did not include consumers.

Interviews were conducted from March until December 2019. Key informants were offered the option of a face-to-face or phone interview or focus group participation. A topic guide was developed for interviews and focus groups, exploring key themes such as: key concerns about the current service delivery, facilitators and barriers to effective service, gaps or breakdown points in the system, and suggestions for improving service provision. The semi-structured nature of the interviews and focus group enabled the researcher to explore additional issues emerging during interviews relevant to the aims of the study.

Ethics approval for the project was obtained from SLHD Ethics Review Committee (RPAH Zone) and site specific governance approval was obtained from SLHD, WSLHD and SWSLHD.

Data analysis

Interviews were audio-recorded with consent and professionally transcribed. The data was coded using NVivo qualitative data analysis software. To employ an explorative approach in line with the aim of constructing a more complex understanding of the needs and priorities of substance-using members of the MaAS community, selected aspects of grounded theory procedures and tools, were applied (Charmaz, 2006). In keeping with the principles of a grounded theory approach, categories were established as they emerged from the data through initial line-by-line and focused coding (Charmaz, 2006). Initial line-by-line coding involves studying and coding the data closely, which allows for the conceptualising of ideas to begin, whereas focused coding involves the process of sorting, separating, and synthesising the emerging codes. The resulting codes represent concepts of differing levels of generality. The quotes are exemplary to illustrate patterns in the aggregated data. In efforts to de-identify the quotes only the employment sector of the participant is identified under a quote (namely, community or mainstream).

Literature review

Australia is considered one of the most culturally diverse countries in the world, with around 46% of the population were either themselves or one parent born overseas (Markus, 2018). Arabic is the second most frequently spoken language at home other than English (ABS, 2017) and 1.4% of the Australian population (321,728 people) come from an Arabic cultural background. In Sydney, this proportion is higher, as Australians with an Arabic cultural background constitutes 4.0% of the residents in Greater Sydney. However, broad diversity exists within the Arabic speaking community. The Australia Bureau of Statistics reports that 44% of Arabic speaking Australians were born in Australia, 25% in Lebanon, 10% in Iraq and 6% in Egypt (ABS, 2016). Additionally, although most Australians with an Arabic background identify as Muslim (70%), Islam is also the dominant religion in many Southeast Asian countries such as Malaysia and Indonesia. As such, Arabic cultural competence and Muslim cultural competence for health care providers are not necessarily identical. For the purpose of this research, the focus is on Australians with an Arabic background who identify as Muslims.

Research continues to highlight the comparatively lower level of drug and alcohol use among refugees (Salas-Wright & Vaughn, 2014) and migrants (Li & Wen, 2015) in Western countries. There is, however, limited evidence pertaining to the prevalence of substance use among people from culturally and linguistically diverse (CALD) backgrounds in Australia (Rowe, Gavriel, Jaworski, Higgs, & Clare, 2018). A study from 2012 found that compared with the general NSW population, lower levels of short-term risky drinking and illicit drug use existed within the Australian Muslims community, but there were higher rates of daily smoking (Donato-Hunt, Munot, & Copeland, 2012). The study found that 56% of Arabic-speaking participants in NSW were alcohol abstainers and only 1% reported risky or high-risk alcohol consumption (Donato-Hunt et al., 2012). Conversely, an Australian study found people who inject image and performance-enhancing drugs to be more likely to be younger and more culturally and linguistically diverse compared with other groups who inject drugs (Rowe, Berger, Yaseen, & Copeland, 2017). In this study, participants from Middle Eastern backgrounds were more likely to report sharing needles and less likely to have ever been tested for blood-borne viruses, compared with Anglo-Australian participants (Rowe et al., 2017).

Despite the lower levels of substance use issues for ethnic minorities in Australia, newer research suggests that CALD communities face significant barriers when seeking and attending drug and alcohol services (Rowe et al., 2018). A recent study using data from the 2013 National Drug Strategy Household Survey (NDSHS) found that CALD participants who reported having ever used alcohol, tobacco or other substances, were less likely than non-CALD participants to report having accessed drug and alcohol services including opioid pharmacotherapy, telephone or online support, peer support group, withdrawal management, residential rehabilitation or counselling (Rowe et al., 2018). Such findings suggest a likely under-utilisation of existing drug and alcohol services among ethnic minority groups relative to the local populations (Reid, Crofts, & Beyer, 2001).

Individual and community-level factors impacting upon service utilisation

Understanding the reasons hindering utilisation of health services for the Muslim and Arabic speaking community is vital in providing services which meet the specific needs of this community (Erickson & Al Timimi, 2001). Barriers to utilising drug and alcohol services can be divided into

individual-level barriers, that is factors intrinsic to the prospective consumer and/or community, or service level or extrinsic factors. Extrinsic barriers to drug and alcohol services are arguably more amenable to intervention than those relating to the consumers themselves. However, identifying individual and community level cultural beliefs and expectations which may influence experiences of substance use, identification of problematic substance use, and responses to treatment is important to work effectively with CALD consumers (Kirmayer, 2012).

Many factors have been reported to impact on substance use and help-seeking behaviour for CALD communities. These include social, political, and historical factors shaping the migration experiences (Posselt, Galletly, de Crespigny, & Procter, 2014), the composition of community networks and local support structures (Flaherty & Donato-Hunt, 2012), culture and family management practices (Ghayour-Minaie, King, Skvarc, Satyen, & Toumbourou, 2019) and responsiveness and helpfulness of health services (McCann, Mugavin, Renzaho, & Lubman, 2016). Pre-migration traumatic experiences (Kozarić-Kovacić, Ljubin, & Grappe, 2000) and perceived discrimination in the host country (Salama et al. 2019), have also been associated with higher prevalence of problematic substance use. The barriers in accessing health care for the broader migrant community identified in the literature mirror those experienced by the MaAS community (Botfield, Newman, & Zwi, 2017; DAMEC, 2014; Lamb & Smith, 2002). However, variation in culture and social acceptability of substance use have been found to contribute to migrants' substance use habits (Salama et al., 2019). For example, alcohol or drug consumption is unaccepted according to traditional Islamic teachings and widely prohibited in the Middle East (Al-Ansari, Thow, Day, & Conigrave, 2015; Ali, 2014). These factors may help to explain the lower levels of drug and alcohol use in Middle Eastern migrant communities in Western host countries.

Access to and use of health services in countries of origin may contribute to and sustain health inequities between CALD communities and the broader population. Several studies have identified limited awareness of health care services in general and drug and alcohol services in particular among ethnic minority groups residing in Australia compared with their Australian counterparts (Phan, 2000; Tobin, 2000; Youssef & Deane, 2006). Similar findings have been reported in other Western countries with large minority communities (Na, Ryder, & Kirmayer, 2016). Members of CALD communities may be hindered by limited knowledge of mental health and substance use issues (Donato-Hunt et al., 2012; Furber, Jackson, Johnson, Sukara, & Franco, 2013; Scott et al., 2014). Qualitative research conducted by the Drug and Alcohol Multicultural Education Centre (DAMEC) found that members of CALD communities were more likely to delay substance use treatment until their condition became severe and generally tended to attempt to resolve health issues without assistance from health services (Khawar & Rowe, 2013). A similar finding has been reported regarding reluctance to receive assistance with smoking cessation amongst the Arabic-speaking community in Sydney (Phillips, Monaem, & Newman, 2015). Such limited health literacy coupled with a reluctance to make use of available community services (Mazbouh-Moussa & Ohtsuka, 2017), may further confound harm minimisation efforts (Yakushko, Watson, & Thompson, 2008).

Concerns about confidentiality when dealing with sensitive health issues have been identified as a major barrier to care for consumers from minority ethnic and cultural backgrounds (Botfield et al., 2017; Youssef & Deane, 2006). Australian research exploring factors influencing mental health (Youssef & Deane, 2006) and sexual health (Botfield et al., 2017) service utilization in Arabic-

speaking communities in Sydney, identified shame and stigma as the most dominant barrier in accessing such services. Culturally specific and sensitive issues related to being a migrant and a member of the MaAS community may also impact upon openness and willingness to seek help outside the immediate family. Deep cultural prohibitions on exposing personal or family matters to outsiders were found to impede help-seeking (Youssef & Deane, 2006). Strong family ties within many Arabic families coupled with cultural beliefs regarding family honour, makes it difficult for some to discuss problems with people outside the immediate family (Yakushko et al., 2008).

Addressing the substance use issues in the MaAS community is additionally challenged by a general distrust in the authorities and welfare system, a lack of trust in service providers (Youssef & Deane, 2006) and a reluctance to consult with psychologists and counsellors (Mazbouh-Moussa & Ohtsuka, 2017). An Australian study comparing the levels of trust in GPs and the ability to direct help-seeking behaviour across Cantonese, Vietnamese, Mandarine and Arabic-speaking groups, found the lowest level of trust in GPs and specialists amongst Arabic-speakers. Overall, this group expressed a greater sense of fear in relation to help-seeking for health concerns compared to the other groups (Scott et al., 2014). These factors are compounded by a heightened risk of being ostracised from family, friends and the MaAS migrant community following self-disclosure of mental health issues (Hamid & Furnham, 2013). The limited utilisation of drug and alcohol services by the Australian MaAS community may also be explained by their reliance on other sources of help, for instance family members, religious leaders, traditional healers and local Arabic-speaking doctors and service providers (Tobin, 2000; Youssef & Deane, 2006). Of particular concern in these instances is the level of appropriate substance use and substance treatment knowledge available among these sources of help.

In summary, intrinsic barriers to care for the MaAS community involve factors such as fear of shame and stigma, concerns about family honour, concerns around confidentiality, low health literacy and awareness of drug and alcohol services, traditional and cultural dependence on other sources of help, and a negative attitude towards professional help-seeking due to cultural constraints. MaAS communities' use of, and barriers towards, drug and alcohol services are best understood in the context of such factors.

Structural and service level barriers to service utilisation for the MaAS community

Within the Australian context, drug and alcohol services are commonly delivered through mainstream health services, although some specialist services exist (South Eastern Sydney Local Health District, 2011). Consequently, mainstream services are required to cater for both the broad population as well as communities with specific needs. Structural barriers for the MaAS community in accessing health care are similar to those experienced by the broader migrant community and other marginalised groups (Botfield et al., 2017; DAMEC, 2014; Lamb & Smith, 2002). These include barriers related to assessment and intake processes and centralised entry pathways. As mentioned, some MaAS individuals may be reluctant to attend a specialist drug and alcohol service for fear of being identified (VAADA, 2016). Additionally, it is noted in the literature that approaching MaAS individuals directly about substance use issues may not be culturally appropriate due to the stigma and shame associated with substance use (VAADA, 2016). A focus on wellness and health service more generally, with substance use an underlying issues for consideration, has been suggested as a

more culturally sensitive approach (VAADA, 2016). Alternative assessments, referral and entry pathways for CALD community members have also been recommended. Barriers relating to mistrust in mainstream services and lack of awareness of the supports and services available may be assisted by the use of outreach services combined with support for linkage and service navigation (VAADA, 2016).

Health care professionals' capacity to provide culturally responsive care to CALD consumers relies to a large extent on their ability to engage with community members and build trusting relationships at the individual, family and community levels (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). However, the development of trusting relationships, rapport, client-centred approaches and interpersonal engagement is time-consuming (Jaworski, Green, Mayol, & Rowe, 2019). Longer appointments for treatment and more flexible appointment arrangements such as the use of drop-in services, and a focus on community engagement and partnership building with established community services have been suggested as ways to more effectively engage with MaAS communities in Australia (VAADA, 2016). Nevertheless, such community engagement efforts are incremental and need to be considered as part of the longer-term development of cultural responsive services.

Cultural competence of health care providers

Research shows that cultural competence in health care settings improves substance use treatment for CALD communities (Gainsbury, 2017; Guerrero, Campos, Urada, & Yang, 2012). In Australia, principles for achieving a culturally competent health system has been embedded within current clinical guidelines (National Health and Medical Research Council, 2006). These principles encompass creating and sustaining reciprocal relationships with CALD consumers and communities and building on the knowledge and strengths of these communities (National Health and Medical Research Council, 2006). However, how such broad principles are understood and become operationalised, and the degree to which frontline workers feel enabled to work effectively in cross-cultural situations, is less evident. Recent Australian research suggests that uncertainty remains among frontline workers regarding what cultural competency entails in everyday practice (Mollah, Antoniades, Lafeer, & Brijnath, 2018). This is further complicated by lack of consensus about how 'culture' should be defined along with the associated terms of 'cultural sensitivity', 'cultural safety', 'cultural responsiveness', 'cultural humility', 'cultural awareness' and 'cultural literacy' (Mollah et al., 2018).

Despite such ambiguity pertaining to the operationalisation of cultural competence, the centrality of cultural competence in working with MaAS consumers continue to be emphasised (Maroney, Potter, & Thacore, 2014). Several strategies for making drug and alcohol services more culturally competent has been identified such as: addressing consumer's understanding of treatment, offering bilingual services, ascertaining the importance of consumers' cultural identity, displaying thoughtfulness regarding culturally sensitive topics and understanding culturally specific social roles and communication patterns (Rowe, 2014). An increased focus on client-centeredness, information-giving, partnership building and consumer engagement in communication processes with CALD consumers has also been suggested as ways to improve health outcomes for minority groups (Shen et al., 2018). Additionally, flexible and creative responses able to incorporate elements of cultural

philosophy and communication styles were found to improve outcomes (Rowe, 2014). Youssef and Deane (2006) argue that increased awareness by practitioners regarding the characteristics of Arab minority communities, including those tied to gender, family and family-community relations, may improve health service utilisation.

Health practitioners are often required to modify their practices to provide client-centred interventions to consumers from diverse cultures, including enhancing their cultural awareness and flexibility of service delivery (Maroney et al., 2014). Clinicians' knowledge of drug and alcohol related cultural issues have been shown to increase the effectiveness and positive impact of drug and alcohol treatments (Hamid & Furnham, 2013). Research into cultural issues regarding gambling addiction within the Australian Arab community identified the importance of clinicians taking into account consumers' cultural point of view to most effectively support them with their gambling addiction (Mazbouh-Moussa & Ohtsuka, 2017). Along similar lines, a study on psychosocial rehabilitation of Afghan consumers in Australia found that the goals of the Western orientated concept of rehabilitation were at odds with Afghan consumers' specific social and religious beliefs (Maroney et al., 2014). For instance, traditional Afghan beliefs about causes of illness involving non-adherence to the principles of Islam and will of God lead to problems of compliance with therapy or medication and accessing social supports (Maroney et al., 2014). Obtaining adequate information regarding the consumer's condition was also a significant issue. Language problems, reluctance to use interpreters out of fear of information leaking out into the community and disinclination to share information outside the immediate family, were cited as specific issues in this regard. These issues were worsened for female consumers, as access to female members of a family was restricted due to cultural reasons.

Conversely, lack of cultural competence, and suitable intervention strategies among mainstream health professionals, have been found to make mainstream services less user-friendly for consumers from MaAS communities (Youssef & Deane, 2006). Such research suggests that health services need to strengthen their cultural competence to improve their accessibility for members of the Muslim and Arabic speaking community. Literature specifically pertaining to the development and applicability of culturally competent drug and alcohol services targeting MaAS consumers is, however, limited. Consequently, the development of culturally appropriate practices directed towards Muslim and Arabic speaking consumers have been called for (Michalopoulou et al., 2014).

Consumer-physician concordance

Consumer-physician concordance refers to the level of agreement or harmony between consumer and practitioner such as those related to gender, social class, ethnicity and language. These also include beliefs about health, cause of illness, values and attitudes to medication, substance use and treatment decisions (Keshet, 2019). Many studies highlight that consumer-physician concordance relating to race, ethnicity or language may improve health outcomes. A recent systematic review examining the effect of racial concordance on consumer-physician communication found that racial concordance was associated with better communication (Shen et al., 2018). Likewise, Street and colleagues' study of both white and black Americans found that similarity between physician and consumer in terms of values and communication style leads to higher ratings of trust, satisfaction and intention to adhere to treatment (Street, O'Malley, Cooper, & Haidet, 2008). However, several

factors were found to affect the degree to which consumers saw themselves as similar to their physicians, including physicians' use of patient-centred communication. In most studies, although consumer-physician concordance was associated with certain positive health outcomes, consumer-physician concordance or discordance was not the most significant factor impacting disparities in health (Kurek, E. Teevan, Zlateva, & Anderson, 2016). Factors such as continuity of care and a sustained relationship with a specific practitioner proved to be better predictors of positive health outcomes than ethnic concordance.

Other studies complicate the suggestion that ethnic matching of staff to consumers will lead to better health outcomes (Meghani et al., 2008). Several studies have suggested that minority consumers may prefer not to be treated by physicians from their own ethnic group (Keshet, 2019; Miller, Kinya, Booker, Kizito, & Ngula, 2011). In more collectively oriented cultures and close-knit ethnic communities, such as the MaAS community in Sydney, where many people know one another, it may be difficult to maintain confidentiality. Concerned about the violation of privacy and being stigmatised in one's ethnic community may in some cases outweigh the advantage of consumer-physician concordance relating to race, ethnicity or language (Miller et al., 2011). Miller and colleagues (2011) found that concerns about confidentiality made consumers prefer ethnic discordance in healthcare. The intertwined nature of minority ethnic networks and collectively oriented cultures were found to jeopardise consumer privacy (Miller et al., 2011). A similar finding was made by Keshet (2019) who studied the preferences of Arabic minority patient in Israel. Keshet found that many Arabs preferred consumer-physician ethnic discordance, due to issues of confidentiality. An evaluation of a large-scale health initiative in England targeting black and minority ethnic communities suggest that more consideration is needed concerning migrant consumers preferences. The researchers found that although some consumers preferred having workers with a shared ethnic background, others actively avoided such staff and services due to fear of being stigmatised and having their privacy compromised (Craig et al., 2007). It seems that preferences for consumer-physician ethnic concordance or discordance should be understood in the context of the centrality of community, honour and family reputation in many ethnic minority cultures. In summary, the ethnic matching of staff to the community cannot universally be perceived as an effective engagement strategy, as there is inconclusive or insufficient evidence in support of the notion that consumer-physician concordance leads to positive health among minority groups.

Qualitative findings

The following analysis seeks to explore barriers and facilitators for utilisation of drug and alcohol services from the perspective of service providers and community leaders servicing the MaAS community in Sydney, Australia. Thirty-two key stakeholders participated, these included health service providers (clinicians, managers, and health promoters) from health and multicultural community services providing care to members of the MaAS community, representatives of non-government organisations, peak bodies and academics with expertise in these issues. Of these, 17 were employed by one of the three participating Local Health Districts and 15 were recruited through NGO, community or peak organisations. Twenty-two of the participants were interviewed individually or in pairs and the remaining 10 participated in two focus groups. All focus group participants were frontline workers. The report details the perceptions and perspectives of the participants and is not necessarily a reflection of the treatment approaches of neither mainstream nor culturally designated services.

Appreciating the complexities of cultural factors impacting substance use within the MaAS community in Sydney

People from a migrant background commonly bring with them habits, values and cultural patterns from their country of origin. Consequently, a major aspect of being a migrant is being confronted with comparatively different values and norms in one's host country. Belonging to an 'ethnic community', coupled with opportunities to participate in one's new country, are important factors for becoming well-established in a new country (Correa-Velez, Gifford, & Barnett, 2010). An ethnic community can be defined as a network of networks centred on complex ethnic and cultural histories (Tabar, Poynting, & Noble, 2010). The MaAS community in Sydney can be defined as such an ethnic community, both consisting of a high degree of similarities such as those tied to cultural, geographical, linguistic and religious factors combined with a degree of demarcation for instance between social-economic backgrounds, refugee or migrant status, educational levels, English language skills, health literacy and knowledge of substance use issues. The members of the MaAS community also spans across several generations, some being first generation immigrants, others having been born in Australia. Along similar lines, the degree of attachment people might feel towards the local Muslim and Arabic speaking community in Sydney also varies and may at times in an individual's life take on more or less importance. Despite such differences, and the importance of acknowledging the diversity of experiences and circumstances within the community, several participants discussed the closeness of the MaAS community in Sydney, as well as the support, friendship and community-spirit available here.

> *People are drawn to what they know, drawn to their own kind. It's a comfort for them. (Community)*

In many ways, the community networks and associated cultural and religious aspects provided community members with guidelines for acceptable and unacceptable behaviour. Such community norms were seen as a protective aspect by some participants, referring to the generally lower alcohol and drug consumption within this community. Others highlighted that this close-knit community and prescriptive cultural habits could at times impede substance use treatment seeking behaviours. Religiosity was especially highlighted as both a protective factor contributing to

substance use recovery and a barrier to disclosure and help-seeking, a finding reiterated in the literature (Nazir, 2013; Unlu & Sahin, 2015) and illustrated below:

> *The good thing with the Muslim community as well, some are very involved with their religion, and they also use their religion as a protective factor as well to support them. So that's one thing that – one of our patients said that, "I have thoughts of using. I have cravings to use. But whenever I do pray and whenever I remind myself that – about this religion," and then she will say that, "I'm not going to use because of that." (Mainstream)*

> *The culture is really that we keep all of this very secret. We don't tell other family members, in particular we don't - we just have to deal with it on our own. That's the attitude because we don't want anyone else to know about it, and I think the culture is not to talk about it because it's the fear. That in itself makes it more difficult for us to reach them and for them to get help and support. (Community)*

As illustrated in the quotes above, the use of alcohol and other drugs in MaAS communities is strictly prohibited, and often associated with shame, stigma, denial and loss of face within the community, factors contributing to a widespread unwillingness to disclose substance use issues. The issues of stigma were seen by many participants as the underlying driver of 'sensitivities' in the drug and alcohol arena, both preventing people from talking about substance use, gaining knowledge about addiction or disclosing personal or familial challenges relating to substance use. This stigma also created a widespread denial of substance use issues in the community.

> *It's because it's taboo to even talk about it. So how are they ever going to gain that knowledge? So, if no-one in the community is talking about drug and alcohol use or services, they don't actually have ways to access this information. They don't know, because oh no, we don't talk about this. (Community)*

> *I have had a number of patients who have had active hepatitis C, syphilis, gonorrhoea, chlamydia, other sexually transmitted illnesses, because they have not accessed treatment. The access of treatment is not because of failings of the public system or failings in the private healthcare system; it is the fact that they're working in a community and in a family which often does not want to know or has very stigmatising views of it. (Mainstream)*

A contributor to the taboo surrounding substance use is the association with mental health issues, another area considerably stigmatised in the MaAS community (Youssef & Deane, 2006). Psychosocial problems, as well as substance use and addiction, have been equated with weakness of the self or weakness of faith for which a punitive approach is believed to be the most appropriate (Hamid & Furnham, 2013). As also noted by Hamid and Furnham (2013), in Arab culture, distinctions between physical and psychological health are uncommon and substance use issues are habitually viewed as a spiritual crisis for which psychological or medical treatment is ineffective. The mere suggestion that an individual might be suffering from a psychological issue could, for some members of the community, be considered offensive, as the quote below illustrates:

> *But in terms of mental health, I guess if I was with an older relative and we go let's say to the GP and I'm the translator and the GP gives concerns regarding mental health or something like that, I would not even translate things like that because it's seen as an offence, like are you calling me – you know, x, y and z? And that's not even if they're just a relative. Even if*

they're just from the community. That would even have a lower chance of me translating because I don't even know them. (Mainstream)

For these reasons, it was believed that MaAS consumers may be more comfortable having any psychological concerns dealt with as somatic symptoms. Social stigma combined with cultural understandings of substance use as a weakness of faith or a condition caused by a supernatural spirit was perceived to make it harder for MaAS consumers to seek substance use treatment. Such cultural and religiously-based understandings of substance use and the nature of addiction were believed to lead many consumers and families to primarily seek religious solutions and reject psycho-social or mainstream type services.

They tend to go to who they know, which is like a religious leader. It is sometimes they have this perception that if they go to the religious leader, the religious leader will do magic [sic] and the person will be absolved from all this problem. And sometimes families and people don't understand addiction. And they feel that it's sometimes more of a curse that has been placed upon them. So, it is important to demystifying those myths as well. (Mainstream)

Collectivist culture, family reputation and community values

Several participants mentioned the pivotal role of the family in determining whether Muslim and Arabic-speaking people would utilise drug and alcohol services. Participants explained that in Arab culture, the behaviour of an individual is perceived to reflect the extent to which the whole family upholds social values, norms and expectations.

Culturally if one family member has a mental illness or a drug and alcohol, substance abuse, that affects the entire family unit. So, it's a collectivist culture which means – let's just say they have a sibling. That affects their sibling's prospects of getting married. It's a massive shame factor. And then the extended family – right, the aunty. Oh, we can't associate with them. So, then they become more marginalised. So, collectivist culture, you need to be connected to your communities and your families. If this comes out, you become marginalised. So, this does not come out. We'll just pretend it doesn't exist. (community provider)

Participants described that a common way of reducing the shame of having a family member with a substance use issue and regaining the reputation of the family was to reject the person and cut all ties with the individual. Keeping in contact with a son or daughter who uses substances could be seen as an endorsement of substance use, which could lead to the entire family becoming excluded by the community.

It depends on the father because the father might either say I want to keep my family clean, and my name. So, then others when they – for example, mention, "Oh you know, one of his sons is a drug addict," they're like, "Oh no, no, but he kicked him out," you know? So, it's kind of just like oh you know, that son is out of the picture, so the stigma becomes less. So even like now, you know, if someone's uncle has done an issue or a robbery or whatever it is, if the father doesn't talk to the uncle any more it's kind of less – a bit less stigmatised than if the father's in a good relationship. (Mainstream)

Especially in this community, it's a very, very high level of stigma. If parents found their children is addict, the first actions they do, they kick them out. Which means the problem is going to be worse 100 times. (Mainstream)

The complexity of such a collectivist culture in the context of drug and alcohol treatment meant, according to participants, that members of the MaAS community tended to be orientated towards self-reliance and self-isolation in meeting drug challenges, as fear of ostracism from the family and MaAS community prohibited them from disclosing their struggles. Fear of being isolated from one's family, meant many consumers did not disclose substance use issues to family members or peers in the community. Moreover, in instances where the family knew about the substance use, many went to great lengths to hide this from the community, including discouraging the individual from seeking drug and alcohol treatment or assistance from outside the family, hoping instead that the family themselves could solve the problem. In some cases, the person with a substance use issue was sent overseas for treatment, to hide the issues from the community.

Everyone in the family had denied that it's addiction. They've gone down every other explanation – possession, bad friends, not doing well at school, no discipline. We don't know what we've done wrong. It must be this country. So, we ship them back overseas and in fact what's ended up happening is that they've ended up in a psych ward overseas where there's no care. Except we're going to lock them up, sedate them, that's it. And so, the child is essentially – if they have come back, it's because they've been sedated and they're now dependent on other drugs. (Community)

There is also an issue of people with drug problems being regarded very negatively by the Lebanese Muslim community and I think in a sense that they wanted to remove them from the community, send them overseas, freshen them up, get them right and then they could come back. We tried to say it doesn't really quite work like that. If you've got an addiction, there's something that people will need to put some time and effort into in the long term, not just go there for three months and be fixed up. It seems that there was an aspect of magical thinking in that notion. (Mainstream)

The participants convey that the MaAS community, in general, express a deep-seated sense of commitment and connection to the worldview of their ethnic community. This community belonging was seen as both a protective factor and a hindrance for substance use recovery, as shame and denial merged with limited understanding about substance use, addiction and recovery. This collectivist approach is important to understand the significant resistance the individual experiencing substance use issues might be facing from his or her family members when wanting to seek mainstream drug and alcohol treatment. Additionally, the strong impetus of the family members to seek alternative, less public solutions, comes back to such collectivist culture and concerns over family reputation within the MaAS community.

Conflict between community values and ideologies guiding mainstream services

Mistrust of mainstream services and health professionals and fear of stigma are common barriers for consumers of drug and alcohol services, widely reported in the literature (Brener, Cama, Hull, & Treloar, 2017; Paquette, Syvertsen, & Pollini, 2018). Prior negative contact with health services or

systems of authority has also been reported as barriers for marginalised groups (Fowler, Reid, Minnis, & Day, 2014; Watson, 2005). Similar engagement barriers for the MaAS community were reported by the participants in this study. Many, however, highlighted the 'double discrimination' Muslim consumers may experience, caused by having a substance use issue and societal stigma connected with being a Muslim. Negative past experiences of racism and Islamophobia within the Australian society, as well as within health services, were mentioned as obstacles:

> *The general health services but also the whole system of Australia. I think being Muslims who are always targeted as, you're terrorist, terrorism being Lebanese, you're racist, you're racist, they hate the system. So, they don't want to interact with the system at all. But then you've also got what I was mentioning, was the whole, the actual service as itself, they've had bad experiences or they know of someone, they don't want to interact with that. (Community)*

> *Actually, you're very sensitive to those cues and those kinds of nuances. You're sensitive to picking up – is this person invalidating, dismissing, disrespecting me. And if you pick up on that regardless of where that's coming from, you're going to completely disconnect and disengage. You are actually looking for it. Because you're always on the lookout for what's the next threat, what's the next danger. (Community)*

A recent report on Australian Muslims' experience of racism and Islamophobia found that 57% had experienced racism (Dunn, Atie, Mapedzahama, Ozalp, & Aydogan, 2015). Although there is no research directly investigating the extent to which Australian Muslims experience racism in their meeting with health services, it is likely that negative past experiences of racism in general, combined with personal negative encounters with health professionals and the experiences of others in the community, prevent many MaAS individuals from seeking treatment.

> *One of the ladies went to the early childhood clinic within Health, she was wearing a scarf, she went in there and when she spoke the lady told her, "Oh, you speak English?" and she never went there again. There was another incident of another lady as well, along similar lines, and there are no repeat visits. (Community)*

Perceptions of conflicts between family/community values and ideologies of mainstream drug and alcohol services were also identified as a barrier to accessing the health system, specifically drug and alcohol services. In particular, mainstream services' harm minimisation approach was experienced as in conflict with the abstinence-focused, more 'punitive approach' often advocated within the community. Participants highlighted that underlying these tensions were intergenerational differences in approaches, as second-generation MaAS consumers were believed to be more accepting of the ethos of harm minimisation.

> *We are definitely a harm reduction approach, and so even just using that term can be quite challenging for families to get their heads around because they're used to this punitive, zero-tolerance, tough-love approach. (Community)*

> *The dad's role - he's usually quite removed and usually quite zero-tolerance. You know, they believe that we should just be able to fix it by, say, keeping that child at home or that person at home, or by restricting and controlling as much as possible what they're doing they will be able to fix it. (Community)*

To complicate matters further, several participants mentioned that seeking assistance from services outside the community, regardless of these being substance use related, could lead to community rejection. The fear in this regard often pertained to a perspective that discussing taboo issues with 'outsiders' might damage the reputation of the Muslim community in general. In such instances, seeking help from outside the local community was considered a betrayal of the family and the community.

> *I know for example of – I think it's called the Muslim Women's Association. But they have like a place where women suffering from domestic violence could go to and be protected and so on. And I think that is something that needs to happen within the Muslim context. Because if a person – if a Muslim woman that's suffering from domestic violence goes to the police or goes to a non-Muslim organisation, then culturally or even within her family or her community she'd be seen as – "oh she went to the others to complain about us". (Mainstream)*

> *A lot of people don't want to admit to drinking or admit to other things that they've done wrong, is because they feel like– because they stray from within the community. They stray as Muslims, they stray as I'd say caring Muslims for the Muslim community. So, they don't want to be – their name to be associated with the community in a negative way. Like even for outsiders to think "oh look at the Muslim communities and all these drug and alcohol people within them". And I guess that's part of the reason why there's a lot of denial within Muslim countries about drug and alcohol issues and other – even for example, sexually transmitted diseases and other things. They want to say we don't have that problem because that's an easier way out than just to say okay we have these issues; we need to address them. (Mainstream)*

Such concerns about damaging the reputation of the MaAS community needs to be considered in the context of an already marginalised community's fear of producing further stigmatisation, exclusion and Islamophobia. Furthermore, community and family concern that mainstream services might lead individuals away from their religion, was felt to make it difficult for community members to engage in mainstream services. The importance of services being 'culturally safe' was stressed by some:

> *Parents are scared. They go like, "Oh well if he goes in there, he's got to learn the Christian way and we're Muslim," for example, and that's the reality, you know. And I'm sure that if a Christian went to a Muslim rehab, they're going to shit themselves. They'll be like, "Oh, are they going to be Muslim now?" (community)*

> *We've actually had people – before even making a referral, they'll call to enquire and they'll say, "But is she going to give my son/father/brother/daughter advice that will go against the religion?" So, before they'll even connect them, they want to be sure that they're going to be safe with you. (community)*

On the other hand, although specialised local services targeting the MaAS community were considered culturally safe, others stressed the need for services to not be directly associated with culture or religion, as this would add further stigma. The aforementioned sensitivities associated with substance use, shame, stigma, community denial, fear of ostracism from the family and the

community were believed to discourage people from seeking treatment from MaAS designated services.

> *We've found there was a real strong stigma attached to approaching any place of worship facility – if that's where you were having an office, the local mosque would open up, say, an office to allow practitioners to speak and people wouldn't go because they didn't want to be seen as going into this clinic. And it can't take place in a place of worship. And it can't be attached to anything that's a religious entity. (Community)*

> *So for me to go to the mosque, and the hypocrisy that's attached to it, you know, I'm going to pray at the mosque and then I'm going to go and do methadone treatment or straight away after go and use heroin. You know, no one is going to understand that. I don't want the judgement being passed on me, especially from someone who is of a practising faith that's similar to mine. So I'd rather not engage in services and continue down this path of destruction than engage in services and have to deal with the repercussions of being humiliated, embarrassed and in fear for myself about disclosing information that I really don't want to disclose in the first place." (Community)*

These compounding factors of widespread secrecy and denial within the community, powerful drivers to uphold the reputation of the family and the community, cultural beliefs concerning substance use, and concern that mainstream services might offer advice inconsistent with Islamic teachings, provides context to the complexities surrounding substance use in the community. An associated barrier in this regard is fear of confidentiality breaches, as will be discussed in the following section.

Fears about breaches of confidentiality

Fears about potential breaches of privacy in making use of a drug and alcohol service were seen as a major barrier for consumers from the MaAS community, particularly if using an interpreter or health worker from within the consumers' own community. This fear of confidentiality breaches is echoed in much literature pertaining to consumers from minority and culturally and linguistically diverse backgrounds including Aboriginal consumers, and also pertain to other 'stigmatised' services such as mental health or sexual health services (Botfield et al., 2017).

> *Because of the nature of the community, that people may be very reticent about speaking openly to somebody who is from their cultural background not appreciating the principles of confidentiality. When I explain confidentiality which I maintain, they get it. They understand that but - they wonder whether somebody from their own background might not maintain confidentiality or would just let slip in a community meeting or just in their general social life, that they were seeing somebody. (Mainstream)*

> *One of the first things they always say to me is "Are you Lebanese?" Or "Are you from this cultural background? Do you speak this language because I don't feel comfortable, just in case I happen to know someone in the community and I'm going to go and disclose information about them." They don't even understand the concept of a therapy session where everything is confidential and nothing gets relayed out to anybody. (Community)*

Concerns about personal stigmatising information leaking into the community created significant anxiety for consumers. The Sydney-based MaAS community was described as a small, localised community, where many knew of and recognised each other. Many participants mentioned that non-conformity to community norms would lead to criticism and rejection and that stories about dishonourable behaviour of the people within this community were shared widely. The below story about an equally stigmatising condition, mental illness, illustrates this dynamic:

> *A friend of mine who's suffering from a mental health issue and there's a relative of mine who's doing so. And then they went to a local – basically mental health centre in Western Sydney. And then one of them texted me and this is the friend that said, oh you know, "I saw this person here. Is she okay?" You know, "What's going on?" And obviously, I knew of both their cases. But both have only confided in me. So, I couldn't share. So, I was like, "Oh maybe she's just passing through or she's just trying to find out what's happening." And then this other person also asked me "Your friend was there." And I'm like, "Oh yes, he said that he saw you and he wanted to say hi and so on, but he didn't want to disturb." So it's kind of– it's good, because I knew both had an issue. But imagine if I didn't. (Mainstream*)

Such fear of being recognised lead many to avoid attending local 'stigmatising' services. Participants stressed that greater awareness and education in the community around practitioner–consumer confidentiality may help some consumers overcome the fear of privacy breach.

Promoting social cohesion while offering culturally appropriate services

Although there was general consensus among the key informants about the complexities of cultural factors impacting substance use issues within the MaAS community, less agreement was found regarding the degree to which these were barriers specifically pertaining to the Muslim and Arabic speaking community. Many participants stressed that issues of shame, stigma and denial concerning substance use issues were barriers for all consumers. Additionally, many emphasised that concerns over family and community reputation, limited drug and alcohol literacy and intergenerational conflicts about suitable treatment approaches were tensions relevant to most migrant and marginalised communities.

> *I want to go back to your question, what are the barriers in accessing health issues. I don't think it is much different to any other community accessing those services, because of the notion of drug attached to it, I really think that. It might be it varies a bit more, but the issues are the same, they don't want to be seen as taking drugs, because of what drugs is viewed by the general society. (Mainstream)*

> *In terms of what you say that they find it difficult to engage, well, people in general find it difficult to engage. Of all the people who have a diagnosable substance use disorder, only 10% at any one time are engaged in any kind of health service related to that substance disorder. (Mainstream)*

Many participants cautioned against segregating the MaAS community out from other migrant communities or from the Australian mainstream community, advocating instead for a strengthened focus on social cohesion through making mainstream services more culturally appropriate. In this

regard, a divide was apparent as some participants suggested health services needed to enhance their focus on providing inclusive, culturally sensitive, universal care while others advocated for more MaAS designated service. Fragmentation of effort, segregation and limited integration was mentioned as important factors in support of universal approaches:

> *We have to break that barrier. Everybody needs to integrate. It is about social cohesion, you know. I need to learn to not be judgemental of someone who happens to be of the same culture as me but doesn't belong to the same ethnic background as me. I can't be like that. I can't pass that level of judgement. There needs to be a shift there somehow. So as much as I think segregation may work for specific cultural groups, I don't think it should be across the board because I think the latter part is really important, you know, that we have to break those barriers to force social cohesion. (Community)*

> *I don't think the onus is on the public system to provide specific services for every different ethnic and religious group. I think that there is this enormous problem of fragmentation of effort and I think it's making sure that the people in the public system providing drug and alcohol services are at least aware. (Mainstream)*

> *No, I don't agree with this. If we do this, this means we separate this type of people from other Australians. We have to remember always we are all Australians, we live in one community, has to interact with each other. To put these people in a separate category, that is not appropriate. (Mainstream)*

Others emphasised the unique needs of MaAS consumers. In particular, faith-based perspectives on substance use, as well as understandings about the local community values were mentioned as gaps in the current service provision.

> *One of the things that clients would say, is that they know, if they bring up issues that have a spiritual religious element to it, they're going to be open. They don't feel comfortable opening up about those particular topics to mainstream, in case they get judged and frowned upon, and because there's kind of Islamophobia as well. Or they'll be heavily misunderstood as well. (Community)*

> *Because there is that shame factor that is involved, because drugs and alcohol are forbidden in our religion. So sometimes you'll get clients who don't want to access – in case they get judged, they prefer going external. We've had clients, for example, who've gone externally, but still feel as if something is missing, but then they find it when they go to a practitioner of the same faith, for example, and is able to connect the dots for them, and obviously reduce that shame and stigma which they haven't been able to really address in the mainstream service because they know – they're not from my community, they don't get it. (Community)*

A similar division was present regarding the appropriateness of ethnic matching of health staff to the community. As described earlier, consumer-physician concordance refers to the level of similarity between consumer and practitioner such as those related to gender, social class, ethnicity and language (Keshet, 2019). Many studies highlight that consumer-physician concordance relating to race, ethnicity or language may lead to better health outcomes (Shen et al., 2018), although other studies suggest that for marginalised groups such concordance may further increase fear of stigma (Keshet, 2019; Miller et al., 2011). Among the participants in this study, such ethnic matching of staff

was not universally perceived as an effective engagement strategy. Many participants suggested that for some consumers, having workers with shared ethnic backgrounds would be seen as an advantage, where for other consumers, ethnic similarity would be an additional reason to avoid health services, especially given the small community and concerns that privacy may be compromised.

> *There are very prejudicial attitudes and behaviours displayed within the Arabic-speaking Muslim community, towards people, particularly young people, who have drug and alcohol problems. So, that means that there is a barrier there and then one way of overcoming that barrier is to seek advice from somebody who is outside the community and that is often what a lot of people do. I still don't think that there is a barrier which the public healthcare system has primary responsibility for. I think the initiatives need to be within the Muslim community to explain a better understanding of what drugs are, addiction is, and that perhaps a more understanding, if not more accepting approach would be helpful in order to encourage people to engage in treatment. (Mainstream)*

> *On my night shifts at the hospital, because I've got black hair I'm seen as the Arab speaking person, so if somebody comes – they look at my surname and they would be like, "Are you Lebanese?" Straight away to see if I'm from the same family. If it's something that they don't want to disclose, they will not see me. They'd rather see another person on duty. (Mainstream)*

Most participants suggested that some consumers found it easier to engage precisely because their health practitioner was of a dissimilar culture and religion. It seems that for some consumers, the stigma and shame were lessened when receiving care from a culturally-dissimilar health practitioner.

> *I think they're more open with us being not a Muslim one because we don't judge them about their faith, through their religion, because I think one of the patients who said as well that if they say something that they've done wrong, and then it means that they will be questioned about their faith. So yes, they are more open with non-Muslims– that's our experience. (Mainstream)*

A possible way to balance the need for relatability against the fear of confidentiality breaches and community judgements was to strengthen the cultural competence of staff.

> *A lot of the times they'd say "I don't want to be in a space where I'm doing therapy with someone who actually doesn't feel comfortable with my faith or my religion. You don't understand me." Usually that was the discussions that came out of therapy, like "How do you understand what I'm going through or what my faith is dictating to me?" but then at the same time, they don't want to access services that are actually faith-based or catering for their needs. So, it is a double-edged sword. There's a need there but they still don't want to access services that will meet that need. How do you bridge that gap? (Community)*

> *So, what's the solution? I don't actually have a solution. But I would assume the best thing is to have people outside of the culture, but are very well culturally trained. And that way you kind of have the best of both worlds. (Mainstream)*

Others again emphasising that the diversity of the MaAS community should be reflected in the service approaches and services should respond by offering a diversity of substance use treatment options, as opposed to a culturally-driven 'one size fits all'. Where some consumers might find comfort in the familiar, others might prefer to go to a mainstream service because it is more disconnected from the local community.

Pathways into care - limited linkage between mainstream and community services

The compounding factors of community denial, culture of secrecy, cultural beliefs about the cause of substance use issues, and concern about the cultural appropriateness of drug and alcohol services dovetail to obscure the level of need in the community. Both community and mainstream services struggled to target the level of intervention due to the limited clarity regarding types of drugs and severity of the substance use disorder.

> *Even when we met with the guys at [MaAS designated service], they weren't really able to clearly communicate, this is the cohort we're seeing, this age, this gender, this drug. Like there wasn't really, it was all more hearsay stuff. Weren't any direct examples, we've got this guy coming in, he seems intoxicated, he's got infections from where he's been injecting. There was nothing like, you know, when you talk about examples. So, for us to really nail, well we've got a whole big area, where do we go, what do we do, what we're targeting, what message are we giving out, because we don't really know what's happening. (Mainstream)*

Despite such limited clarity, key informants identified two main referral pathways into drug and alcohol services for MaAS consumers. One being through referrals from Arabic general practitioners into mainstream drug and alcohol services and another involved referral to MaAS designated service, typically through cultural or religious leaders.

Many mainstream service providers lamented the perceived tendency of MaAS community organisations to avoid referring to mainstream services and use such treatment pathways. Few, if any, referrals were made from community organisations to mainstream services making it difficult to ascertain the level of need in the community. The MaAS consumers who were engaging in treatment from mainstream services were typically referred through Arabic general practitioners.

> *I know a lot of people that the first point of contact would be just that denial phase, there's nothing wrong with them. Then they'll go see a specialist or a medical doctor, completely away from their surrounding or the area. Somewhere very, very far away, so that nobody would see them. (Community)*

> *In terms of accessing the healthcare system, I think mostly that community initially would see an Arabic Muslim general practitioner and then they would access the healthcare system through them, that's the GP as the gateway. (Mainstream)*

Newly arrived migrants, or less integrated individuals, were seen as more likely to avoid mainstream services and instead utilise the religious leader pathway into treatment. A driver underpinning the tendency to avoid mainstream services was, as mentioned, a concern that advice given, and treatment plans suggested by mainstream services would be unacceptable within Islamic teachings.

Unfamiliarity with the Australian health system, limited substance use literacy, and a tendency to seek out what is comforting and known, may also influence these decisions.

> *I suppose also that you've got people that are more Australianised, and others who are a little bit more vulnerable and not so linked in with the Australian community. (Mainstream)*

> *The stigma. The stereotypes that exist in the community. Because there's a lot of that. And it's not just in the drug and alcohol space but it's across the board. So, a lot of families won't seek assistance from clinical services that are available to them or health services that are available to them. Their first point of contact would be their local mosques and stuff like that because they think that religiously they may be able to combat the problem, but we all know it doesn't work like that. (Community)*

In instances where the religious leaders were the first point of contact for assistance, concerns were raised by participants about the promotion of abstinence and collectivist parental norms overwriting harm minimisation messages. The general knowledge about substance use issues by religious leaders and their ability to provide non-judgemental care was also raised.

Although many participants mentioned fear of culturally inappropriate practise within mainstream services as a barrier for some groups in the community, often these barriers related to consumers being afraid of what they did not know, or a perception that they would not be met with understanding, more so than based on actual negative experiences.

> *First of all, there's a view in the community that they won't understand what our issues are (Community)*

> *Because people don't know, so it's more related to ignorance than anything. People think that if they're going to get screened in a breast screening centre there are males there and there's cameras and things. My mum went through this. She needed to go to RPA. She went there and she was blown away by the service, there was no men, all of that, but people don't know. (Mainstream)*

Such fears are important for health practitioners to be aware of, as fears and misunderstandings might be aided by clinicians taking additional time during appointments to explain procedures and reassure and comfort consumers. Engagement efforts specifically targeting the proportion of MaAS consumers who were likely to avoid mainstream services was emphasised by key informants. Additionally, the limited referral between mainstream and community services likely constrains consumers' opportunity for recovery from substance use disorders and from benefitting from available services.

Harm minimisation: difference in approach between community and mainstream services

A simple solution to the issues discussed in the sections above might appear to be the availability of MaAS designated services in conjunction with mainstream services, as well as offering MaAS consumers the choice, where possible, of seeing health professionals of either similar or different ethnic backgrounds. However, several key informants raised concerns regarding the inconsistencies

between the ideologies guiding mainstream and community services. In particular, tensions over the philosophy of harm minimisation was raised:

> *My other concern is obviously we work under the harm minimisation philosophy and I wonder what sort of philosophy then the community services would work under. And I just worry about the message. If it's going to come from a culturally particular service and how conflicting it will be for that person that they may lose their way, instead of find their way. (Mainstream)*

> *Some services, like maybe if they come from a religious aspect, then obviously the framework or the philosophy could be abstinence-only. And not many people can actually achieve abstinence. If they can't achieve abstinence, then they have nowhere else to go because that service does not meet them or does not fit them. I mean religion is great, but it needs to be tailored to that person where they are at. I know a lot of people that have kind of found God in that sense and are doing well. But we just need to make sure that the message is appropriate. (Mainstream)*

Harm minimisation-based services can facilitate engagement of people who use drugs in health services by reducing the stigma associated with substance use (N. Lee & Petersen, 2009). Harm minimisation programs prioritise improvements in consumers' social functioning, quality of life and changes in substance use (S. Lee & Zerai, 2010). Framing the aim of drug and alcohol services in this way aims to shift perceptions away from condemnation and the "stigma life sentence" of addiction (Lloyd, 2010). Participants raised concern that, given the strong prohibition of substance use within Islam, religious organisations might only offer abstinence-focused programs. Such dual ideologies could mean that consumers receive quite different messages about substance use and addiction from MaAS designated services than from mainstream services. This could create confusion and conflict for the consumers, making it difficult for consumers to access the information and services needed for substance use disorder recovery, and create additional obstacles for mainstream drug and alcohol service to reach them.

Familiarity and professional boundaries

Several key informants mentioned the range of difficulties health workers from Arabic backgrounds might face when providing care to consumers from shared ethnic backgrounds. MaAS practitioners could, at times, struggle with discussing sensitivities regarding substance use with consumers from their own background. Role ambiguity and concerns around professional boundaries were cited. Some participants feared that staff might feel pressured to work outside what could be considered the scope of their professional practice, combined with a sense of protectiveness and resistance to refer MaAS consumer to mainstream staff. One key informant expressed a general frustration that was evident in many of the interviews:

> *Sometimes they feel that rules may not apply to them if they're trying to, if they've got a worker that is from the same Arabic background because you have that understanding. Or you know, "doctor, you can see me five times a day. It's okay". 'I'm allowed to come into this room because, you know what I mean? Or you can take me outside for a walk but not the other patients. So, it's kind of those, it just depends on how - whatever is happening for*

them, but they try and kind of always push the boundary and want you to break the rules for them. They try to push the boundary too far. (Mainstream)

Below is an illustration of this particular dynamic where a participant reports a consumer expecting special treatment from health practitioners of similar cultural background.

I had this one patient a couple of weeks ago only, and she ended up in the ER because her husband was abusive. And he had literally ripped her lip by punching her. And not only her husband, but three of her husband's friends. And she was too afraid to call the police. So, I literally had to call the police on her behalf. She had left three kids at home with the husband. And she refused – she goes no, it's fine. I just need to get stitched and I'll go back home. So, the fact that she would be so afraid – and then she was telling me, "But you're from my culture. You're supposed to help me as a woman. You're supposed to keep our secrets." I'm like, "Yeah, I'm confidential. There's a fine line between confidentiality and knowing what is right and what is wrong." So, things like that, when they relate to you. (Community)

Participants mentioned that especially community providers might struggle to uphold such boundaries due to the more informal and familiar nature of the service delivery. A similar potential for feeling pressured into overstepping one's professional boundaries when dealing with consumers from a similar cultural background was mentioned for GPs. Concerns about repercussions in the community, too much familiarity and community bounds might lead some GPs to over-prescribe opioids.

Especially with Arabic speaking GPs, that is culturally something, like good relation with a doctor, an Arabic doctor will do him more favour, give more script, less problem, more patients and more addiction. What I'm trying to say is, GPs plays a very big role in addiction. So, if a GP got kind of guidance or awareness, I think the problem of addiction would be less. (…), as you know, we have high percentage of these patients come with prescribed opioid problems. So, if we could work on the origin of this problem, the treatment would be better. If the GP knew more about what is addiction, what's should be or is the limit for prescribing benzo or opioids? I think the problem will be minimised. (Mainstream)

Participants suggested more education about opioid prescribing practices and addiction targeting MaAS GPs. Strengthened procedures in this regard and offering additional debriefing and mentoring opportunities may support mainstream and community staff in adhering to the scope of their professional practice, in particular, concerning professional boundaries.

Cultural competence, relatability and client-centredness

Despite the tensions regarding fear of judgement from religious and ethnically similar practitioners and services, the centrality of cultural competence in working with MaAS consumers was emphasised by key informants, a finding reiterated in much literature (Jaworski et al., 2019; Maroney et al., 2014). Several participants discussed the importance of cultural competency training to health professionals, with one noting that cultural competency was especially important for consumers who did not wish to receive care from a practitioner of similar cultural background:

So, with those who are requesting those who are white, or someone that's not from their cultural group, they still want the cultural humility. So, the thing is, there's this assumption that just because I'm using drugs don't think I've dropped everything from my faith. There's still certain boundaries. And it might seem contradictory, but as humans we don't follow everything to the T. And so, they may want to hold onto some Islamic practices and not others. So, they may still want to be treated by the female versus the male doctor, right? But they may not want to tell the Muslim person, because there's too much same and oh my God, they may know someone from my community. (Community)

Increased awareness by practitioners regarding the characteristics of MaAS communities including those tied to gender, family and family-community relations was felt to improve health service utilisation. A sensitivity towards and acknowledgement of MaAS consumers' cultural and religious perspectives and habits also included Islamic literacy such as knowledge of religious holidays, halal food and religious fasting.

But from my opinion, as I am from an Arabic background, what we can offer this community is understanding their social life and their habits. Something like if they're fasting, all these issues we have to consider it very well. We have to respect it, we must respect it within the Australian context and limit as you would. (Mainstream)

Although most participants recognised the efforts made by the public health system to accommodate the MaAS community, such as the availability of translators and materials in Arabic, many regarded mainstream services as, in some cases, not fully understanding the issues felt in the community. More understanding of how culture affects consumers' treatment needs and presentations, and how practitioners could better respond to cultural features to ensure better engagement and outcomes was mentioned as current gaps.

Knowing our community there's a specific, I guess, cultural consideration that needs to be taken into account in providing health services. We find there are a lot of barriers to accessing certain services, however, if these barriers are broken or minimised then we know we can tap into the community. Some of those barriers are barriers of language, understanding religious beliefs and cultural norms of those people, to be able to take that into account when providing, for example, a mental health service. (Community)

Halal food is always an issue, and obviously if a woman's, she's scarved, and she needs to take her scarf off or she needs to undress or something, how is that going to happen in an environment where there are men? Just some of these considerations come into play. (Community)

Rehabilitation services were mentioned as a particular concern for MaAS consumers. The barriers here especially related to Christian-based services. Participants explained that it might be both confronting and alien for MaAS consumers to attend rehabilitation services with very few other people from a similar culture.

Look it's the Christian-based ones. It doesn't mean they don't do a great job, but the fundamental is all Christian-based. And as for the Muslim community it might be great because no one's going to know who you are; or as the days go by, and the withdrawals have gone and they trying to get that, they're still absolutely alone. But they want to turn, and

they want to go on that prayer mat, or they want to fast or whatever it is. Because some of the clients go in there and its Ramadan and when they're there fasting and they do try to cater to halal food and stuff, they feel alone because they want that brotherhood or that sisterhood that they're not the only ones fasting. (Community)

In some instances, participants related situations where lack of cultural awareness meant that health practitioners were unable to fully appreciate the cultural complexities of a situation. In such instances, a limited appreciation of cultural aspects of a consumer's challenges was felt to minimise the opportunity to provide care, as the below quote illustrates.

I remember one conversation I was having with a counsellor. I was telling them that my parents had these tasks and it's very difficult to manage these and studies and other things together. And instead of telling me to better manage the other things, they straight away go "well why don't you just say no to your parents and put those tasks – like when your Mum and Dad ask you something just tell them no I don't have time". Whilst a culturally aware person would actually be the other way around. They'd be like well why don't you put a week break on work and actually finish the tasks for your Mum and Dad, which would have made much more sense in my context. I'd rather take a week off work and do that rather than telling them no I have work. So, in a sense that was kind of assessed as – the solutions were not appropriate for my context. (Mainstream)

Building the bi-cultural and bi-lingual workforce was seen as a way of addressing some of the health-seeking behaviours discussed. Participants suggested that consumers were looking for a degree of relatability, that is, empathy, commonality and familiarity.

What people were telling me from the Muslim community was that they need someone that they can relate to. So, having a bilingual worker, they want some commonality. And, generally, when I asked what that commonality was, it is either religion or language or culture. So at least one of them had to fit in, before they even get comfortable. And so those three were really, really important for the Arabic speaking community. (Community)

Cultural stereotyping has been noted in the literature (Botfield et al., 2017), as a particular risk for service providers, that may lead workers to make particular assumptions about the beliefs or values of consumers, or to draw conclusions that people from a certain cultural community identify with that community. In this regard, treating MaAS individuals as a homogenous group, would neither be appropriate nor ensure that consumers received the most appropriate person-centred care. An example of such problematic cultural stereotyping could be a reluctance from service providers to engage MaAS consumers in discussions around substance use due to concerns about cultural or religious sensitivities. Participants highlighted the importance of health staff having adequate training to avoid such cultural stereotyping.

Well, you create stereotypes. So, you've given them a tiny bit of information and they apply it to everyone. Instead of taking it as that one step to understanding who this person is. Yeah. As professionals we do have to be careful of that. And even though we're from culturally diverse backgrounds, we don't know of other cultures. (Community)

But if we go to, is it better for a certain patient to go to a Muslim practitioner or a non-Muslim practitioner, I would reiterate that it's better if everyone is trained to – and not to

assume, that it's not a checklist, because people are very different. You know, like for example, there's people that wear a hijab that are not ready to take off their hijab at all except if they're in their houses. And there's others that wear a hijab and they even might walk out of the house on short trips and not wear a hijab. They only wear it when they're going out for a long day out or something like that. (Mainstream)

In this regard, many participants highlighted the importance of person-centred practice as a way to avoid making assumptions based on outward appearances or preconceived notions of MaAS consumers' preferences. In a health care context, client-centredness relates to the dynamics of professional-consumer interactions, particularly the inclusion of consumers in decisions regarding their care. Emerging in the 1960s, in parallel with the political changes of that time, person-centredness represents a shift away from expert-driven models and medical paternalism towards an approach that recognises consumers' right to autonomy and choice when it comes to the conduct of health care (Hughes, Bamford, & May, 2008). Among participants, person-centredness involved taking the time to engage and build rapport with consumers to understand their goals and assist in developing a plan for achieving these.

And maybe not making assumptions, just because they're Muslim – not making assumptions around that as well. Really just connecting with that person and finding out about them. (Mainstream)

The one thing more than knowing the language or the culture, it's just being polite, polite and convey empathy. These are basic human characteristics of healthcare providers and they go a long way to overcoming barriers. (Mainstream)

Cultural sensitivity within mainstream services was universally supported as an important mechanism for enhancing engagement. However, participants stressed the importance of not assuming homogeneity of MaAS consumers' needs. Person-centred practises and an emphatic, non-judgemental approach was found to help build therapeutic alliance as well as improve the accuracy of the diagnosis and the appropriateness of treatment.

Mainstream staffs' experiences providing drug and alcohol care to MaAS consumers

As part of the interviewing process, mainstream service providers were asked if they felt able to deliver culturally appropriate services to MaAS consumers. Across all three participating Local Health Districts mainstream service providers expressed feeling well equipped to engage MaAS consumers and emphasised that they were accustomed to providing care to highly diverse cultural groups.

I do think we provide a really good service. I think it's really culturally appropriate. I think we really recognise the importance of religion and culture in our clients, and we absolutely incorporate that into our work. (Mainstream)

We try and provide them with some flexibility. But still, at the same time, this flexibility is done for every other person that comes here. And that's also looking at and including people with LGBTI or some sort of disability requirement which we've had here. And we've provided some flexibility for them to ensure that they stay here and get provided with the appropriate services. (Mainstream)

Health practitioners are often required to modified their practices to provide person-centred interventions to consumes from diverse cultures (Maroney et al., 2014). Mainstream service providers offered examples where they had provided flexibility and exercised cultural awareness for MaAS consumers.

> *In terms of for the inpatient unit, people require halal food, so that's obviously provided for them and we always ask them what's your food type or what would you like to have. So, we do take into account their religious and cultural background and try and provide them with services that will actually help them. Similarly, in the community as well, if they are on medication like methadone or suboxone and they can't come to the clinic in the daytime because they are fasting for Ramadan. Then we have provided services for them to go to a community pharmacy to pick up medication after that fasting period. So, we have - we do take into account their cultural background, religious background, and facilitate services that will actually help them. (Mainstream)*

> *I've seen Arabic Sunni Muslims. I've seen Arabic Shiite Muslims. One of the things that I do is talk to them about my experience of their countries, the ones I've visited, or I talk to them about what is happening in their country at the moment, obviously highly relevant for people from Egypt and Syria, from Lebanon, from Iraq, from Iran and so, I can relate to that and they seem to relate well to me. There doesn't seem to be any particular issues. There are more issues, I think, between them and certain members of their community than there are between them and mainstream health professionals. (Mainstream)*

Gender-specific concerns such as preferences for same-sex practitioners were mentioned repeatedly as areas where staff felt able to offer flexibility of care.

> *I'm a physician, so I examine patients. If it's a female patient, I'll do so with a female present. Never have I had a Muslim female patient refuse to be examined. I ask them. I tell them about what the consultation will consist of and they say yes if they remove their scarf or niqab or whatever they're wearing. They said, "If it's medical, no problem." So, I think there's a lot of misunderstanding by healthcare providers, people in the healthcare system, as to what is and is not appropriate to do. (Mainstream)*

Many staff mentioned that in instances where they might be unsure about some cultural aspects of care, they had sought out advice from a colleague from a similar ethnic or religious background.

> *I think it's just the simplicity of that, isn't it? We have a Muslim colleague – I would readily consult with her about anything that would come up that I needed to know, that I was unsure about. We share knowledge. I just think being in Canterbury, it's so diverse that it's just part of your daily work, being around lots of different cultures and respecting that. (Mainstream)*

From the perspective of mainstream staff, the MaAS consumers who did engage in services did not encounter any particular barriers compared to other migrant consumers or indeed consumers from the general Australian community. However, whatever barriers consumers who did not engage with mainstream services might experience, was unknown.

So, I mean we don't know what we don't know in terms of if someone is not coming here, who has got an issue, how many people do have issues in each area. So, we don't know the extent of the problem and who we're not servicing. We do know the - obviously the ones that we do service, they do come back to our services. And they come back a lot. (Mainstream)

Overall mainstream staff reported no cultural or religious barriers to engagement particular to this community. Participants articulated general rapport building, interpersonal engagement, client-centred approaches and adaptability to suit the needs of any consumer as relevant strategies to overcome consumers' reluctance to engage.

Structural and institutional barriers to engagement

Significant barriers exist for disadvantaged groups in accessing health services, these include the complexity of the health system and service fragmentation (Carrillo et al., 2011). For migrant groups, differing expectations of health and healthcare, limited health literacy, or a lack of understanding or use of healthcare information can also contribute to difficulties in navigating the system. This was raised by participants as a barrier pertaining to providing services to CALD minority communities.

We've had a few emergency cases. They just don't know where to go. They actually – their awareness of services is so minimal. I recall we had this walk-in, her son was a chronic user of ice and some other drug that I actually hadn't even heard of. And he was at the point where he was hallucinating. And you know, he had scabs and he was hallucinating and – so he was quite – and he'd been doing it for quite some time. So, it was at the other end of the spectrum of using. And they just had no clue. What do we do? What if we ship him to another country? There might not be drugs there. Thinking it's an isolated issue in Australia. They don't know where to go. (Community)

There's a lack of awareness of how broadly systems here work. Health systems, legal systems, any systems whatsoever. And so, what ends up happening is, I don't know where to go but also, I don't trust what I don't know. And I'm fearful of what I don't know. (Community)

Language barriers were noted by some participants as a challenge for providing information and accessible service to people from MaAS backgrounds. The availability of interpreters was mentioned in this regard as some reported issues obtaining an interpreter at short notice. Others mentioned that sharing sensitive information with interpreters from a shared cultural background may not always be appropriate due to consumers' confidentiality concerns. Where doctors, nurses and addiction specialists did not consider the use of an interpreter a significant barrier, for psychologists and counsellors, language barriers was more of a concern.

Well, the other thing is, I would personally prefer to refer someone to someone that can speak their language because I think having an interpreter, it does change the dynamics in counselling. So, if there is a possibility that we could link them in with someone that could speak their language I think that's actually preferable, just in terms of building rapport. (Mainstream)

Participants representing mainstream service emphasised that the limited availability of culturally appropriate options was not a consequence of resistance to offering such services. On the contrary, most mainstream service providers showed interest and motivation to increase their accessibility, but felt constraint by funding and resource pressures.

> *It's not that easy just to say, dedicate a room for a prayer room, or especially in a service that's 24-hour like a rehab, you now have halal food available every day. Like, there's a cost associated with that, and there's changes that need to be brought in to do it, and, it's not like rehabs are sitting on money. (Community)*

> *You've got to increase capacity in those services. Like, just, there's no point saying yeah, well all the services now have to provide Muslim appropriate or culturally appropriate services to Muslim and Arabic speaking people and are given nothing to do it with, that's just not going to work. There's no point making commitments without dollars really. Because you're not going to get any pushback from the services either, but how do we pay for this? Like this is not a cost-free exercise. (Community)*

Participants emphasised that limited capacity of mainstream and rehabilitation services is not just an issue for the MaAS community, but an issue for all people facing substance use issues.

> *You can't say because it's referred by a Muslim doctor or whatever, this person goes to the top of the queue, they have to wait in the line. (…) There's isn't a quick fix, there's no magic solution out there that is available to everyone but Muslim communities. Everyone struggles, every community, every family regardless of their background is struggling when someone in the family has a drug problem. And, they need to be realistic of what they can do and what their options are and, also understanding what the services can provide. (Community)*

In general, funding for both mainstream and community services were identified as a barrier. Although MaAS designated services and NGOs were identified as offering high quality and culturally appropriate services, the current resources did not meet demand. The importance of recognising the organisations and health professionals already working in MaAS designated services was highlighted by several participants. This included acknowledging and supporting these better:

> *So, there are people of Muslim faith there and Arab cultures, and they're able to provide a service for them, and provide all their needs, from prayer rooms to Halal food and all that. So, the cafeterias can cater to all their needs, to allow them to engage in the treatment like everybody else. So, and that I think is a good model for - but the problem they've got is they're full all the time like with most rehabs. So, that option then becomes difficult for people. (Community)*

Facilitators of community and consumer engagement

Holistic services and integrated care

For culturally and linguistically diverse groups, making first contact with health and treatment services is potentially difficult (Craig et al., 2007). Many participants identified the need to provide integrated health services that were easily accessible for MaAS consumers, and to ensure

professionals across mainstream, community and NGO services worked together effectively to deliver care, a finding strongly supported in the literature (King & Meyer, 2006). The delivery of integrated care has been identified as a key NSW government health priority (NSW Legislative Assembly Committee on Community Services, 2018; NSW Ministry of Health, 2018). Integrated care involves running programs which address consumers substance use issues within the context of a whole range of issues that a person might be experiencing such as health and wellbeing, mental health, trauma, sexual abuse, lack of family support, unemployment or limited economic opportunities.

> *So, there was a feeling that drug and alcohol was existing in isolation, people wanted – people described how they was experiencing a whole range of mental health, social economic inclusion, family support issues. I remember talking to some newly arrived – conversations with newly arrived communities and people would suggest solutions that they would like see in terms of like a holistic sort of warp around response for the person experiencing an issue and sort of being able to follow that person, so not just like a one-off intervention but being able to support their person through that health-seeking treatment journey. (Community)*

Additionally, embedding drug and alcohol services within broader health or community programs were felt to provide less identifiable pathways to drug and alcohol services. In recognition of the significant stigma in the community, changing the language to safeguard consumers' anonymity was cited as a potentially less stigmatising approach.

> *Even in our clinic we don't have a sign on our clinic, so those that walk into the clinic are not going to be identified by community members that they've got a mental health issue that needs to be diagnosed. (Community)*

Partnership approach

Better linkage between mainstream services and MaAS designated services and improved collaboration were identified as important factors to enhance engagement with the MaAS community. Effective inter- and intra- service cooperation is influenced by multiple factors such as coordination, partnership models, preparedness to share power and information, challenges to professional identity, competing goals and agendas across services and lack of reconciliation of different ways of working (Grace, 2015). Identifying the organisations already established in this area and resourcing these, building capacity for networking, collaboration and referral pathways between services were suggested. Strengthen the interface and linkage between community services and mainstream services were especially highlighted:

> *I think some quick wins which wouldn't take money, would just be to have a couple of existing services have a strong MOU with us. And all the practitioners involved, whereby we could all help each other in terms of being a much more streamlined service. (Community)*

> *There's no point in reinventing the wheel when it's already available. The supporting was already there. So, if there is services out there that's been catering for this particular sector, then supporting them financially would be really beneficial. (Community)*

Participants stressed the need for better referral pathways between MaAS designated services and mainstream services in acknowledgment that substance misuse recovery and rehabilitation for MaAS consumers often required engagement with both mainstream and MaAS designated services. In recognising of the diversity in the community, and variety of pathways into drug and alcohol care (for instance through GPs, religious leaders or MaAS designated services), a variety of services needed to be supported. To enable such partnership, participants suggested that consumers, families and the community needed to be reassured that mainstream service would be culturally safe. Religious and community leaders would in such cases be required to endorse mainstream services.

> *Also, I can trust what you're telling me to do, because I know you're not going to lead me away from my culture, my family, my religion. And I think that's huge, because a lot of people will go to others and I'm sure others are culturally competent and religiously competent. But if the client doesn't believe it, there's no point. They're not going to do it. (Community)*

> *If someone's got drugs, it's got to a point where you've got a condition and it needs to be diagnosed by a professional and it needs to have a certain pathway to treatment. For some people what they say is, "Okay, in the Koran, do remembrance of God. That can help your mental state," but when you have clinical imbalances in your body and there's a condition, that's when both work hand-in-hand. So, what we're telling the people is, "Yes, but that's not the only way. There's professionals who can treat these things," and Islamically that's good. (Community)*

Participants from mainstream, NGO and community services were in favour of efforts to build better links between services, including offering more knowledge about available services, information about what these services can provide and making drug and alcohol service promotional materials available in both Farsi, Arabic and English. Although mainstream services and the MaAS designated services needed to work in partnership, many emphasised that it would be most appropriate if these services were not combined. Offering a culturally safe, familiar but not religious point of contact acting as the interface between the community and mainstream services was suggested.

Community education and substance use awareness

De-stigmatisation of substance use and treatment seeking were proposed by many participants as important steps to strengthen engagement of MaAS consumers with drug and alcohol services. Outreach strategies targeting MaAS designated community programs not associated with drug and alcohol or other 'stigmatising' services were suggested, as word of mouth and working locally was considered the most effective engagement strategies.

> *I'm saying in my experience, you have to work extremely locally and it is a word of mouth thing, because word of mouth is very powerful in these communities. I think it's really a good way, and it happens very, very slowly. I mean, if we could have a lot more workers on the ground doing this kind of thing and just starting groups and going in communities and sharing knowledge and information and key messages around, it's okay to talk about this*

stuff. If you start talking about it, you will get help and support. You will learn how to cope. (Community)

To improve perceptions of drug and alcohol services and move away from conceptualisations of substance use as a moral or personal failing to that of a health issue, religious leaders needed to be engaged in any educational programs targeting stigma in the community. A similar finding was reported by an Australian study exploring smoking within an Arabic-speaking community in Sydney (Phillips et al., 2015). Providing religious leaders with knowledge of substance use and appropriate services may lessen the stigma and allow for better care of individuals experiencing substance use issues. Additionally, raising the knowledge and understanding in the wider community regarding harm minimisation and management of substance use issues were seen as crucial. Harm minimisation education needed to be considered in a culturally sensitive manner.

Well, I think it's one of the gaps we have at the moment is that a lot of harm reduction education is directed more at Australian communities. And, most of multicultural communities, even though the current generation or the youngest generation tend to understand the harm reduction measures, there's a real disconnect between the expectation and views of their parents and grandparents' generation about drug use. And, I think harm reduction is seen as something that is inappropriate a lot of times, because the only message would be, don't use drugs. We shouldn't be accommodating any drugs use at all is the view I think we often run up against. So, we come up against Muslim parents, for instance, who have kids in trouble and those sorts of things, and they shouldn't be using at all, and just make them stop. (Community)

Education campaign for families, assisting families to move away from a punitive approach towards a more supportive and helpful approach, as well as generally supporting families to cope with the challenges surrounding substance use was highlighted. Education targeting MaAS GPs was also recommended, in recognition that primary health care and GPs is a typical first point of contact for drug and alcohol care across this population, and often play an important role for MaAS community members who are unfamiliar with navigating the health system.

Cultural awareness training to mainstream service providers

Treatment interventions able to adapt to the unique risk and resilience of diverse communities have been found to be most effective in reducing barriers to care (Mollah et al., 2018). Despite the strong finding that most mainstream service providers did not experience any particular challenges engaging with MaAS consumers, there was a general openness towards and interest in knowing more about this community among mainstream staff.

Maybe even some sort of education around just cultural awareness or how to actually engage with people from that community would always be useful. I know just taking another example of working with Aboriginal people, just knowing that there's certain things like not making direct eye contact and having seats next to each other, those sorts of things for the Aboriginal community has helped me build rapport with that client group. So, if there's things like that to be aware of that would be good. (Mainstream)

Having bilingual and culturally-trained workers able to reach special needs groups were recognised as important and potentially more appropriate than the ethnic matching of staff to consumers. Professionals spending more time building rapport, discussing the implications of confidentiality and explaining procedures to reassure and comfort consumers was also cited. Using cultural and religious leaders as advisories and partners in developing culturally appropriate models of care was seen as an important way to ensure cultural inclusiveness.

Conclusion

The key themes identified here reveal critical aspects of how health professionals engage, work with and make sense of the complexities of providing drug and alcohol services to the MaAS community. The use of alcohol and other substances in MaAS communities is strictly prohibited and often associated with shame, stigma and loss of face within the community, factors contributing to a widespread denial of substance use issues. Psychosocial problems, as well as substance use, are often equated with weakness of the self or weakness of faith for which a punitive approach is believed to be the most appropriate. The issues of stigma were seen by many as the underlying driver of 'sensitivities' in the drug and alcohol arena, both preventing people from talking about substance use, gaining knowledge about addiction or disclosing personal or familial challenges relating to substance use. Religiosity was cited as both a protective factor, a contributing factor in the substance use recovery process and a barrier to disclosure and help-seeking.

The compounding factors of widespread secrecy and denial within the community, powerful drivers to uphold the reputation of the family and the community, cultural beliefs concerning addiction and substance use, and concern that mainstream services might offer inappropriate advice inconsistent with Islamic teachings provides context to the complexities surrounding substance use in the MaAS community. Such concerns are important for health practitioners to be aware of, as fears and misunderstandings might be aided by clinicians taking additional time during appointments to explain procedures and reassure and comfort consumers.

Barriers and pathways into drug and alcohol services

The 'double discrimination' Muslim consumers may experience, caused by having a substance use issue and societal stigma connected with being a Muslim was emphasised. Negative past experiences of racism and islamophobia within the Australian society, as well as within health services, were mentioned as obstacles for help-seeking. Perceptions of conflicts between family/ community values and ideologies of mainstream drug and alcohol service were also identified as barriers to accessing the health system, specifically drug and alcohol services. In particular, mainstream services' harm minimisation approach was experienced as in conflict with the abstinence-focused, more 'punitive approach' often advocated within the community.

Fears about limited confidentiality of information acted as a strong barrier to disclosing substance use issues in formal settings, in particular, to staff from culturally and ethnically similar backgrounds. Fear of violation of confidence in many cases was perceived to create a preference for treatment from mainstream services. Although specialised services targeting the MaAS community were seen as culturally safe, many highlighted the need for services to not be directly associated with religion, as this could add further stigma. Participants emphasised that the diversity of the MaAS community

should be reflected in service approaches. Offering a diversity of substance use treatment options was suggested as more effective than a culturally driven 'one size fits all'. Where some consumers might find comfort in the familiar, others may prefer to go to a mainstream service because of its detachment from the local community.

Engaging mainstream health services

Participants cited differing expectations of health and healthcare, limited health literacy, a lack of understanding or use of healthcare information and difficulties in navigating the health system as barriers pertaining to providing services to the MaAS communities. The aforementioned sensitivities associated with substance use obscured the level of substance use in the community and made it difficult for community and mainstream services to target the level of intervention relating to types of substances and severity of substance use disorder. Nonetheless, participants cautioned against segregating the MaAS community out from other migrant communities or from the Australian mainstream community, advocating instead for a strengthened focus on social cohesion through making mainstream services more culturally appropriate. Fragmentation of effort, segregation and limited integration was mentioned as important factors in support of universal approaches.

Two main pathways into drug and alcohol services for MaAS consumers were identified. One being through referrals from Arabic general practitioners into mainstream drug and alcohol services and another involved referral to MaAS designated services, typically through cultural or religious leaders. Few, if any, referrals were made from community organisations to mainstream services or contrarywise. In instances where a religious leader was the first point of contact for assistance, concerns were raised about the promotion of abstinence and collectivist parental norms overwriting harm minimisation messages. On the other hand, many regarded mainstream services as in some cases not fully understanding the issues felt in the community. More understanding of how culture affects consumers' treatment needs and presentations, and how practitioners could better respond to cultural features to ensure better engagement and outcomes were mentioned as ways to address these gaps.

Cultural competence, relatability and client-centredness

Cultural sensitivity within universal services was well supported as a mechanism for enhancing engagement. Increased awareness by practitioners regarding the characteristics of MaAS communities including those tied to gender, family and family-community relations was felt to improve health service utilisation. However, participants stressed the importance of avoiding cultural stereotyping and not assuming homogeneity of MaAS consumers' needs and preferences. Building the bi-cultural and bi-lingual workforce was seen as a way of addressing some of the health-seeking behaviours discussed. Participants suggested that consumers were looking for a degree of relatability, that is, empathy, commonality and familiarity.

A word of caution was cited by many key informants to not present a picture of the MaAS community and MaAS consumers as highly dissimilar from other migrant communities, and indeed mainstream Australian society in general, when it came to engaging with drug and alcohol services. Many noted that providing services to culturally and linguistically diverse consumers was a highly normalised part of working in health. Staff reported few difficulties engaging with MaAS consumers, once they found their way into mainstream services. Participants highlighted the importance of trust, rapport, time and culturally responsive services for good consumer outcomes. However,

whatever barriers consumers who did not engage with mainstream services might experience, was unknown.

Facilitators of drug and alcohol service engagement for the MaAS community

The need for community education campaigns aimed at reducing stigma and increase acceptability of harm minimisation ideologies was a strong theme from the interviews. To ensure such an education campaign is culturally responsive and able to reach the community, extensive liaison with religious leaders, community champions and consumers is needed. Building bridges between community organisations and mainstream services was seen as crucial to facilitate better referral pathways and engagement with the community.

Providing more culturally responsive services and increasing community-wide knowledge of substance use treatments options may allow for better pathways to care. Participants suggested more education about substance use and opioid prescribing practices targeting MaAS GPs. Strengthened procedures and additional debriefing and mentoring opportunities may support mainstream and community staff in adhering to the scope of their professional practice. In recognition of the significant fear of stigma and community exclusion, MaAS consumers should be offered choice, where possible, of mainstream or MaAS designated service engagement.

Recommendations

Several recommendations arose from the research.

- Increase efforts to provide integrated health services that are easily accessible for MaAS consumers. Develop programs to ensure professionals across mainstream, community and NGO services work together effectively to deliver care.

- Work in partnership with MaAS designated organisations to develop outreach strategies, in recognition that working locally is considered the most effective engagement strategy.

- Run awareness campaigns aimed at de-stigmatising substance use within the MaAS community. Such awareness campaigns need to target religious leaders, community champions, families and the wider community and be developed in consultation with the community.

- Education for families and communities aiming at increasing community awareness regarding the road to recovery and addiction in many cases being a chronic relapsing condition.

- Education about substance use and opioid prescribing practices targeting MaAS GPs.

- The development of culturally responsive harm minimisation strategies taking into consideration the strong cultural, familial and collectivist traditions and approaches in the community.

- Support efforts to build better links between services, including more knowledge about available services, information about what these services can provide and drug and alcohol service promotional materials in Farsi, Arabic and English.

- Increase funding for both mainstream and community services offering high quality and culturally appropriate services as current resources do not meet demand.

- Strengthen procedures and additional debriefing and mentoring opportunities to support mainstream and community staff in adhering to the scope of their professional practice.

- Efforts to increase understanding in the community around practitioner–consumer confidentiality to help consumers overcome any fear of privacy breach.

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