



A Framework for Working with Alcohol and Other Drug Clients from Diverse Communities

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Introduction

Australia is a society which believes itself to be multicultural. In line with this it is hoped that health services set up within this environment are able to cater to the needs of the diverse cultural and linguistic backgrounds of its population. Unfortunately this is often not the case. Australian social systems are still very much tied up in those of the dominant Anglo-Saxon/Anglo-Celtic culture.

It is in this light we suggest a new framework for working with Alcohol and Other Drug (AOD) clients from Culturally and Linguistically Diverse (CALD) communities. We believe this to be more suitable to the current environment.

Before moving on to the framework we need to define our terms of reference. Terms such as culture and ethnicity are commonly used in discussions around people from CALD backgrounds. These terms and their meanings in relation to the dominant Anglo-Saxon / Anglo-Celtic Australian culture will be examined briefly.

Culture

According to Orlandi (1992) culture is an amalgam of the shared values, traditions, norms, customs, history, folklore, art, and institutions of a group of people. The Victorian Department of Human Services (DHS) Drug Treatment Services (DTS) 'Report on Cultural and Linguistic Diversity and Drug Treatment Services' (1998) takes this definition one step further by stating that the above mentioned characteristics must be shared by a group of people who are united by ethnicity, race, language, nationality and/or religion. An amalgam of these two concepts is an effective way of understanding culture.

Ethnicity

Notions behind ethnicity are often referred to as culture, and hence the two are often confused. The notion of ethnicity is about the real, or imagined, belief by a group of people in a shared origin (Bottomley & de Lepervanche, 1990). One problem with definitions of ethnicity, as was discovered by the authors of the 2000 DHS document "Drugs in a Multicultural Community: An Assessment of Involvement", is that for every different

database collecting information on ethnicity there is a different definition of the term. Most often ethnicity is confused with country of birth. The problem with this definition is that it negates the ethnic identification which might be felt by second, third or fourth generation migrants. It also assumes that any person born overseas will always identify with their culture of origin. This is a static definition for a concept which is not. It is important to recognise the notion that third generation migrants in Australia are likely to have more in common with British migrants than with new migrants from their country of origin (Parsons, 1990). This lack of a uniform definition has led to some confusion in the health field. The statistics in any given area will change depending on which definition for ethnicity is used. This will in turn affect numbers, and may well affect government funding. However, ethnicity as ethnic identification is currently the most commonly used definition. It is also deemed to give the most accurate figures and as a result will hopefully become the accepted definition for future publications.

According to the DHS DTS Report on Cultural and Linguistic Diversity in Drug Treatment Services (1998; p5) the term ethnic is defined as:

“Belonging to a common group—often linked by race, nationality, and language—with a common cultural heritage and/or derivation”.

This term derives from the Greek noun ‘ethnos’ meaning nation of people, and still retains its basic meaning. In Australia, ethnic is commonly confined to immigrants from non-English speaking backgrounds and their descendents. The DTS definition of ethnicity, as the most encompassing definition, will be used for the purposes of the framework.

To date many of the changes that have been made by drug treatment services to better accommodate clients from CALD backgrounds have been relatively simple changes; such as employing bi-lingual and/or bi-cultural workers, utilising interpreter services, translations, collaboration and community consultation (DTS Report 1998). Many of these changes are relatively successful in the short term. However, due to the dynamic and changing nature of the work force they are often not sustainable in the long term.

The translations, collaboration and community consultations are vitally important parts of the treatment framework. It is not uncommon for the client to go outside their community for assistance as there are issues around fear, stigma and shame; being discovered by other members of their community. This is where much of the work that has already been done

comes unstuck. If, for example, a Vietnamese drug user approaches a GP for assistance outside of his/her community, chances are that doctor will not have the translations, collaboration or community consultation background to help them work with the Vietnamese client. This does not mean however that they should refer them on to another agency that does have these ties. The Vietnamese client has obviously approached them for a reason and to turn them away when they have finally built up the courage to ask for assistance could have potentially devastating side effects.

Many members of ethnically identified communities show reluctance to approach a practitioner within their own community because of shame and fear that their alcohol or other drug use may be exposed to their community (DHS, 2000; Reid, Higgs, Beyer & Crofts, 2002). Many AOD clients from CALD backgrounds are caught in a double bind when it comes to seeking help for their alcohol and/or other drug treatment. They are often unwilling to go to practitioners within their own community for the above mentioned reasons, and yet also feel unable to approach western practitioners for fear of being seen to have failed their new country or that they are living up to negative stereotypes (Reid, Crofts & Beyer, 2001). Many problems also revolve around people from CALD backgrounds simply not knowing how to access AOD services (DHS, 2000).

The framework developed below is strongly based on the works of Arthur Kleinman (1980) and Maryanne Amodeo (1997). It is useful not only for working with people from CALD backgrounds, but with all clients. Although the most obvious use is for people from CALD backgrounds, if this framework was used with all clients, practitioners would have the tools with which to gain a greater understanding of not just their clients, but also their own understandings of disease and illness. It is a way of enabling health professionals to recognise that they are coming from a culturally loaded and hence culturally biased position, even if they are from the dominant culture and working within the dominant framework.

As western medicine has become more accepting of other forms of treatment (eg: non bio-medical), now is an appropriate time to implement this broadly encompassing framework. Bi-lingual and bi-cultural workers are important as many clients from CALD backgrounds have limited English capabilities. But they are not enough. Community consultations and collaborations are also an intrinsic part of any treatment modality. But they are not enough.

This framework takes us a large part of the way to equalising access to, and improving outcomes from, drug treatment services for people from CALD backgrounds.

Framework for Health Professionals working with alcohol and other drug clients from diverse communities

The framework is broken down into four sections outlined below:

SECTION ONE: *Understanding your (the health practitioner) cultural grounding.* Work through Kleinman's list to assist in understanding your own cultural expectations. This need only be undertaken once to start you thinking about any biases and preconceived notions which may affect your role as a health professional

SECTION TWO: *Understanding where the client is coming from.* This needs to be undertaken with every client. However, this only need be done at the first appointment. This stage moves the emphasis from the individual to their cultural base. That is, what is the clients' cultural grounding and how are they informed? How acculturated is the client? This may or may not differ from your cultural understandings. Assuming shared cultural understandings with the client, regardless of any apparent or perceived similarities is something that we should always try to avoid.

SECTION THREE: *Using the model.* Amodeo's five stages of culture specific AOD dynamics is a very effective guide to use when working with the client. This gives you something solid to work with and to keep going back to for guidance. It may be a good idea to record the information gathered at this stage for future reference.

SECTION FOUR: *The Response.* The final stage is essentially how you respond to the situation and is case specific. The first three parts are merely guidelines for assisting you as you work with each client. Choice of treatment modality may be based on the interactions and discussions generated by undertaking the first three parts.

SECTION ONE

Understanding your (the health practitioner) cultural grounding. Work through Kleinman's list to assist in understanding your own cultural expectations. This need only be undertaken once to start you thinking about any biases and preconceived notions which may affect your role as a health professional.

The practitioner/client relationship is derived from the clinical orientation of Western medicine. As such it is assumed that this relationship is dyadic. However, there are many societies in which the practitioner/client relationship involves not only the sick person, but their family as well and hence is often for more complex than a simple two way relationship.

The importance of using Kleinman's list lies in its ability to make you aware of what your position means to both you and your client. This list should be referred to intermittently, but reviewed with every client to keep a fresh and open perspective on mutual expectations and beliefs about the practitioner/client relationship. The list is broken down by category, with reflective questions within each. This information does not need to be written down. However if writing the answers helps your understanding and recall then it is important that you do so to receive maximum benefit from the information gained.

The questions are for you, not your client. They are intended to show your expectations and understandings of the practitioner/client relationship. The clients' expectations and understandings of the practitioner/client relationship are covered in parts two and three. By being aware of your answers to these questions any differences in the expectations of both you and the client will become explicit.

AOD cultural framework - practitioner data

Institutional Setting	1. How do you view your role?	2. Where does society place you and the role you play?	3. Are clinical settings the norm your practice?			
Characteristics of the interpersonal interaction	1. Who are you treating – the client, the presenting individual, the family unit?	2. For what length of time is treatment appropriate (episodic or continual?)	3. Is your relationship formal or informal?	4. How do you and your client perceive (view) each other? Is this view mutually ambivalent?		
Characteristics of the health practitioner	1. How do you relate to your client?	2. Why are you working in this field?	3. How did you get here? What was your path to this position?	4. How/where were you trained and how does this affect your work?	5. Where do you work? Is this a clinical setting?	6. How are you perceived by the area/community in which you practise? Status?
Idioms of communication (Are your views and those of your clients in conflict?)	1. Are you expected to relate to your client on a religious/spiritual level?	2. Are you expected to relate to your clients on a social/moral level?	3. How do you communicate with your client? Do you hear what your client says?	4. How do you explain illness/disease to your client?	5. How is treatment decided upon?	
Clinical reality (Is the treatment culturally biased?)	1. Secular or sacred? (Is religion important to you or your client?)	2. Disease oriented or illness oriented?	3. Who / where is the locus of treatment? (Who is the treatment focused upon?)	4. Are you the only person treating the client?	5. Is the interaction about you or the client?	6. Who holds the locus of responsibility of care? (You, the client, their family, the community?)
Therapeutic stages and mechanisms	1. What is the process of treatment?	2. What are the mechanisms of change (catharsis, insight, social, psychophysiological)?	3. Adherence? (Why does/doesn't the client adhere to the treatment regimen?)	4. Termination? (How and why does treatment end?)	5. Outcome evaluation (treatment evaluation and compliance)?	
Extratherapeutic aspects (non therapeutic issues which may interfere in the treatment process)	1. Where is the social control? Does this effect how you practise?	2. Who has the social control in the relationship with your client?	3. Whose ethics and codes of practice are adhered to?	4. Are there any social constraints on treatment?	5. Are there any economic constraints on treatment?	6. Are there any political constraints on treatment?

SECTION TWO

Understanding where the client is coming from. This needs to be undertaken with every client. However, this only need be done at the first appointment. This stage moves the emphasis from the individual to their cultural base. That is, what is the clients' cultural grounding and how are they informed? How acculturated is the client? This may or may not differ from your cultural understandings. Assuming shared cultural understandings with the client, regardless of any apparent or perceived similarities is something that we should always try to avoid.

Part two is a guide for you to use with each client. This is to aid you in gaining a greater understanding of what the client's cultural grounding is and hence how they may interpret or understand the clinic setting in which Australian western medicine is practised. This is divided into three areas: context of migration (if they are a migrant), subgroup membership (these are the more personal details) and degree of acculturation.

Context of migration:

- Why did the client leave their country of origin?
- How did they get to Australia?
- What is their current legal status?
- Do they have residency?
- What (if any) trauma experiences have they been through?

Subgroup membership: (much of this will be recorded as a matter of course by many health practitioners)

- Ethnicity
- Age
- Gender
- Class
- Sexual orientation
- Do they reside in a rural or urban area?
- Do they have any religious affiliations?
- Are they refugees or immigrants?

Where do they live; i.e. within an ethnic community or isolated, etc?

Degree of acculturation:

Traditional: Does the client hold fast to traditional values and behaviours brought with them from their country of origin?

Bicultural: Has the client adapted their traditional values by taking on board some of those from their new country but still holding on to other values and beliefs from their country of origin?

Acculturated: Has the client modified their traditional beliefs and values in an attempt to adjust to and embrace the beliefs and values of the new culture?

Assimilated: Has the client given up their traditional values and beliefs completely and wholly taken on board those of the adopted country?

How the client responds to any, and all of these, will affect individual client needs.

SECTION THREE

Using the model. Amodeo's five stages of culture specific AOD dynamics is a very effective guide to use when working with the client. This gives you something solid to work with and to keep going back to for guidance. It may be a good idea to record the information gathered at this stage for future reference.

Using Amodeo's five stages of culture specific AOD dynamics provides you with a structured way in which to raise understandings of specific problems and hence assists in indicating ways in which any arising issues may be managed.

Stage 1: *Using substances*

Initially the health practitioner discusses with the client their attitudes, values and behaviours around alcohol and other drugs. They also explore the clients attitudes, values and behaviours related to being intoxicated or being "high" on alcohol and other drugs.

Stage 2: *Developing problems*

Discussion now identifies problems perceived by the client in relationship to alcohol or other drug use.

- At which point did the client (begin to) perceive their AOD use as problematic?
- What (if any) explanations and meanings have they given to the problem?
- Social unit perceived as owning the problem; i.e. family, school, government – Who do they "blame" or whose fault is it they have the problem?
- What is the degree of guilt and shame (if any) associated with the problem?
- What (if any) social sanctions have been applied?
- What do they perceive as the difficulties most likely to be associated with this problem?
- To what extent (if any) do they attempt to cover up the problem?

Stage 3: *Seeking help for the problem*

Discussion now focuses on where help may have been sought prior to this episode. The health practitioner now explores the point at which the help was sought and where from, and the impetus for any initial behaviour change. (Can link into stages of change model at this point – see appendix A for more information)

Stage 4: *Experiencing a return to problems or relapsing*

A contingency plan is now drawn up for the client. High-risk situations are dealt with, including behaviours or experiences that may trigger a return to problems, and the associated meanings and consequences.

Stage 5: *Recovering from problems*

Once the problem in its current state has been dealt with and strategies by which the problem might be avoided in future have been established, it is time to work on longer term recovery. Discussion now turns to the nature and degree of social reinforcement necessary for permanent behaviour change.

For ease of reference, data may be tabulated for each of the five stages, and some examples are shown below utilising key questions. A case study is also supplied (Appendix B) and an example of how extrapolated data may be tabulated for one of the stages.

AOD cultural framework - client data

Stage 1: Using substances	Subgroup membership (ethnicity, age, gender, class, sexual orientation, do they reside in a rural or urban area, do they have any religious affiliations, are they refugees or immigrants.)	Context of migration (why did the client leave their country of origin, how did they get to Australia, what is their current legal status, do they have residency, what (if any) trauma experiences have they been through)	Degree of acculturation (traditional, bicultural, acculturated, assimilated)
Attitudes, values and behaviours related to alcohol use	Is alcohol seen as having positive or negative qualities and what are these qualities?	Is alcohol seen as a medicine effective for treating illness? Is it used as a reward, in religious ceremonies, in celebrations? What are the implications of this?	Is serving alcohol meant to be a sign of hospitality, friendship, or respect? Does the serving of alcohol say something about the social status of those serving it? What are the implications of this?
Attitudes, values and behaviours related to using other drugs	Are drugs seen as having positive or negative qualities and what are these qualities?	Are drugs seen as a medicine effective for treating illness? Is it used as a reward, in religious ceremonies, in celebrations? What are the implications of this?	Is the serving drugs meant to be a sign of hospitality, friendship, or respect? Does the serving of drugs say something about the social status of those serving it? What are the implications of this?
Attitudes, values and behaviours related to being intoxicated or being high on alcohol	Is being intoxicated on alcohol viewed as a sign of maturity, as a way of bonding with peers, as a natural 'rite of passage' into adulthood?	Is it seen as an acceptable response to trauma, stress, or emotional discomfort? Or is it viewed as deviant, as a problem that should be censured?	Who is most likely to become intoxicated and when? Are there cultural methods in place to censure behavioural difficulties encountered due to alcohol consumption?
Attitudes, values and behaviours related to being high on other drugs	Is being high on drugs viewed as a sign of maturity, as a way of bonding with peers, as a natural 'rite of passage' into adulthood?	Is it seen as an acceptable response to trauma, stress, or emotional discomfort? Or is it viewed as deviant, as a problem that should be censured?	Who is most likely to become high and when? Are there cultural methods in place to censure behavioural difficulties encountered due to drug consumption?

AOD cultural framework - client data

Stage 2: Developing Problems	Subgroup membership (ethnicity, age, gender, class, sexual orientation, do they reside in a rural or urban area, do they have any religious affiliations, are they refugees or immigrants.)	Context of migration (why did the client leave their country of origin, how did they get to Australia, what is their current legal status, do they have residency, what (if any) trauma experiences have they been through)	Degree of acculturation (traditional, bicultural, acculturated, assimilated)
Point at which AOD use is defined as problematic	At what point does the culture describe certain drinking behaviours as 'misuse' or deviant? Is this influenced by the type of alcohol used or the way in which it is used?	At what point do these behaviours elicit disapproval? At what point are they defined as requiring modification or intervention?	Would the smallest infraction related to use result in labelling the behaviour as a problem, or would such labelling be preceded by severe medical, social or psychological consequences?
Explanations and meanings given to the problem	Is the problem defined as a moral weakness, a sin, an illness, a symptom of something else?	Is the aetiology viewed within a moral, religious, medical, psychological, political or sociological framework?	Is it defined as an individual, family group or community problem?
Social unit perceived as owning the problem	Is the problems seen as belonging to the individual, couple, family or community?	To what extent does the family or community feel responsible for causing or solving the problem?	Does this shared responsibility hasten or slow the help-seeking process? OR if the problem is the sole responsibility of the individual, is it difficult to involve others in problem solving?
Degree of guilt or shame associated with the problem	To what extent is stigma associated with the problem? What social unit becomes stigmatised?	What is the content of the stigma, what negative assumptions are made about those who bear it? Do religious beliefs reinforce shame?	To what extent does the stigma result in increased self-blame or fear of punishment for individuals with the problem? What types of individuals are most likely to be stigmatised?
Type and severity of social sanctions applied	What consequences do persons with the problem experience?	What impact does the problem have in terms of exclusion from group memberships?	Is help seeking voluntary or coerced?
Difficulties most likely to be associated with the problem	What individual, family and community difficulties are most likely to be associated with the problem?	Are disorders or difficulties such as PTSD, HIV/AIDS, etc, likely to accompany alcohol problems in this culture? *	Are disorders or difficulties such as PTSD, HIV/AIDS, etc, likely to accompany alcohol problems in this culture? *

Extent to which the problem is hidden or covered up	To what extent to societal responses ignore or minimise the problem and thereby hide it from outsiders?	For individual and families, to what extent does the fear of stigma or other societal sanctions result in secretiveness and hiding the problem? *	For individual and families, to what extent does the fear of stigma or other societal sanctions result in secretiveness and hiding the problem? *
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* NB: Due to differing *Context of Migration* and *Degree of Acculturation* experiences amongst clients, questions from both columns may or may not be applicable to all clients. As a result some questions may appear in both columns.

AOD cultural framework - client data

Stage 3: Seeking help for the problem	Subgroup membership (ethnicity, age, gender, class, sexual orientation, do they reside in a rural or urban area, do they have any religious affiliations, are they refugees or immigrants.)	Context of migration (why did the client leave their country of origin, how did they get to Australia, what is their current legal status, do they have residency, what (if any) trauma experiences have they been through)	Degree of acculturation (traditional, bicultural, acculturated, assimilated)
Point at which help seeking occurs	What types of problems or symptoms need to occur for help seeking to be initiated? Is help seeking prompted solely by the drinking behaviour or by drinking related problems?	To what extent must individuals go against cultural norms to identify themselves as having these problems? Or is helping seeking generated by an external agent?	To what extent is help seeking influenced by the group's legal or social status in Australia?
Where individuals or families go for help	Where are individuals with the problem likely to go to obtain assistance?	To what extent is help available in the form in which people seek it?	Are formal helping organisations available? Are natural support networks available?
Type of person from whom help is sought	Do individuals turn to relatives, religious leaders, professional counsellors, etc. or other individuals or families who have similar problems?	N/A	N/A
Type and availability of help sought	Is help available?	What are the barriers to receiving help (financial, language, stigma, etc)? To what extent do these barriers influence recovery?	What kind of help is provided (physical, spiritual, etc)? What form does it take?
Nature and degree of reinforcement for initial behaviour change	To what extent does the culture support or provide social reinforcement for behaviour change?	What is the nature of this support or reinforcement?	To what extent are role models available?

Stage 4: Experiencing a return to problems or relapsing	Subgroup membership (ethnicity, age, gender, class, sexual orientation, do they reside in a rural or urban area, do they have any religious affiliations, are they refugees or immigrants.)	Context of migration (why did the client leave their country of origin, how did they get to Australia, what is their current legal status, do they have residency, what (if any) trauma experiences have they been through)	Degree of acculturation (traditional, bicultural, acculturated, assimilated)
High-risk situations and behaviours or experiences which may cause a return to problems	What types of situations or behaviour might stimulate relapse?	What traditional ceremonies, celebrations, or other events might constitute high-risk situations?	What experiences such as intergenerational conflict, acculturation stress, unemployment, or loss of a loved one might lead to a relapse?
Meanings and consequences associated with return to problems	To what extent would relapse become a source of shame or humiliation for the individual or family? To what extent might relapse be hidden?	What meaning would be associated with relapse – that the person had failed and was not worthy of further help or that perhaps the problem was resolved and AOD use could now be handled appropriately?	What consequences does relapse have for the individual, family and community?

AOD cultural framework - client data

Stage 5: Recovering from problems	Subgroup membership (ethnicity, age, gender, class, sexual orientation, do they reside in a rural or urban area, do they have any religious affiliations, are they refugees or immigrants.)	Context of migration (why did the client leave their country of origin, how did they get to Australia, what is their current legal status, do they have residency, what (if any) trauma experiences have they been through)	Degree of acculturation (traditional, bicultural, acculturated, assimilated)
Nature and degree of social reinforcement necessary for permanent behaviour change	If social support was available for initial behaviour change, to what extent does this support extend to permanent behaviour change?	To what extent would an individual or family have to challenge or oppose cultural norms to achieve permanent behaviour changes?	Do cultural forces draw individuals toward previous behaviours? Are these forces overt or covert? How is permanent change perceived or defined?
Type of help that results in success	What type of help is effective (physical, psychological, social, etc)?	N/A	What elements of the culture need to be part of the help provided for it to be successful?
Availability of models who have been successful	Are there individuals in the culture who have successfully changed their behaviour?	What are the implications if no members of the cultural group who have successfully changed are available?	How are successful individuals viewed? What impact does this have on individuals considering change?
Point at which help would be considered successful	What behaviours indicate that recovery has occurred?	N/A	N/A
Types of individuals or families members who are successful	What characteristics or behaviours typify those who are successful?	Do successful individuals have strong family ties, or do such ties seem to lead to worse outcomes?	Do successful individuals have to leave the social group in order to establish new patterns?

SECTION FOUR

The Response. The final stage is essentially how you respond to the situation and is case specific. The first three parts are merely guidelines for assisting you as you work with each client. Choice of treatment modality may be based on the interactions and discussions generated by undertaking the first three parts.

There is no expansion necessary for part four. As explained above, this is where you respond to any problems identified during the work done in the three previous sections. The first three sections are the guidelines you may use to aid your work with each client on a unique basis.

Conclusion

The information gathered from your clients through this framework is not new information. It is highly likely that they have divulged much of this before in conversation. However if it is not something that you have been specifically listening for, then you may have missed the clues. For example we were able to ascertain that the patient in the case study was not in paid employment. Not because she directly told us, but through other information she gave us. We know from the conversation that whilst married she worked full time as a housewife and mother and that since her separation and subsequent divorce she spends almost all day, every day, with her mother, usually at her parent's house. We can therefore conclude from these comments that she is not in paid employment. These are the types of cues that it helps to listen for when the client seeks your help.

As much valuable information is able to be garnered from the way in which the client tells you why they have come to visit, and the context of this within their life, as there is from the questions which you need to ask for clinical diagnostic purposes.

The key to the successful implementation of the framework is threefold:

1. Think about how you understand illness and disease and the role you feel you play for your client in this context.
2. Ask your client why they have come and take the time to listen, even if at first you do not see the relevance of what is being said. This information is likely seen as important to the client.
3. Record this information for future reference so that neither of you feel that you are repeating yourselves in future consultations.

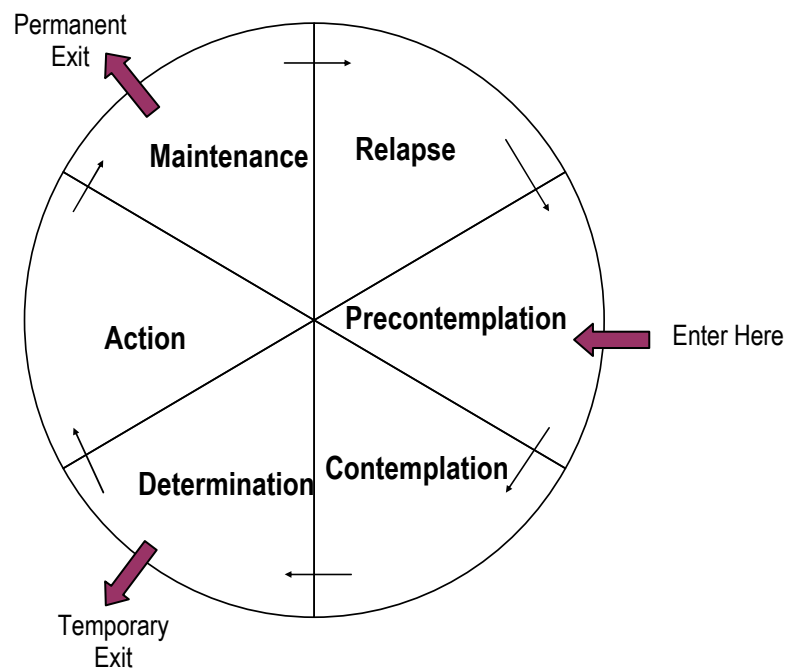
References

- Amodeo. M, Robb. N, Peou. S & Tran. H (1996) Adapting Mainstream Substance-Abuse Interventions for Southeast Asian Clients, *Families in Society: The Journal of Contemporary Human Services*, September 1996, pp:403-413
- Amodeo. M & Jones. LK (1997) Viewing Alcohol and Other Drug Use Cross Culturally: A Cultural Framework for Clinical Practice, *Families in Society: The Journal of Contemporary Human Services*, 78, pp:240-254.
- Amodeo. M & Jones. KL (1998) Using The AOD Cultural Framework To View Alcohol and Drug Issues Through Various Cultural Lenses, *Journal of Social Work Education*, 34(3):387-399
- Bottomley. G & de Lepervanche. M (1990) The social context of immigrant health and illness, in J. Reid & P Trompf (eds) *The Health of Immigrant Australia: A Social Perspective*, Sydney: Harcourt Brace Jovanovich Publishers.
- Department of Human Services Victoria (2000) *Drugs in a Multicultural Community: an Assessment of Involvement*, Public Health Division, Victorian Government Department of Human Services, Melbourne Victoria
- Drug Treatment Services (1998) *Developing Best Practice Drug and Alcohol Treatment Service and Support Models for Young People of Cambodian, Lao and Vietnamese Origin*, Department of Human Services, Victoria.
- Kleinman. A (1980) *Clients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*, Berkeley: University of California Press
- Orlandi. MA (1992) Defining cultural competence: an organising framework, in MA. Orlandi, R. Weston & LG. Epstein *Cultural competence for evaluators: a guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities*, U.S Department of Health and Human Services, Public Health Service.
- Parsons. C (1990) Cross-cultural issues in health care, in J. Reid & P Trompf (eds) *The Health of Immigrant Australia: A Social Perspective*, Sydney: Harcourt Brace Jovanovich Publishers.
- Reid. G, Crofts. N & Beyer. L (2001) Drug Treatment Services for Ethnic Communities in Victoria, Australia: an examination of cultural and institutional barriers, *Ethnicity and Health*, 6(1):13-26

Appendix A

The Stages of Change

- Precontemplation - “the happy user”
- Contemplation - ambivalent about alcohol and / or drug use
- Determination - decision made re need to change
- Action - making the change
- Maintenance - maintaining the changes made
- Relapse
- Relapse



Adapted from the work of:

Prochaska, J.O & DiClemente, C.C (1982) Transtheoretical therapy: Toward a more integrative model of change, *Psychotherapy: theory, research and practice*, 19, 309-403.

Appendix B

Case study

Maria is a 31 year old Greek-Australian. She was born in Australia and is Greek Orthodox in her beliefs. She currently lives alone in suburban Melbourne. She spends most of her time at her parents' home, especially in the company of her mother. Maria is divorced with three children all of whom live with their father. She has not seen them since the divorce. She is currently unemployed.

Maria married 10 years ago. At the time she was ostracised by the community to whom she had been quite close, and from her family, as she married a Muslim man. The marriage caused her great stress and as a result she started to binge drink on a weekly basis when she was home alone. During her drinking binges she would often call her parents. Through these phone calls her mother came to realise that she was in trouble and became increasingly distressed.

Her parents began to search for help for their daughter, eventually hearing about a Dr Thomas who specialised in patients with alcohol and other drug problems. They made an appointment on their daughter's behalf. During this time Maria had separated from her husband and given him custody of their children as she did not feel that she was capable of looking after them at the current time.

Maria has now been in treatment for 2 years during which time she has had minimal contact with her ex-husband and children. Her mother attends all appointments with her (Maria's licence was disqualified for DUI); she has had difficulty understanding why/how this happened to her child and often berates her for her behaviour and allowing herself to get into this situation.

Maria understands that her drinking is a problem, and has refused to re-enter into her community and social networks by which she was ostracised when she married – even though they have accepted her back. She is intensely embarrassed by her behaviour.

Maria sees Dr Thomas' role solely as treatment; it is the doctor's job to look after Maria. Maria places the locus of responsibility for her treatment with her doctor as she is the one

with the qualifications. Maria sees her treatment as coming to an end when she is “better”, although as she doesn’t fully understand why she is seeing the doctor. She is staying in treatment due to family pressure.

Maria negotiates her traditional beliefs with some difficulty as she has a sense of guilt around issues of betrayal (both her betrayal of her parents, and her parent’s and community’s betrayal of her when she married). She struggles greatly with the disparity between her traditional beliefs and her lived experience. She is still very much ‘in’ her culture, despite feeling separated, and as a result often leaves gatherings early or ‘hides’ from her peers.

AOD cultural framework - client data

Stage 1: Using substances	Subgroup membership (ethnicity, age, gender, class, sexual orientation, do they reside in a rural or urban area, do they have any religious affiliations, are they refugees or immigrants.)	Context of migration (why did the client leave their country of origin, how did they get to Australia, what is their current legal status, do they have residency, what (if any) trauma experiences have they been through)	Degree of acculturation (traditional, bicultural, acculturated, assimilated)
Attitudes, values, and behaviours related to using alcohol	Client is a 31 year old, Greek Orthodox, Greek-Australian woman. Alcohol use is part of her cultural upbringing, used both religiously and socially.	She was born in Australia to migrant parents. Often feels torn between her parents' culture and that of her lived experience outside the home. Finds this a constant struggle. However identifies more strongly with Greek Australian culture than her parents traditional Greek culture.	She is bicultural in that she adheres to her parents' traditional values in the home and her learnt Australian values outside the home. Alcohol is readily available in all her lived environments.
Attitudes, values, and behaviours related to using other drugs	People who use illicit drugs are addicts and are associated with all things bad and negative. No or limited contact with people who use illicit drugs.	They are a part of Australian society although not something that she has had much association with. Possibly acceptable amongst youth but not one else.	Blames any increase in drug use amongst members of her community on the problem of living between two cultures.
Attitudes, values, and behaviours related to being intoxicated or being high on alcohol	No reservation about getting drunk, as long this does not affect her ability to be a wife, a mother or a daughter.	Binge drinking incidents increased as isolation from her community became more profound in conjunction with her deteriorating relationship with her husband.	Does not associate binge drinking with being an alcoholic is she does not drink everyday, only once a week.
Attitudes, values, and behaviours related to being high on other drugs	N/A	N/A	N/A