

The Key Informant Interview Phase

Health, Welfare and
Drug Treatment Services

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Description of the Health, Welfare and Drug Treatment Service Key Informants

Key informants from the health, welfare and drug treatment service sector were chosen on the basis of their understanding and knowledge about ethnic or illicit drug-related issues and on the basis of their experience or their seniority. The key informants were from a broad range of organisations and were largely chosen by Project Steering Committee members and the recommendations of prominent others in the field.

The key informants were grouped under the broad headings of drug-specific services, medical doctors and ethnic-specific health and welfare services. One Melbourne City Councillor was also interviewed. They included the following:

- Two medical doctors who provide health services for drug users in inner Melbourne.
- Twelve drug specific service workers, including: those directly involved in drug treatment and detoxification; outreach drug support workers; managers of needle syringe programs; outreach needle syringe workers; drug and community research officers; and a coordinator of a self-help drug resource centre.
- Ten people involved in ethnic-specific health and welfare services including senior managers of community health centres attracting a high number of clientele from NESB; coordinators of ethnic youth and health services; a multicultural commissioner; and senior welfare workers within the Vietnamese community.
- One Melbourne City Councillor involved with safe city and drug-related initiatives.

Methodology

Twenty-five key informant interviews were conducted between September and November 1998. A telephone conversation outlining the project and requesting their participation, occurred with each key informant. A list of questions and topics to be covered was sent prior to the interview to each participant who agreed to participate.

All interviews were conducted on a one-on-one basis. The majority of the key informants were interviewed in their work environments. Each key informant provided consent for the interview to be taped. Only one key informant requested a transcript of the interview and this was followed by a request to add more information to the transcript.

The questions were semi-structured, with probing questions to elicit more information on issues of particular interest. Interviews were approximately 45 minutes in duration. The majority of those interviewed had many work demands on their time and extending the interviews was not usually an option. Most of those interviewed needed little encouragement to speak about the issues of illicit drugs within the various ethnic communities. Many of those interviewed had years of experience in the field and spoke freely about their personal and professional observations. None was hesitant about their views being publicly known.

Summary of Key Informant Interviews on Health, Welfare and Drug Treatment Services

Common Main Issues

At the commencement of each interview the main issues on the question of illicit drugs for culturally diverse communities, as perceived by the key informants, were diverse but various common themes did emerge. Frequently cited was the issue of unemployment and the impact this could have upon the individual and the community. Finding a job is of crucial importance and can be looked upon by the youth as a stabilising manoeuvre. **Youth unemployment**, particularly among newly-emerging ethnic groups, is extremely high and unfortunately results in wide-ranging, serious consequences:

We have discovered that trading in illicit drugs is a quick way of making money. Young people get involved due to issues of unemployment or simply because of being an entrepreneur...they have lost their purpose due to a lack of employment, lacking a vision of what they want for themselves for the future (Commissioner with Victorian Multicultural Commission).

Ironically, for even those who can achieve employment, the **wages** can sometimes be extremely poor and the commitment to work excessively can prove disruptive to the family unit:

Gradually as unemployment rose people were driven to things like outwork where they would slave away for 12-18 hours per day. The whole family became involved in sewing and pressing and so on and limiting the time with their kids, time to socialise, to study and basically pick up a fairly normal life (Community settlement service worker and cross-cultural consultant and trainer).

A result of unemployment is that the trafficking of illicit drugs has a tendency to be incorporated into an **informal economy**. It is suggested that a drug culture offers relatively low risk – initially by diversion – and then becomes income generating:

Any kid that I have worked with has always wanted a job. They tend to see illicit drugs as the rest of society views it and that is as a crime. These kids do not necessarily want to be involved in this trade but it is an option and sometimes they make their choice (Outreach/Project worker, Jesuit Social Services).

Some spoke about the changing **drug market** scene and how it had evolved from being something clandestine to a current state of remarkable explicitness. Accessibility, affordability and purity levels, particularly with regard to heroin, have all changed:

Ten years ago you needed a contact. Now all you need to do is walk down the streets, anonymously and score. The convenience factor has kicked in, technology has kicked in, the service aspect has kicked in. It's like any product. Certainly the Vietnamese have absolutely played a role in this marketing mutation (Inner City Needle Syringe Program).

The **refugee experience** and the oft-difficult process of settlement were discussed. In recent years, many refugees to Australia have come from areas of social and political upheaval often resulting in the emergence of personal characteristics of vulnerability:

Whether they are Vietnamese, from the Horn of Africa or from Bosnia, these refugee experiences can create vulnerability problems. Experiencing severe disruptions to families, where people have been killed, their parents or the adolescents may be severely traumatised, a relationship breakdown...prior experiences of trauma may have the effect of making people more vulnerable to the use of illicit drugs (Victorian Foundation for Survivors).

With recent migrant arrivals the support structure and **settlement services** available have increasingly been dismantled propelling aspects of vulnerability to develop:

The less support that is available for them when they arrive, the greater the chance they have got of getting lost in the system, not making contact, remaining outside the system, becoming more isolated and alienated (Community settlement service worker and cross-cultural consultant and trainer).

Ethnic identity conflicts, homelessness, family abandonment, educational difficulties and issues of racism, marginalisation and discrimination all contribute to a **lack of inclusiveness** within the broader community. The pressure upon ethnic communities to succeed is great, and it has been suggested that the acceptance of diversity within these groups has diminished:

What we are denying them is that we are expecting them to be either extremely successful or to be criminals and that there is nothing in between (Centre for Culture, Ethnicity and Health).

A **denial** of drug use within various ethnic communities is still very common and although the shame of such activities has lessened within some groups, **ignorance** about drug treatment services, accessing services and general confusion about illicit drugs remains a perennial problem:

The older generation does not have a full understanding about illicit drugs. What are they, what are the side-effects so they can identify when something is happening. There is not a lot of information as to where they can get help (Ethnic Youth Issues Network).

It had been suggested that an **honest dialogue** and an openness when talking about drug issues needs to be fostered:

Real education – not scare education – are going to help young people and their families in an appropriate way (Outreach worker, Open Family).

Only one key informant suggested the *War on Drugs* needed to be enhanced to resolve the problems of illicit drugs within the community:

I see the drug problem out there as a war. We won't win all the battles but someone has to do it (Melbourne City Councillor).

Ethnic Communities and Illicit Drugs

There were various **ethnic communities** on which the key informants could comment regarding illicit drug use. These included Vietnamese, Cambodian, Laotian, Chinese, from the Horn of Africa (Somalia, Eritrean, Ethiopian), Greek, Italian, Yugoslavian, Turkish, Lebanese, Macedonian and East Timorese. However, one key informant suggested that:

It is big in all the communities and other subcultures within these cultures (Outreach worker, Open Family).

Understanding of Harm Reduction

When the key informants were asked about their understanding of harm reduction, the overwhelming number were well versed in their commentary about the concept. Some key informants provided very succinct descriptions, while others broadly defined and interpreted the concept to also include not going to jail as a way of reducing harm:

It is not saying no, you cannot use drugs. If they [youth] say I do not want to give up yet then harm reduction is a way of allowing young people to be connected to a range of networks and information resources that will allow them to minimise the dangers to themselves (Ethnic Youth Issues Network).

Many of the key informants divided their response into first talking about the reception of harm reduction amongst the drug users themselves, followed by an understanding and applicability with the wider ethnic community. The majority of key informants believed that harm reduction was definitely a concept that could be successfully applied among drug users of ethnic origin. It was suggested that drug users are not always consciously aware of implementing a harm reduction approach but issues related to not sharing needles are increasingly understood. Drug users could be very receptive to advice and were increasingly accessing services:

Just because people use illicit drugs does not mean they are self-destructive. I do not believe they wish to harm themselves or they wouldn't be using the needle and syringe program (North Richmond Community Health Centre).

The kids (Vietnamese) are much more aware of their syringes being placed into containers, not to share needles and so on. They are much more open about asking for stuff which is really a remarkable change (Youth worker, VIP Youth Housing).

The transfer of harm reduction knowledge to drug users does have obstacles and primarily this is to do with **language** difficulties, poor **strategic planning** and the **political** issues of an acceptance of drug use within communities:

I guess they are very surprised when they find you are not judgmental and are accepting with their drug use. A Vietnamese GP would not be so likely to be accepting of their drug use or talk so openly about what they can do to make it safer for themselves (GP, Gertrude Street Clinic).

A number of ethnic youth, particularly those from recently-emerging communities, do not have a very good grasp of English. It was remarked that a sizeable number of Vietnamese youth also have difficulties with reading Vietnamese, therefore misunderstandings of harm reduction do occur. Strategies to promote harm reduction need to be flexible for the concept to be embraced among all drug users:

Grasping the concept of harm reduction will depend on what community you are talking about, the newly-arrived or the more established communities (Ethnic Youth Issues Network).

The overwhelming majority of interviewees did not believe that the wider ethnic community has come any closer to accepting the harm reduction concept. **Harm reduction** was frequently viewed as a **promotion of drug use** and the problems could be resolved if people simply **abstained** from these practices:

To the ethnic community there are a lot of myths and misconception about the use of drugs...it is equated with criminality and equated with the loss of control and also the cause of a lot grief for individuals and their families. People have not been able to distinguish between drug use and harm reduction (Action on Disabilities within Ethnic Communities).

For the older person from the ethnic community, it is more of a state of resistance and fear of losing their kids basically (Ethnic Youth Issues Network).

Interestingly, **methadone** programs – widely viewed as a successful harm reduction approach – have little support among Vietnamese doctors treating drug users:

They look upon it as another drug. It's addictive. The difficulty is that when they recommended this to their Vietnamese patients they really don't want that involvement. They want to detoxify the person, stop it (Springvale Community Health Centre).

In recent times there has been a **lot of focus upon Vietnamese drug users** and this has caused **much consternation** among the wider **Vietnamese community**. While still reluctant to embrace the harm reduction concept, a cautious change of opinion is slowly emerging:

I think people are learning that the 'get rid of them' attitude has been totally ineffective and so people are beginning to look at other options, which is really quite positive (Youth worker, VIP Youth Housing).

The **division** of acceptance of harm reduction between drug users and the wider community appears great among the ethnic groups:

I would say the majority of people view the use of illicit drugs as a crime to be punished. For the youth I would say the concept (harm reduction) is definitely being accepted and readily taken up (Australian-Vietnamese Women's Welfare Association).

Although there can be a **deep resistance** to harm reduction among all non-drug-users in ethnic communities, it has been suggested that the focus must first be directed to the drug users themselves, as they are the ones who are most at risk:

My feeling is you by-pass the community and worry about them later. From my point of view harm reduction is when you are working on the streets, with the users, or engaging the users with specific projects or models that they have helped to generate (Self-help and Addiction Resource Centre).

Levels of Drug Use

Key informants had various views about the level of drug use in ethnic groups, compared with mainstream communities. Only one key informant explicitly stated the problem was less among ethnic communities. A number of the interviewees could not comment with confidence about the level of drug use and stated they had no idea of the situation. As suggested by one key informant, the level of drug use within *all* communities could be viewed as a moot point:

We have the household survey and a couple of other things which we always lean on for our stats to justify our work. The fact is we don't really know the level of drug use and how many people have been introduced to drugs (Self-help and Addiction Resource Centre).

Many key informants suggested there really was **no difference** when measuring the level of drug use between ethnic groups and the wider mainstream community:

I would assume there is illicit drug use in all communities (Moreland Community Health Centre).

I cannot statistically say if it is less or greater but there is substantial amount of illicit drug use in the Vietnamese, Greek, Turkish and Yugoslavian communities (GP, Fitzroy Central Clinic).

A number of the interviewees maintain links with the Indo-Chinese community and, in particular, the Vietnamese. An intimate working relationship with Vietnamese youth has fostered major concerns about their **greater level** of illicit drug use. However, there was a common reluctance to focus on just one ethnic group:

I do not believe this is a problem with the Vietnamese ethnic community alone. It seems to be also among new communities to Australia that are establishing themselves (Case manager in Methadone and Drug and Alcohol services).

Interestingly a few of those interviewed remarked how **identification** of particular ethnic groups has fostered a heightened societal perception about differing levels of drug use. Many of those from the Asian community are 'visible' and this has potentially given rise to inaccurate interpretations as to the extent of drug use within this community:

Ethnic communities tend to stand out more. I do not know per head of population whether there are more Vietnamese choosing heroin compared with Macedonians or the Anglos, it's just they tend to be more visible because of their appearance (Nurse with the home/outpatient detoxification team).

It is difficult to work out who is the Australian community now. There are some ethnic communities who have now been here for second and third generation and there is not much attention paid to them because they are more difficult to identify; they do not stand out (Drug and Alcohol Worker, North Richmond Community Health Centre).

Understandably ethnic communities do not like the focus being placed upon them and while the level of drug use may be serious, the **evasiveness** of such issues can be crucial to save face among the wider community:

Some of the communities tend to hide behind the other communities. It's more in that community than ours. We don't have this problem. When you delve into it you will find there are people out there who are affected. It's a question of some communities needing to face the truth (Commissioner with Victorian Multicultural Commission).

Patterns and Correlations

The patterns and correlations of illicit drug use among different ethnic groups were believed to be varied. The age of illicit drug initiation, process of experimentation with 'hard' drugs, and continued use were remarked upon as commencing during adolescence. A few of the interviewees specifically focused, although not strictly, upon the Vietnamese youth when commenting about patterns:

A lot of the Vietnamese people tend to be younger. Often we are getting people (into treatment) from the ages of 15–16 and even the ones who are 20 years-old started when they were 17–18 years. The Macedonian people I see tend to be older, early 20s (Nurse with home and outpatient detoxification team).

Some of the younger groups, ethnic or Australian groups, are first going to heroin and not going through the learning curve...trying the harder stuff first up. This is a trend I have noticed and it is my impression that many ethnic groups are following this pattern (GP, Fitzroy Central Clinic).

Many of the interviewees spoke confidently about their insights of Vietnamese youth and how this ethnic group had a much stronger tendency to commence **smoking heroin** prior to the process of **injecting**. However, even following this transition onto injecting, the pattern of use could oscillate:

Most of the Vietnamese I work with smoke heroin. They are not keen on injecting heroin because they believe it is more dangerous because you become more addicted (Case manager methadone and Drug and Alcohol services).

It seems once people start injecting from that group they are not necessarily exclusively injecting drug users from then on. This is a very different pattern from other drug users. It appears the smoking of heroin is unheard of among Anglos or other drug users (IDU Vietnamese Project Officer, Macfarlane Burnet Centre).

A few interviewees stated that the patterns and correlations were no different. It was also remarked that to generalise about drug use behaviour patterns among ethnic groups without considering an array of other circumstances was deeply flawed:

The patterns within different groups are in fact very similar when looking at particular circumstances. Vulnerability and accessibility to the drugs by ethnic groups is very similar particularly if they have a personal disposition to using drugs (Outreach worker, Open Family).

It is difficult to have a one-dimensional perspective on this and it needs to be seen in a broader context and just looking at ethnicity is quite inadequate without adding in other elements: gender, class, migration experience... (North Richmond Community Health Centre).

The **choice of drugs** does vary but most of those interviewed believed the Vietnamese favoured **heroin** greater than any other drug. However, **polydrug use** was still relatively common among the identified ethnic groups, depending upon availability and price. Illicit and licit drugs that were mentioned include marijuana, amphetamines, hallucinogens, Valium, Temazepam, Serepax, Rohypnol and steroids:

Steroid use is fairly active in this area. We have a few gyms in this area and we have a lot of young people who come in here for injecting equipment, clearly for steroid use (Moreland Community Health Centre).

A few interviewees commented upon the pattern of the drug market and the behaviours associated with the scene among the Vietnamese:

The obvious thing with the young Vietnamese is they are fairly indiscreet – from our point of view – about a lot of their drug-using behaviour. There is a presence that you get and you notice it. It's on the streets, in front of you. With Western cultures they are more discreet (North Richmond Community Health Centre).

Vulnerabilities

It was difficult for some people to state which ethnic communities were at risk of illicit drug use but are not the focus of much attention and/or **most** at risk of illicit drug use. It was clear the Vietnamese were remarked upon frequently as being at risk but, as was indicated by some key informants, the Vietnamese are probably the most analysed and targeted of all the culturally diverse groups. Many spoke not on

ethnicity being the risk factor but identified a need for more emphasis to be placed upon the numerous characteristics of vulnerability:

It is interesting to see so many poverty-stricken people using drugs and the number of people with no work and no stable home using strong dependant illicit drugs (Outreach worker, Open Family).

Among illicit drug users there would be a significant number who have experienced homelessness, abuse or have been caught up in the criminal system. This has got nothing to do with whether they are English, Australian, Irish or whatever. It's to do with their characteristics of their past experiences. I think it is the same for people of different cultural backgrounds (Victorian Foundation for Survivors of Torture).

The migratory and/or **refugee experience**, the trauma and pressures of the settlement process, cultural or identity confusion, interrupted education and the background of general disadvantage, was believed to affect both the first and second generation ethnic groups:

Those people who have not come as whole family units have experienced many difficulties. Young people who feel neither Vietnamese, Cambodian, Laotian nor Australian are having a number of problems working out their identity. This can cause confusion and inner conflicts fitting in with their community as well as the wider community (Australian-Vietnamese Women's Welfare Association).

The younger you are, the more dysfunctional the background you are from, the more likely the learning disability. Makes it much harder because you are not literate and then there are problems (GP, Gertrude Medical Clinic).

Ethnic groups that were mentioned which may not be the focus of much attention with regard to illicit drug use included those from the Horn of Africa, the Greeks, the Italians, Macedonians, East Timorese, Croatians, Filipinos and the Lebanese:

You see kids coming into the exchange [Needle Syringe Program] who are obviously of African extraction. Even though they are only a very new community coming through, they do make up fairly big numbers on the inner city estates and the associated difficulties of living there can involve various social problems (IDU Vietnamese Project worker MBC).

As cited by many interviewees, focusing on illicit drug use among particular ethnic groups raises many complex issues. There are a myriad of **vulnerability characteristics** that potentially place a person at risk of illicit drug use. One key informant stated:

I don't believe you can narrow it down to ethnic communities that you believe are at high risk. Broadly speaking, we are a substance-abusing community and it is no surprise that a place like Australia has apparently a high rate of people using illicit substances...we are all in a way at more risk of using these drugs (Outreach/Project worker, Jesuit Social Services).

The degree to which ethnic groups may encounter a high degree of **social exclusion** in terms of poverty, educational disadvantage, unemployment and housing deprivation – and how these factors **may influence illicit drug use** in ethnic communities – varied. However, an overwhelming majority of those interviewed indicated that one or more of these factors did influence illicit drug use. Housing deprivation was rarely mentioned but the issues of **poverty, unemployment** and **educational disadvantage** were believed pivotal to accelerating marginalisation and a feeling of despair within the wider ethnic community:

If you are unemployed or marginalised within your own community or do not have a stable place to live then how you view yourself will be somewhat diminished. If you do not perceive yourself to be useful to society then it is more likely you will use pain-reducing substances (Outreach worker, Open Family).

Predominantly, illicit drug users come from disadvantaged backgrounds. There is a high proportion of Vietnamese drug users who are illiterate both in their mother tongue and the English tongue. This of course significantly impedes their ability to seek employment, education or training, and access appropriate support services (Youth worker, VIP Youth Housing).

A lot of these things are a cause, create an emotional response in people and often to cope with the emotional response, people will turn to substances that will allow them to change their reality or the level of feeling (Project worker, Needle Syringe Program, Springvale).

While supporting the influences of these factors, others believed the issues were more complex – involving various other social characteristics including mental, physical and sexual abuse. However, the **complex** nature of these **factors**, as identified by one interviewee, needs cautious interpretation:

I think there is a real danger [of making] these external factors and say if you have A,B,C and D, E is a consequence of it. Earlier on, before the problem even arises, if you have a really good structure to support you may then prevent a lot of the issues from happening later on...but if the person has unresolved issues because of a whole range of things that have not been dealt with, the person may not be able to access the structures (Centre for Culture, Ethnicity and Health).

Only a couple of the 25 key informants found it difficult to measure or accept the factors of influence to use illicit drugs:

The factors that you have raised in the question I believe are of low degree. There are many wealthy people where the kids turn to drugs because the parents have been working too hard and they never see their kids (Australian-Vietnamese Women's Welfare Association).

Some of the interviewees were asked about the connections of being **socially excluded** and the impact this may have on being involved in **drug trafficking**. All believed there was an intimate connection between the two and for many drug users, trafficking increasingly became a legitimate occupation:

As a society we are conditioned to the concept of being comfortable and in money. The reality is there are a lot of people out there who do not have that. They are accessing alternative economies where they can get a bit of the action (Self-help and Addiction Resource Centre).

The more financially viable the [drug] culture becomes the more difficult the replacement is going to become. What is it we have to offer them? Jobs in factories. We need to have some sophisticated thinking around these issues (Centre for Culture, Ethnicity and Health).

Denial of Drug Use

There are various reasons why ethnic communities have great difficulty openly acknowledging the problem of illicit drug use within their community. The vast majority of interviewees agreed there was a great deal of **shame** and **loss of face** involved in acknowledging illicit drug use within their community. For many communities, their sense of pride had been tarnished with this problem. The earnest desire to achieve acceptance by the wider, 'non-ethnic' community was of paramount importance:

They try to hide the drug problem because it is almost like having to prove to the wider Australian community that we are good community, you have let us in, we are settling in well, we are integrating. To say we have a problem community...it becomes a blotch on the record. It is almost that you have to keep this facade of a good community (Ethnic Youth Issues Network).

There is widespread belief amongst these groups that they are privileged in coming to Australia and that acknowledging special treatment is a repayment of being hardworking and being loyal to Australia. Admitting they are second generation Vietnamese, selling heroin on the streets of the CBD, may not fit that formula (Outreach/Project worker, Jesuit Social Services).

For many communities it is not just a state of denial but also confusion as to how best to address this problem:

Sometimes I get the feeling the communities just don't know how to tackle it, where to begin to discuss it because...for some it is in such contrast from their country of origin (Community settlement service worker and cross-cultural consultant/trainer).

The manner in which the media have presented the connection between ethnic communities and illicit drug use has often been sensationalised and – some have suggested – with a tone of **racism**:

If people say Australians are drug users, problems would arise. People don't say Anglos are drug users. The problem is because it is put forward as a racial stereotype (Springvale Community Health Centre).

The Indo-Chinese community are already heavily targeted by the media as being the source of heroin, almost the cause of the heroin problem. To openly acknowledge the problem, it is almost to target yourself for further criticism, which is racially-based and discriminatory (GP, Gertrude Street Clinic).

However, there is a slow mutation towards **acknowledging** the truth of the problem as the frightening mystique of illicit drug use, held by many people, is fading. This change has partly occurred from the consistent exposure this problem has received in recent times:

The more it becomes less hidden the easier it is to handle. It's a bit like shopping gossip stuff, the fact you can talk about someone whose grandson or cousin is using. Once it becomes a reality it's not just the kids you see dealing in front of Safeway in Smith Street. There are actual people you can attach to those things (IDU Vietnamese Project Worker MBC).

There can be a variety of reasons why the discovery of illicit drug use often results in the problem being addressed within the family and **not disclosed** to others. The majority of the interviewees remarked on the entrenched **shame** and **sense of failure** that families experienced when a family member was involved in illicit drug use. It is possible that most families, no matter what their origins, behave in a similar manner. However, as was indicated, poor proficiency in English can further prevent disclosure as there are obstacles to seeking out the appropriate channels of assistance:

I suppose people from English speaking backgrounds would have a better understanding what is going on because they are reading the papers and looking at the services that are being provided in the community. They are more inclined to contact somebody and get some help (Nurse with home and outpatient detoxification unit).

The strong desire to maintain a high level of **family pride** can be crucial and can either result in a closing up of the family unit or an absolute conflict resulting in eventual family breakdown:

Many with the community [Vietnamese] wish to keep the family name clean and do not wish to have the family linked with drug issues. With a widespread belief that drugs are bad and the family name wishing to remain clean, this would be a big reason for not wishing to use a service (Drug and Alcohol worker, North Richmond Community Health Centre).

Often, the way a problem is solved within the family is that people are ex-communicated from the family. Within the family it is kept secret as long as possible and then it comes out of the shadows into the light. This can result in turmoil and angst for the family (Inner City Needle Exchange).

A few interviewees did remark that some **change** was occurring in recent times. In circumstances of despair, families were increasingly more comfortable removing the veil of secrecy to those who may not be part of the ethnic community. In fact, talking to someone *not* ethnically linked to the community can sometimes allay fear about problems being revealed to other ethnic community members:

Only three years ago if a young person came to me seeking advice about a drug problem I would ask that person 'does your family know and can we get your family to help us?' The response would always be 'no'. Now 99 out of 100 say 'yes', talk to my family a real conscious shift has occurred. Many Vietnamese families approach me before their children about what can they do about this problem (Outreach Worker, Open Family).

Drug Service Providers

Unrealistic expectations of service providers – quick-fix solutions to long-standing problems, such as illicit drug use – among not only ethnic groups but the wider community, was believed to be a major problem. It was clear that most interviewees believed there was a strong desire for **quick-fix solutions** but such an expectation was **endemic** across the various strata within society. The complexity of illicit drug use and issues of addiction are frequently misunderstood and not realistically addressed:

For the user there is an expectation of a quick fix. It's a socially-constructed aspect of drug use. They are looking for the magic pill to stop the rot. There is a lot of press around about quick fix solutions. Drug users are like everyone in that they read papers. They read about the quick fix and then they will come in and say how do I get onto this (Inner City Needle Exchange).

Just recently I had a case of a magistrate basically saying ‘what is wrong with this person?’ they have had support, they have had counselling and why have they not stopped using heroin? Many people have unrealistic expectations about what can be achieved within a certain timeframe (Outreach worker, Open Family).

Solutions to addiction problems were frequently believed to be too **narrow** and often not sensitive to the needs of the client, either because of their youth or because of their particular circumstances. The pressures to detoxify promptly and the struggle to attain one solution have often resulted in repeated **failures** for all those involved. Society often rejects long-term solutions and the magic cure is highly sought:

I have clients who have been on the methadone program and appear to be doing well after two months. If the parents are involved with the treatment or are aware about it they are saying to me ‘they should be fixed now’. Can they finish with the program now because they are feeling much stronger and they should be able to do without methadone and go out and get a job? (Case manager in methadone and Drug and Alcohol services.)

Most of the interviewees believed a comprehensive **educational** approach was imperative – not only for the drug users themselves, but for all service providers and the whole society – before the issues of drug use and addiction could be better understood. Some commented on the importance of educational **clarity** and of the necessity for **reinforcement** of information:

Education needs to be a key to their understanding of the solutions. Education must be available. It needs to get back to the community development approach and the community needs to begin the education in their own cultural context (Western Region AIDS Prevention, Needle Exchange).

Often in the service provision we speak a certain shorthand language and we expect the consumer will understand what we are talking about – counselling, treatment, support, etc – not realising the client does not understand the treatment regime, why you are doing it, what is the outcome for the service provider or what the implication will be for the individual over a period of time (Action on Disabilities within Ethnic Communities).

There is full agreement among the interviewees that the current approach of **institutionalised drug treatment services** (clinic-based) is **not serving** the needs of ethnic communities. The **barriers** themselves are believed to be **numerous**, including issues related to language, layout design of the clinic, inappropriate food, poor communication and support, paucity of information, prolonged waiting times for treatment, fear of broken confidentiality, and an increasing awareness by the drug users themselves of treatment failures:

The Vietnamese community in particular and of non-English speaking background people do not get much further follow-up counselling whether they have completed a detoxification in the clinic or at home. Generally speaking, the treatment ends after the detoxification and they do not get any further follow-up counselling. There is no obligation to follow-up (Nurse with home and outpatient detoxification unit).

I do not think the people understand what the service does, what is the treatment, how long will it take, how long do I take from the front door to the bed. All of these questions require people to negotiate with a great deal of effort (Action on Disabilities within Ethnic Communities).

It is such a middle class, white, Anglo, disease-based model. Treatment does not work and we spend a fortune on it every year. No one is prepared to take the risks. Those that do are often under-resourced, marginalised or ridiculed (Inner City Needle Exchange).

While the treatment services were viewed as inappropriate, a number of those interviewed also believed the **pervasive negativity** of illicit drug use was endemic within the ethnic community, resulting in a reluctance by drug users to seek out assistance. The importance for media information to become less sensationalised on drug issues may reverse many of the fears held by ethnic communities, in order to address drug problems:

With my non-Vietnamese clients, if they go onto the Methadone program they are quite proud and it is an achievement and they are very open about it. For the Vietnamese person this is not the case. Being on Methadone, you never talk about it. It means, 'I'm waving a flag that I am a heroin addict'. It's very negative (Youth worker, VIP Youth housing).

In the Utopian world we would have well-qualified, researched and informed journalists who were able to write on drug issues. We would have more alternative points of view. Less histrionics. Information from good mainstream articles needs to be filtered down to ethnic publications (Inner City Needle Exchange).

As has been suggested, the failure to be **flexible** and **sensitive** to the cultural roots of both the client and the community further obstructs the motivation to seek out assistance, particularly for those who have the advantage of knowing what is on offer. The problems were generally acknowledged to be largely **bureaucratic** and **systemic** and it was believed that unless an attitudinal change occurred, treatment services would continue to function inappropriately:

The challenge for drug treatment services is to reinvent their programs of care around their individual client and not to make generalisations about who they have got. They tend to provide standardised 'Big Mac' solutions for what is a complex issue (North Richmond Community Health Centre).

We need to manage diversity of the community. Whatever the institution there should be within that structure people who are able to deal with these issues or at least know the network to seek assistance or a counterpart organisation to draw into your service to deal with the issues. Diversity has brought along a lot of diverse issues and problems and we need to understand these (Commissioner with Victorian Multicultural Commission).

What needs to be done is to have political will and a real, genuine commitment to self-examination. We are talking about organisational cultural shifts that need to happen. There needs to be organisational vision as to where it wishes to go (Ethnic Youth Issues Network).

It was widely agreed that the number of ethnic groups which turned up for **treatment services** was small. There appeared to be a real breakdown in communication both within the service and in its ability to interact effectively to address the needs of a wider and culturally diverse community:

In terms of the Methadone treatment, the Vietnamese drop out of treatment very quickly. They may not understand how it works. To give it a formal context, I think it is about expectations. They just did not get what they expected (Western Region AIDS Prevention Needle Exchange).

Drug and alcohol services present themselves in a way that attracts only certain groups and in fact discriminates against some other groups. We need to look at successful institutions and see what they do (North Richmond Community Health Centre).

Illicit drugs and the **legal ramifications** of using such substances are frequently misunderstood, resulting in a reluctance to seek out treatment unless necessary:

The more formalised it is [the treatment service], the greater it smacks of legal type structures and barriers. They can be very scary for people. Not understanding the process and not understanding what is going to happen. The justice process can create a real barrier...not knowing about confidentiality or what this actually means (Moreland Community Health Centre).

Challenging the rigidity of many of the treatment services and acknowledging the complexity of seeking solutions requires **innovation**, a **holistic** overview, a sense of **working together** for a common purpose. A **broader debate** with the community about drug-using issues was believed very important. The traditional treatment approaches for ethnic communities were spoken about as being deeply flawed, and the challenge to trial new enhanced **supportive** methods cannot be discounted:

A community house – where you ideally set up a house where you would expect a family member to stay with them. It dilutes the intensity of the drug culture. There is a drug-dependant person and a non-drug-dependent person staying. It makes it much more likely that somebody will stay (GP, Gertrude Street Clinic).

You must spend more time with a person from a different background so as to create a channel of communication to convey the really important knowledge stuff and what is available (Outreach/Project worker, Jesuit Social Services).

Detoxification at the family home was looked upon as a viable option when appropriate support could be provided by treatment services. Families are often of crucial importance within ethnic communities and incorporating them into the process of home detoxification was believed to have much merit:

Drug treatment services have a very artificial environment and they are not taking into account the fundamental importance of the family. With the family there, they can all go through the difficult phase together and provide support for each other (Australian-Vietnamese Women's Welfare Association).

Interviewees frequently commented upon the complexity of addiction and how detoxification is often not successful the first time round. While it was believed there were many benefits to home **detoxification**, various **obstacles** to attaining success still remained:

I don't think it matters whether a person is detoxing in a unit, at home or on an outpatient basis. It depends on where that person is at, the process of having to go through a detox and their motivation (Nurse with home and outpatient detoxification team).

Community Development

Half the interviewees were asked about community development strategies that could be implemented to address drug issues within the ethnic community. The majority emphasised that it is the inclusion of **community consultation**, guided in many ways by primary health care principles, which would prove the most successful approach. Not only must the wider ethnic group be involved throughout the process of developing strategies, but the **ethnic drug user** themselves must be incorporated in order to enhance their understanding of the issues. As research has indicated, drug users can successfully assist in the transfer of knowledge and information to their peers:

The community leadership needs to endorse the strategies and state they are good and do a good job. You cannot isolate a service. Drug treatment services need to be part of a primary health care treatment network as it has the least capacity to stigmatise a person (North Richmond Community Health Centre).

Communities need to be looking inwards and using people from their communities as educators and also using peer approaches (Western Region AIDS Prevention, Needle Exchange).

It is going back to the community and asking them how they perceive the problem, what is the problem and how they will deal with it. How would they deal with it in their country of origin and how they will deal with it in Australia (Ethnic Youth Issues Network).

Amongst the interviewees, there occurred opposing **ideological views** on community development strategies and how drug users are perceived. The result is either maintaining traditional marginalisation of drug users or alternatively believing that by fostering their self-esteem they will be able to engage more productively with the wider ethnic community:

I am happy to give them free needles but why can we not do it on the fringe of the city? It gives a bad image of the city (Melbourne City Councillor).

It is important to get groups of people who are comfortable with their drug use and not feeling terrible for being drug users. Perhaps they will stop using drugs at some stage but this does not need to be the prime focus of what is actually going on in their lives (IDU Vietnamese Project Worker, MBC).

Community resolve for the cessation of drug use is widely problematic. To address this conflict, an **educational approach** that is clearly understood, accessible and actively marketed by the community, for the community, needs to be encouraged:

We send the message that it is not the end of the world. It is okay, we are not failing because our children are drug users. It happens in other ethnic groups and it is something we can work on together (Youth Worker, VIP Housing).

You need to get community groups themselves more active. It's not just a case of give, give, give. It also has to be a question of what can I do to help. They want to help and want to be active because it has become an issue (Commissioner, Victorian Multicultural Commission).

While the concept of **counselling** was acknowledged as potentially being alienating or confronting for ethnic groups, all interviewees (eight) spoke of successful approaches in order to engage a positive dialogue with the client. Counselling can take many forms and its ability not to always be based on a clinical model was believed to be fruitful. There are no strict rules as to the ethnicity of the councillor or the manner in which it is offered, but flexibility and choice are believed important:

When we developed our program for young refugees who are homeless, our initial assumption was they would not respond to individual counselling...a significant number did want individual counselling. The use of group work programs broke down the sense of isolation and got people sharing their experiences. This for them can be affirming and so forth (Victorian Foundation for Survivors of Torture).

Australia has adopted the philosophy of **mainstreaming** with regard to **migrant services** and the requirement to maintain flexibility and sensitivity to cultural differences of the whole community. A small number of interviewees (ten) were asked to comment upon this current mainstreaming with half believing the approach was needed, while the others were not convinced of its applicability to drug treatment services:

We have had community health workers giving overviews about the migrant experience and about how families are structured, how the health systems are different in each country to the difficulties that people come across. I think this has proven beneficial for the people who work here (Nurse with home detoxification and outpatient team).

The problem is that the Vietnamese worker within a mainstream organisation does not receive support, adequate monitoring or supervision that is required for improved services (Australian-Vietnamese Women's Welfare Association).