The role of family for CALD clients finding help for co-existing drug use and mental health issues

Creating Synergy Conference 2010

Helen Sowey and Tak Cheng Ananda, DAMEC

ncpic
national cannabis
prevention and
information centre

Workshop outline

- Highlights from recent research
- Case study
- Discussion

About us

- About DAMEC and NCPIC
- About the researchers:

  Ian Flaherty and Connie Donato-Hunt (DAMEC)
  Anthony Arcuri and John Howard (NCPIC)

- About the presenters:

  Helen Sowey and Tak Cheng Ananda (DAMEC)

Background to the research

- Much evidence for co-existing cannabis use and mental health issues.
- Evidence for lower health service engagement amongst people from CALD backgrounds.
- Limited research on the experiences of people accessing help for co-existing issues.
- Funding: NGO Drug and Alcohol Mental Health Research Grants program – NSW Health, NADA.

Research question

"What are the experiences and pathways to specialist mental health and drug & alcohol services for CALD clients with co-existing cannabis use and mental health issues?"

Today's topic: the role of family.

About the research

- Qualitative study
  - semi-structured interviews
- Sydney and Wollongong
- 22 services
- 22 workers
- 52 clients (26 CALD background)

Part 1: Co-existing issues

- Drug use and mental health issues
- Family attitudes
- Disclosing issues to family

Co-existing issues

- Nearly all clients had experienced co-existing cannabis use and mental health issues.
- Some connected symptoms of psychosis with their cannabis use.

> **...last year I had a psychotic episode…I have been smoking a lot of weed for the last 10 years and then I just lost the plot one day, and I thought people were trying to kill me...usually when you smoke and you wake up the next morning the feeling's gone…but this time it didn't go away, so I was really scared. (DD, 2009)**

- Others saw their co-existing issues as unrelated.

Disclosing issues to family

- Family's attitudes influenced how much CALD clients disclosed their co-existing issues.

I don't know if that's so much cultural or more just my family, but like that mental illness is more related to, like, a spiritual thing and that if you're – if you're praying and doing what you need to then you won't be mentally unwell… it means that I'm less likely to tell them if I'm struggling. (TO, 2009)

I'll talk to a lot of the guys here and their families disown them. I don't want my family to disown me. So, because I've got Italian in me, that's really like an issue with the family, so I just keep it to my mum. And she said that's fine. (AJ, 2009)

Family attitudes & seeking help

- Family attitudes to help-seeking influenced how and when CALD clients sought help, and how much they discussed their help-seeking with their families.

Growing up I always thought marijuana was like, everyone done it. Because all my family done it I thought it was normal, I didn't realise pot was actually illegal. (SJ, 2009).

And another thing about my parents, I'll give you an example. They say to me, "Okay, we know, you know, everyone knows. Let's move on." It doesn't work like that. I need counselling. I need help. It's a process, but with my parents, it's just "finish". (WW, 2009)

Part 2: Service use

- Catalyst for first getting help
- Referral process
- Multiple & fragmented service use
- Systemic limitations

Catalyst for first service access

Often a crisis situation:

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

[I] had the hose in the back of the car, and I put it out the window…I decided to go and burn all my clothes first…kind of a call for help…my mum and dad were asleep, so but I sort of made a bit of a ruckus so they wake up, cause I didn't really want to do it…then the police came. (NF, 2009)

Referral process

- Self-referral was the most common referral source.
- Respondents stressed their own agency and motivation, although this appeared less apparent among the CALD clients.

Um well, I started hearing voices when I was about 13 and they were a bit frightening and at first, I just thought it might just be something that has come and it will go away but then they started getting worse and worse so I decided to go and see the doctor about it. (LH,2009)

Family as referral source

- Families played a key role in first service contacts.

> …Mum thought I was going downhill, I guess I was I don't know. She made me go and see this guy. She's always been making me go and see counsellors and all that my whole life. (TP, 2009)

- Especially true for CALD clients.
- Subsequent referrals more likely to be made by services rather than family.
- Referrals from family were often "warm" while referrals from workers were often "cold".

Service use history

- Multiple services. Disjointed experiences.

It was very, very stressful...I got little bits of information from different [services], and I'd grab pamphlets from everywhere...hoping that I could find the right place to help me. (LS, 2009)

- Compared to Anglo-Australian clients, fewer CALD clients had been to a drug & alcohol residential rehab (8/26 compared with 23/26).

Disjointed service use

- Reasons for disjointed service use:

The first service would be my local doctor, when I was first suffering from symptoms of psychosis and depression…he didn’t really understand what I was talking about so...he sort of referred me to services that weren’t suitable for my illness…he wasn’t understanding what my diagnosis was. (LH, 2009)

I would never ever ask for help in my life again… the [worker] called me a f***ing dirty junkie slut to my face…He treats me like I am a piece of shit. I don’t understand it because I am a good person. (LS, 2009)

Foreign health system

Limited understanding in terms of:

- Understanding what services are available.
- Understanding what is involved in the service contact.
- Finding other services if dissatisfied with the first.

'Cause they don't know where to go. I mean they might have been here for 20 years, they might have been here for three but...they might have no conception that they would be entitled to some of the things that they might be entitled to...So you know an Aussie would just think, yeah you can go somewhere else if you don't like it, but another person might not. (W:DV, 2009).

Language and literacy

- Clients spoke of language and literacy difficulties workers encountered when communicating with their parents or family members.

Language and literacy

- Limited capacity of agencies to provide services in LOTE.

They [mainstream services] look at people who speak English but they won't facilitate anything like that for people from non-English speaking backgrounds because it's too hard. (W:CA and W:BP, 2009)

- Benefits and challenges of working with interpreters.

The interpreters now over the last 5 years have been really highly professional and I can only think of positives...the only issue is, getting one fast. You always have to wait a week, 2 weeks (W:BT, 2009).

Part 3: What was helpful

Effective approaches

Respondents' recommendations

Effective approaches

- Flexible, individualised and personal service delivery.
- Empathy, positive communication, a caring approach and workers not being judgemental.

If a person comes in and they don't feel that they got some empathy and some support in their first contact, I don't think they're likely to come back. That's why I never followed it up after [service], I just went away thinking, "Well this person doesn't give a shit". (QM, 2009)

Recommendations for workers

1. Understand where people are coming from and find out about their culture.

   If you get a new client and you're not aware of their culture look into it, get educated and be respectful. It's okay to ask questions if you're unsure; just do it in a polite way. (TO, 2009)

2. Make interpreter services readily available, offer interpreters to clients.

   ...if something significant happens or something is going down…sometimes, no matter what you say in English or Australian, it's better in your own language said. (WW, 2009)

Recommendations for services

1. Structure services to work with co-existing issues.
2. Improve services for people with less visible symptoms.

If you show them that you can do things on your own, and you're pretty together, they don't bother to help you…So a lot of people like me, they just slip through the gaps, cracks...They're just put into the main population and pushed through, and they wonder why they relapse. (MA, 2009)

Recommendations for services

3. Promote services so people know where to go for help.

…you don't know these things unless you contact one [service] and then you get referred onto the other and then the other, and it's like it's never ending. (EP, 2009)

4. Liaise with CALD communities.
5. Have a culturally diverse workforce.
6. Continue to develop cultural competency.

It's one thing to be culturally competent in a particular ethnic community, but it's another thing to contextualise that information in mental health and alcohol and other drug stuff. (W:KR, 2009)

Conclusion

- Pathways to services for people with co-existing cannabis use and mental health issues are still complex and unclear.
- This is particularly true for people from CALD backgrounds.
- Within this difficult system, the attitudes and approaches of individual workers made a big difference to the level of client engagement.

Thank you for your interest in this research.

For further enquiries contact:
Helen Sowey
Senior Project Officer, DAMEC
(02) 9699 3552
Helen@damec.org.au