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Cultural Inclusion Evaluation Report: Assessing cultural inclusion in AOD services and the acceptability of a cultural inclusion audit at four pilot sites.

Prepared for: The Network of Alcohol and other Drugs Agencies (NADA)

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Executive Summary

This project aimed to evaluate a joint initiative developed between the Network of Alcohol and other Drugs Agencies (NADA) and Drug and Alcohol Multicultural Education Centre (DAMEC) within NSW's alcohol and other drug (AOD) treatment services. This initiative aimed to optimise the experiences of Culturally and Linguistically Diverse (CALD) clients in mainstream AOD treatment services in NSW. An audit tool (a structured organisational tool that focuses on cultural inclusiveness in mainstream services) was implemented at four AOD sites. The dissemination of the audit tool to AOD treatment services was accompanied by training of CALD community representatives as auditors that focused on supporting organisations to conduct an audit and develop an action plan for improving areas of cultural inclusiveness.

The aim of this evaluation was to:

1) Assess how AOD services fare in terms of cultural inclusion
2) Describe the acceptability of the cultural inclusion audit process, from the perspectives of staff and auditors at the four pilot sites

Quantitative (survey) and qualitative (interview) methods were used to meet these two objectives. Surveys were separated by those participants who were at the four services where NADA had implemented the audit tool ('intervention') and those participants from services that did not participate ('control') in the audit tool implementation. Interviews were conducted with staff at services where the cultural inclusion audit was implemented as well as with the people who delivered the audit to services ('cultural auditors'). For the purposes of this evaluation, the terms 'cultural awareness', 'cultural competence', 'cultural inclusion' and 'cultural responsiveness' are used to refer to persons from non-Aboriginal cultural and religious backgrounds, refugees and asylum seekers experiences of AOD treatment, in contrast to 'cultural safety' which is used primarily in relation with the experiences of Aboriginal and Torres Strait Islander peoples.

Quantitative data: survey

The survey included questions that aimed to assess participant feelings about the cultural inclusivity of their AOD site and focused on 8 domains – 1) Welcoming Environment, 2) Language and Communication Support, 3) Service Delivery for CALD people, 4) Working with Culturally Diverse Organisations and Workers, 5) Service Accessibility, 6). Capable Staff for Working with CALD People, 7) Organization Policy and Protocols in Relation to CALD Issues, and 8) Community Engagement. In addition, the survey included a measure of self-rated Cultural Competency.

- There were 44 adults in the intervention sample and 41 adults in the control sample. 13 participants identified as CALD in the intervention (29.5%) and 19 in the control sample (46.3%).
- Overall, reported cultural inclusion across the different service domains measured in the survey was not high.
- intervention and control groups had similar perceptions of the cultural inclusion of their service.
- There was a large discrepancy between participant scores for the 8 service type domains compared to the measure of perceptions of their own/their colleagues behaviours on the cultural competency scale. While cultural inclusion across the different service types was not high, participants considered themselves and their colleagues as culturally competent.

1. Welcoming environment

Strength:

- dedicated space at the service where clients are welcomed and spend time in the waiting area

Weaknesses:

- signs regarding language assistance posted at key locations
- prayer rooms and other safe spaces available for use by clients
- waiting space at the service that can accommodate children

2. Language and communication support

Strengths:

- intake forms clearly ask if an interpreter is needed
- interpreters provided for non-English speaking clients

Weakness:

- information about service programs, policy and procedures in the primary language(s) of consumers
- persons answering the telephones are unable to communicate in the languages of the speakers
- forms that clients sign are not written in their preferred language

3. Culturally inclusive service delivery

Strengths:

- clients have the flexibility to access the service or staff via outreach/ home visits
- clients/family/ support people included in all phases of treatment, assessment and discharge

- considers the client's culture, ethnicity and language in treatment planning
- offer referral options that are tailored

Weaknesses:

- staff are not taught to work with an interpreter
- telehealth/online options tailored to meet the needs of clients from different cultural backgrounds

4. Working with relevant community organisations –

Strength:

- collaborative projects with relevant community organisations from such as referral pathways or shared work arrangements

Weaknesses:

- New programs introduced in consultation with relevant communities
- new programs started/planned that are targeted towards relevant communities

5. Service Accessibility

Strengths:

- readily accessible by public transportation
- persons from different cultural backgrounds have timely and convenient access to services

Weakness:

- financial access is a concern for some clients, particularly in relation to some services

6. Capable Staff for working with people from different cultural backgrounds

Strengths:

- staff's training needs in cultural competence have been assessed
- provision of cultural support and career progression for staff from different cultural backgrounds

Weakness:

- supervision and/or mentors for staff who are from different cultural backgrounds
- not sufficient processes in place to get feedback on cross cultural skills of staff

7. Organisation Policy and Protocols

Strengths:

- have policies and procedures in place that address cultural inclusion
- staff training material includes information about working with people from different cultural backgrounds

Weaknesses

- identified the demographic composition of their clientele
- no protocol to handle consumer suggestions and complaints in languages other than English
- training material is not developed/reviewed by people from different cultural backgrounds
-

8. Community Engagement

Strength:

- regularly engaging with community members or representatives

Weaknesses

- attend engagement events with local relevant communities

9. Measuring Cultural Competency

Strengths

- participants reported seeing themselves and their service as culturally competent, with almost all participants understanding the importance of cultural beliefs in the treatment process.
- Staff are flexible and willing to find alternatives to meet their clients' cultural needs

Weaknesses

- pictures/reading materials in waiting rooms showing people from different cultural groups
- using knowledge of clients cultural background to help them address current day to day needs

Qualitative data: interviews

In-depth semi-structured interviews were conducted with four cultural auditors and with nine staff from three of four of the residential rehabilitation services that participated in the project; a fourth service cited time constraints for their inability to participate. The staff interviewed – two of them CALD-identifying – had worked in the AOD sector in Australia

from 2 to 25 years, while cultural auditors, all of whom identified as being of CALD backgrounds, had various levels of lived experience and familiarity with the sector.

Participant's responses indicate a high level of acceptability for CALD audit process, as supported by the analysis of their responses against the framework of acceptability developed by Sekhon et al. (2017). Both groups of participants were more convinced of the need for the project after participating in it, and were eager to participate if another opportunity comes up. They appreciated the project's personalised and collaborative approach, felt supported and respected, and felt that the project was well-organised and cohesive. Participants were beginning to see positive changes being made to service provision within the short project period.

Their experiences suggest three factors that support positive uptake of an intervention: first, the key role played by service-level staff in advocating for organisational cultural change in support of equity, diversity and inclusion; second, the importance of prior positive experiences and working relationships with similar projects and stakeholders; and third, a commitment to continually improve processes to more effectively service their evolving clientele.

Their responses also indicated suggestions for future iterations of the project:

1. Services expressed a preference for an overview of the project and the audit tool to be provided prior to the audit visit. This would allow them to consider their services' strengths and weaknesses against set criteria and help them to more effectively prepare for the discussion.
2. The three months duration of the project was deemed too short to adequately measure the outcomes of any changes that were implemented. However, the short time frame did push services to work quickly together to make small changes, which then built enthusiasm, confidence and self-efficacy for action on CALD inclusion.
3. While services and cultural auditors felt that the aims of the project were clear, there were occasional misunderstandings and tensions at audit visits relating to cultural differences, the scope of the project, and divergent understandings of Aboriginal and Torres Strait Islander populations not included within the category 'CALD'. This suggests that more could be done to educate cultural auditors, service staff and executive management on their respective expectations, roles and responsibilities, and about cross-cultural communication issues.

Participants hoped to see the project expanded through the inclusion of more services and auditors, the development of NSW-centric resources and training opportunities for staff, and high-level awareness-building of the importance of focusing on cultural inclusion for senior management.

A rapid review on the role and importance of cultural inclusion in AOD services

People from culturally and linguistically diverse (CALD) communities are under-represented in AOD treatment services, with barriers to services and socio-cultural norms making it difficult for people from CALD backgrounds in need of AOD support to access support and treatment (Victorian Alcohol and Drug Association, 2016). There is a growing body of literature that discusses these barriers faced by people from CALD backgrounds including stigma, limited health literacy and concerns about the cultural responsiveness of services (Department of Health Australia, 2019; McCann & Lubman, 2018; McCann et al., 2017).

Cultural responsiveness is an ongoing process of adapting services to fit with a user's preferences (Kirmayer, 2012). The concept of culturally responsive or appropriate health care has gained increasing popularity over the last 40 years, with several popular cross-cultural communication concepts emerging such as cultural awareness, cultural competence and cultural safety. Care that is considered to be culturally responsive and appropriate includes efforts to address language and cultural barriers (Shaw, 2005).

In line with Australian convention, the terms 'cultural awareness', 'cultural competence', 'cultural inclusion' and 'cultural responsiveness' are used here to refer to the experiences of CALD persons (i.e., persons from migrant, refugee and asylum-seeker backgrounds) in Australia, in contrast to 'cultural safety' which is used primarily in relation with the experiences of Aboriginal and Torres Strait Islander peoples.

Cultural awareness is the knowledge and understanding of differences between cultures (Curtis et al., 2019; Ramsden, 2002; Truong, 2014). Cultural awareness training for health staff is becoming more common in recent years to improve therapeutic alliances with clients from different cultures and to reduce health disparities. However, cultural awareness approaches have at times been found to be over-generalizing and simplistic with a realisation that more needs to be done in order to improve care to people from diverse cultural backgrounds (Shepherd, 2019).

Cultural competency has been described as a recognised approach to improving the provision of healthcare to ethnic minority groups with the aim of reducing health disparities amongst different cultures (Truong, Paradies & Priest, 2014). Cultural competence aims to make health care services more accessible, acceptable and effective for people from different cultural backgrounds, enabling health professionals to work effectively within the cultural context of a client and hence better able to provide care to patients with diverse social, cultural, and linguistic needs (Betancourt et al., 2003; Campinha-Bacote, 1999; Cross, Bazron, Dennis, & Isaacs, 1989; Kirmayer, 2012). While the emphasis in cultural competence is on health care professional's skills, the notion of *cultural safety* takes this one step further and acknowledges the barriers to clinical effectiveness arising from the inherent power

imbalance between provider and client (Laverty, McDermott & Calma, 2017). **Cultural safety** requires healthcare professionals and their services to examine themselves and the potential impact of their own culture on clinical interactions and service delivery, acknowledging and addressing their own attitudes, beliefs, stereotypes and prejudices, that may affect the care provided (Curtis et al., 2019; Ramsden, 2002).

Although mainstream AOD services may aim to provide care that is culturally appropriate, competent and safe, implementing these principles can be difficult to achieve in practice. Despite cultural competence being a focus of health care service in recent years, research suggests that uncertainty remains among healthcare workers regarding what cultural competency entails in everyday practice (Mollah et al., 2018). This uncertainty, and the ambiguity of the different terms used such as cultural sensitivity, cultural safety, cultural responsiveness and cultural awareness, have presented barriers towards the implementation of inclusive health practice (Butler et al., 2016; Mollah et al., 2018).

There is, however, a growing recognition of the importance of cultural awareness, competency and cultural safety at both individual health practitioner and organisational levels to achieve equitable health care. While there is much to learn about the processes of cultural inclusion from Aboriginal and Torres Strait islander inclusivity (NADA, 2017), there are differences with the experiences and needs of First Nations Peoples compared to those who are migrants or people with a refugee experience. Although there are lessons that can be learned across these experiences, for the purpose of this rapid review we have purposefully excluded First Nations communities in both Australia and abroad, and have focused on CALD communities only.

Australian AOD services

It is well known that in order to work more effectively with clients from CALD backgrounds, AOD service providers need to be culturally sensitive, aware and responsive and must implement strategies to make services more accessible and appropriate for all clients in order to deliver safe and effective care to those who are marginalised (Centre for Alcohol and Other Drugs, NSW Ministry of Health, 2020; Commonwealth of Australia, Department of Health, 2018; NADA, 2020). Research suggests that when health services are not inclusive and safe, those experiencing exclusion are less likely to use them (Durey et al., 2013; Hole et al., 2015; Levesque & Li, 2014). Western approaches to health and treatment used in AOD services in Australia may be unfamiliar to many people from CALD backgrounds, negating the importance of cultural inclusion and negatively impacting service uptake (Horyniak et al., 2014; Gainsbury 2017; Roche et al., 2015; VAADA, 2016).

Young people from CALD backgrounds are recognised as an emerging priority population for reducing AOD-related harms in Australia because they face barriers to obtaining appropriate support (Department of Health Australia, 2019). Literature suggests that young people from CALD backgrounds, asylum seekers and refugee populations may be particularly susceptible to heavy alcohol consumption due to a history of trauma, violence, family conflict,

disengagement from services and mainstream society, low socio-economic status, unemployment and insecure living arrangements (Goren, 2006; Horyniak et al., 2016; Victorian Alcohol & Drug Association, 2016). The needs of these at-risk young people from CALD backgrounds must be considered and strategies should be implemented to better engage them in AOD services and prioritise the prevention of AOD use within young CALD communities. It is important for local services to adapt to meet the needs of the population with a diverse range of cultural backgrounds, preferred languages and experiences (Davern et al., 2016).

Providing culturally competent treatment and services is thought to increase retention and successful treatment outcomes among AOD services (Gainsbury 2017; Hodge et al. 2012; Leske et al. 2016; Steinka-Fry et al. 2017). However, what cultural competence actually involves (Jongen et al. 2018), and how it is related to the reduction of health inequities, remains unclear and requires further investigation. Ecosocial theory suggests that inequalities and cultural differences in health must be studied from the individual level to the system level (Krieger 2012; De Kock et al. 2017).

Stigma

There is a vast body of research on the impact of stigma on seeking support, treatment, and successful health outcomes for people who use alcohol and drugs (Ashford et al. 2019; Cheetham et al., 2022; Ledingham et al., 2022; Volkow, Gordon Koob, 2021; Wogen & Restrepo, 2020). However, stigma directed towards AOD use is also a major barrier to the sharing of information and having open discussions around AOD issues with people from CALD backgrounds, especially among young people (Douglass et al., 2020). Studies on the intersection between stigma and racism has further highlighted negative community perceptions towards people of CALD backgrounds and the need to address this intersection in order to reduce stigma within CALD communities (Douglass et al., 2022, 2020; Kulesza et al., 2016). This can be achieved through the use of person-centred terminology, inclusive language and anti-stigma messages created with cultural leaders and community members (Wilson, 2020).

Treatment and service delivery

Western therapeutic approaches are not always appropriate for people from CALD communities. A more flexible way of delivering support and treatment can be seen to be more inclusive of people from CALD backgrounds (Douglass et al., 2020). AOD services predominantly operate through the lens of Western biomedical model of healthcare and do not necessarily consider the beliefs and experiences of people from CALD backgrounds (Durey & Thompson, 2012; Kahissay et al., 2017). Policies and procedures of services are further seen to prevent people from CALD communities from engaging in services with appointment-based services versus drop-in services, time limitations on appointments as well as a limit on the number of sessions impacting CALD clients who may require more time to engage (VAADA, 2016). A recent study that explored the perceptions and experiences of

service providers who provided AOD care for young people from CALD backgrounds in Melbourne found that flexibility in appointment times, the location of the service, the provision of holistic care and sensitivity towards clients' non-clinical needs encouraged engagement and facilitated deeper communication (Douglass et al., 2020). Culturally responsive care is an ongoing process where workers, services and systems need to flexibly respond to cultural differences in a range of ways so that treatment and service delivery is culturally appropriate from the perspective of the client(QNADA, 2022).

The use of family therapy in treatment for adolescents with AOD addiction has been found to be effective, supporting the movement towards family and community inclusive practices (Poon et al., 2019; Tanner-Smith, Wilson & Lipsey, 2014). This style of ecological family-based intervention aimed at focusing on the individual's relationship with family and community (Bartholomeusz, 2021) needs to be culturally sensitive and holistic (Rowe, 2014), with health professionals being mindful that in collectivist cultures, confidentiality and decision-making may be viewed in more communal terms and can lead to shame and stigma (VAADA, 2018). Research further suggests that CALD groups should be offered community support programs that aim to increase awareness and reduce the stigma and shame associated with AOD use and treatment (Horyniak et al., 2016).

Rowe (2017) conducted a study which investigated the ways in which AOD counsellors balance cultural relevance with fidelity to a combination of psychosocial interventions and found that addressing clients' understanding of counselling, offering bicultural and bilingual counsellors, enquiring about the importance of cultural identity to each client, responding to cues from clients about taboos or sensitive topics, and expectations about social roles and communication patterns are important for culturally relevant treatment.

Cultural competence of staff

Cultural differences between service providers and clients can result in significant miscommunication and client mistrust and dissatisfaction (Roe, Zeitz & Frederick, 2012). On the other hand, evidence suggests that increased cultural competence has been linked to increased client satisfaction, treatment adherence, positive health outcomes and more accurate clinician-client communication (Castro & Ruiz, 2009; Paez KA, et al., 2009). Therefore, improving the cultural competency of staff is central to ensuring cultural inclusion of services.

Services that have staff from CALD backgrounds have been shown to improve care for CALD clients by creating a more understanding and non-judgemental environment as well improving communication and reducing some of the commonly-reported language barriers (Rowe, 2014; Thompson & Amorin-Woods, 2009; Posselt et al., 2017; UWA, 2020). CALD or bicultural staff can assist with interpreting, provide valuable insights into hidden, nuanced and sensitive material as well as perceive elements of distress that are unlikely to be detected by workers from the dominant culture (Kirmayer et al., 2011; Gainsburry et al., 2017). In addition, the use of CALD workers has the added benefit of picking up on

underlying intersections of culture, superstition, trauma and managing expectations. This can improve the cultural appropriateness of treatment, removing language barriers and increasing engagement opportunities and effectiveness of interventions (Howard & Lobo, 2020). In fact, just having staff that are committed to and show enthusiasm for the concept of cultural responsiveness can be seen as an enabler to change (Damschroder et al., 2009; Fixsen et al., 2005; Farnbach et al., 2020).

Furthermore, the engagement of senior staff with detailed knowledge about services' processes and policies related to cultural responsiveness and the capacity to decide and enact service level changes has been found to have a significant influence on the cultural inclusion of AOD services (Farnbach et al., 2020). Being culturally aware has been shown to be an important part of being a competent AOD leader (Baille & Bain-Lance, 2003), with culturally sensitive beliefs on the part of managers being directly related to decreased client waiting times, increased retention of staff, and the implementation of culturally competent practices (Guerrero & Andrews, 2011). Hence, training and development of the health staff at all levels is an effective strategy towards the improved cultural competence in AOD services (Jongen et al., 2018).

Social support

Evidence suggests that being socially supported can reduce stigma and shame associated with AOD use, enabling better service engagement and treatment uptake (Birtel, Wood, & Kempa, 2017; McCann et al., 2016). People from CALD backgrounds can benefit from social support in terms of their AOD use and service treatment. This support can take many different forms such as family support, peer support, community support and even social media support (Agramunt, 2020; DAMEC, 2019; Horyniak et al., 2016; Khawaja, Ibrahim, & Schweitzer, 2017).

Some cultural groups see AOD problems as a group issue rather than an individual issue. Cultural and religious beliefs can in these circumstances actually support rather than impede engagement and treatment and thus, receiving family and community support can influence clients' engagement with AOD services (DAMEC, 2019). Engaging both family and community leaders is not only important in establishing a relationship with the client but ensures the client is adequately supported to maintain service engagement (Duncan et al., 2010).

However, disparities in AOD-related knowledge and experiences between young people from CALD backgrounds and their parents can negatively impact family support. Young people of CALD backgrounds often have greater exposure to AOD through their social networks and higher levels of knowledge than their parents, especially the parents who have come from countries where alcohol use is not tolerated. This disparity in knowledge can translate into difficulties between upholding traditional cultural beliefs and peer group values. In Australia, while experimenting with AOD use is considered a normal part of youth culture, parents from CALD backgrounds may not understand these behaviours (Agramunt,

2020). These diverging cultural expectations and acceptance of AOD between young people and their parents need to be examined, in order to improve inter-generational communication and family support, and to reduce the stigma and shame associated with AOD use within CALD groups.

Language as a barrier

Language may impact the ability of people from a CALD background to access services (Hunt & Turay, 2009; Kirmayer et al., 2011; Posselt et al., 2017). In fact, not only does language impede access to services, but language and communication have been reported by some health care workers to be the main difficulty in working with CALD clients. Increased utilisation of the Health Care Interpreter Service and bilingual information is necessary to assist in overcoming such difficulties (Cultural Diversity Unit, 2011; Lee et al., 2014). Community education and awareness tends to rely on clinical terminology and jargonistic language; there is a need to use community language as opposed to simple translation and interpretation as terms and phrases may not exist in many languages and can lead to confusion, misunderstanding and dismissal. However, a study commissioned by DAMEC (2009) found that CALD-specific programs, including those provided in languages other than English, were not seen as a priority or within the scope of the mainstream AOD services, despite their location in areas with high CALD populations (Hunt & Turay, 2009). While the most used tools for working with CALD clients appears to be pamphlets in other languages, many health care workers do not have access to such resources. Service providers do not necessarily have the required funding to use interpreters and those that do are sometimes encouraged to avoid using them due to the high costs. Suggestions for improving access to AOD services by CALD clients include working effectively with interpreters and culture brokers, receiving more support from non-English speaking communities and religious leaders, employing more bilingual workers, being aware of CALD services available and developing pamphlets in different languages (Kirmayer et al,. 2011; Lee et al., 2014; Posselt et al. 2017).

Collaboration between services

The fragmentation of health services is known to create particular access challenges and undermines the clients' ability to engage with a more holistic model of care especially when language is already a barrier (Brener et al., 2019). Research further suggests that a lack of collaboration between services is a major barrier to working effectively with refugee clients from CALD backgrounds (Bäärnhielm et al., 2014). There are many different services that play a role in AOD support, including social, welfare, education, harm reduction and health promotion (Department of Health Australia, 2017). A more coordinated approach between these services increases the effectiveness for CALD communities with better collaboration and communication with other professionals allowing for smoother transitions between services, increased accessibility, and greater continuity of care (Jewson et al., 2012). Improving the collaboration and communication between services would allow for a

smoother transition between services for clients, increased accessibility, and greater continuity of care (Posselt et al., 2017).

Fear about information disclosure

There are numerous research studies which detail how fear of disclosure acts as a barrier to health services for marginalised populations (Love et al., 2017; Theunissen et al., 2015; Woodford et al., 2016). People from CALD backgrounds are particularly concerned about intake procedures in AOD services, as they fear that the information collected would be shared with others, exposing their AOD use to others in their community (Agramant, 2020; Rowe, 2014). Using more confidential and sensitive approaches to managing client records so that private health information is not shared in public settings might encourage people from CALD communities to access services.

Building relationships

Services who are working successfully with CALD communities have found that building trust is the key to building capacity on both sides, with family engagement crucial to success in many communities (Posselt et al., 2017). In communities that work collectively, and in many recently-arrived migrant groups, engaging with leaders is also an essential step towards building relationships. interventions and services that are proactive, flexible and targeted to the needs and profiles of different cultural populations are those most likely to succeed. Furthermore, connecting with the broader communities with which clients identify is invaluable to strengthening relationships. Establishing trust and understanding takes time. By creating formal or informal partnerships, AOD services can provide better care to people who use AOD , especially among those from refugee backgrounds who experience co-occurring mental health and substance use support needs (Szirom et al., 2004).

Outreach

Service providers recognise that there are numerous barriers which make it difficult for young people from CALD backgrounds to access AOD services, highlighting the need for services to actively reach out and meet young people. By connecting with young people in places where they already spend time to promote AOD information and support services, services are able to facilitate community engagement and connect with young people from CALD backgrounds. The same applies to reaching out to the older generation, especially those who do not speak English. Outreach services can go to settings where CALD communities frequent and this will increase service engagement and uptake.

AOD services outside Australia

New Zealand

Research on AOD treatment interventions with clients from different cultural backgrounds in New Zealand suggests the need for clearly defined performance and outcome measures that accurately reflect cultural processes and interventions (Robinson et al., 2006). The

establishment of rapport during the initial assessment stage is seen as important to the development of ongoing engagement with the client. Central to cultural inclusion is an effective AOD worker who is described as someone who is of the same or similar ethnic background with sound knowledge of AOD and cultural issues, with the skills to integrate this knowledge in the most appropriate way with the diversity of people accessing AOD service (Brannelly, Boulton & Wilson, 2013; Nelson, 2017; Samu et al., 2011).

United States of America (USA)

In recent times, a variety of culturally-informed interventions have been designed with a youth focus on AOD use in the USA. These have been shown to be successful with the use of talking circles and family or community involvement as a key part of the intervention (Beckstead et al., 2015; Lowe et al., 2012; Patchell et al., 2015). These interventions range from traditional AOD prevention programs that have had an additional culturally-informed component added, through to interventions that are completely new and have been developed by tribal communities from the ground up (Beckstead et al., 2015). There is also a move to trialling a variety of settings for interventions, such as in community centres or events (Mohatt et al., 2014; Nelson & Tom, 2011). While many interventions continue to target only individuals in their treatment approach, the inclusion of communities and families as the focus on the intervention is an area of growing research interest (Liddell & Burnette, 2017). A study by Lee et al., (2011) found that understanding culture among Hispanic people was important to understanding their drinking behaviour. In this study, greater reductions in alcohol-related negative consequences, such as impulse control, were observed among participants who received culturally-adapted motivational intervention as opposed to un-adapted motivational intervention. Another study that shows the relevance of culturally informed treatment was conducted by Burrow-Sánchez & Hops (2019) whose findings suggest that culturally-accommodated treatment, focusing on ethnic identity, acculturation, and familism, differentially improved outcomes for a sample of Latina/o adolescents with substance use disorder.

Canada

As with the other countries discussed above, adults from CALD backgrounds in Canada face many barriers when accessing health care services, suggesting that there are unmet health care access needs specific to immigrants (Curran et al., 2008; Healey et al., 2017; Thomson et al., 2015). The most common access barriers were found to be language barriers, barriers to information, and cultural differences, which indicate inequities in access to Canadian health care services for immigrant populations (Kalich, Heinemann & Ghahari, 2016). Gulati et al., (2012) found that communication, language ability, and culture can be important barriers to accessing, understanding, and using cancer-related information and the healthcare system and a review of access to mental health services by people from different cultural backgrounds showed an underutilisation of services (Thomson et al., 2015).

Cultural competence interventions have come to be considered a key strategy towards addressing racial and ethnic healthcare and health disparities that exist across Canada. Research suggests that the most popular method of adapting an intervention was to modify the content of materials or dialogue to include racial, ethnic, or cultural facts, values, imagery, or other cultural components (Chowdhary et al., 2014; Healey et al., 2017). Other ways of adapting a service were to increase the time and attention paid to recipients, cultural matching of providers to clients, provision of additional resources and consultation with communities.

Conclusion

While there is little information available about the prevalence of AOD use among CALD populations in Australia, limited access to appropriate cultural programs, language barriers and lack of awareness of support is likely to contribute to a reluctance among CALD communities to access mainstream AOD support services. It is important to promote stronger ties between mainstream AOD services and CALD communities with a focus on improving service access for CALD community members in need of AOD treatment as well as enhancing the knowledge of AOD staff working with individuals and families from CALD backgrounds. There appears to be no universally-accepted standard for evaluating cultural inclusion of services. Better funding, longer term programs and increased staff resources are needed in order to effectively measure cultural inclusion. Findings from existing literature suggest that improving the cultural inclusion of AOD services should not only focus on professional development but on broader systemic approaches, which addresses the underlying service barriers and socio-cultural norms that currently make it difficult for people from CALD backgrounds to access culturally appropriate support (NOUS, 2020; VAADA, 2016). It is important that AOD support be tailored to individual circumstances of different services and that treatment and support focuses on and addresses cultural variables that influence AOD onset, maintenance and relapse risk (Branstrom & van der Star, 2013; Flentje et al., 2015; Lombardi & van Servellan, 2000).

Recommendation based on review that would enable better cultural inclusion

Service delivery:

- Flexible service delivery
- Flexible appointment arrangements such as drop-in services
- Providing holistic and family sensitive care
- Tailoring services to match clients' help seeking behaviours
- Longer timeframes for engagement and treatment
- Outreach with an emphasis on service navigation support

Workforce development:

- Training of staff in cultural inclusion practices
- Use of workers from different cultural backgrounds
- Recruitment and use of skilled bi-cultural consumers/peers, workers and translators
- Use of person-centred terminology
- Inclusive language
- Use of community language vs translation and interpretation
- Educational material and pamphlets in different languages
- Preparation and access to resources appropriate ad relevant resources for workers clients and community

Community engagement

- Focus on community engagement and relationship building (particularly with elders and religious leaders)
- Engagement with cultural leaders, community members and families
- Establishing trust and understanding over time

Self and community perception

- Better education on AOD-related knowledge for parents to combat intergenerational differences between young people and their parents
- Anti-stigma messages

Project background

People from culturally and linguistically diverse (CALD) communities are under-represented in alcohol and other drugs (AOD) treatment services, with barriers to services and socio-cultural norms making it difficult for people from CALD backgrounds in need of AOD support to access support and treatment (Victorian Alcohol and Drug Association, 2016). These barriers include stigma, limited health literacy and concerns about the cultural responsiveness of services (Department of Health Australia, 2019; McCann & Lubman, 2018; McCann et al., 2017). Western approaches to health and treatment used in AOD services in Australia may be unfamiliar to many people from CALD backgrounds, negating the importance of cultural inclusion and negatively impacting service uptake (Horyniak et al., 2014; Gainsbury 2017; Roche et al., 2015; Victorian Alcohol & Drug Association, 2016). To improve service access and uptake, local services need to adapt to meet the needs of the population with a range of cultural backgrounds, preferred languages and experiences (Davern et al., 2016), at the policy and staff level. Research has found that while mainstream AOD services may aim to provide care that is culturally appropriate, implementing its key principles can be difficult to achieve in practice (Downing, Kowal & Paradies, 2011; Victorian Alcohol & Drug Association, 2016). There is a strong need, therefore, to evaluate the appropriateness and applicability of the cultural inclusivity process implemented in select AOD treatment services, to identify areas for targeted improvement in order to more effectively serve CALD populations who might otherwise not engage.

This pilot project aimed to evaluate a joint initiative developed between NADA and DAMEC within NSW's CALD communities, which aimed to optimise the experiences of CALD clients in mainstream AOD treatment services in NSW. An audit tool (a structured organisational tool that focuses on cultural inclusiveness in mainstream services) was implemented at four AOD treatment sites. The dissemination of the audit tool to AOD treatment services was accompanied by training of CALD community members as cultural auditors. The process aimed to support organisations to undergo an audit and develop an action plan for improving areas of cultural inclusiveness.

Research question

The aim of this evaluation was to:

1) Assess how AOD services fare in terms of cultural inclusion
2) Describe the acceptability of the cultural inclusion audit process, from the perspectives of staff and auditors at the four pilot sites

In order to answer these two questions, both a quantitative and a qualitive arm were designed; surveys were used to access levels of cultural inclusion in AOD services and interviews were used to describe the acceptability of the cultural inclusion audit process.

Quantitative arm

Method

Prior to the implementation of the audit tool, participants were recruited to take part in a survey. Recruitment was conducted via email invitations at the four pilot sites where the audit tool was to be implemented. A designated executive officer at each of the intervention sites emailed out the invitation to all staff to take part in the survey. These participants are from here on referred to as the *intervention* sample. The original design of the study was such that this intervention sample would be asked to complete an identical survey after the audit tool implementation has taken place to allow for comparisons between pre- and post-interventions. At the same time as the pre-survey, participants at other AOD sites across NADA member services were recruited through an e-mail blast to all staff on the NADA mailing list to complete the identical survey. These participants formed the *control* sample. All data was non-identifiable. The aim was to link the pre and post survey for the intervention group by a unique code (so that records are non-identifiable and individuals cannot be identified) and compare the data across pre and post surveys. However, we were unfortunately unable to generate an adequate sample for the second round post audit data collection with the intervention group to conduct this comparison. Hence, we present the survey data as once only pre-intervention data.

Participants were eligible for a prize draw (5 x $50 Gift Pay flexi eGift voucher), with prizes randomly allocated and emailed out to the winners. The research had ethics approval from the UNSW Human Research Ethics Committee, and received ethics endorsement from the Community Mental Health Drug and Alcohol Research Network's Research Ethics Consultation Committee.

Survey items

The survey included questions that aimed to assess participant feelings about the cultural inclusivity of their AOD site. There were also three items on service accessibility which looked at access in terms of convenience, transport and cost. Demographic data was also collected.

Scales

Welcoming environment scale

Six items were included in the survey relating to participants' feelings about the way their service makes clients feel on arrival. Items included, "Does your service have a process to greet and welcome people from different cultural groups when they arrive at the service" and "Are there prayer rooms and other safe spaces available for use by clients at your service?". Responses were given on a five-point scale from "not at all" (1) to "a great degree" (5) with higher scores indicating a more positive, welcoming environment for CALD

clients. There was also an option of non-applicable for all items. The internal reliability of the scale for the intervention sample was α=.76 and α=.70 for the control sample.

Language and communication support scale

Six items relating to participants' feelings about the use of language and communication to ensure inclusion for CALD clients were included in the survey. Items included, "Are interpreters provided for non-English speaking clients?" and "Are the persons answering the telephone at your service, able to communicate in the languages of the speakers?". Responses were given on a five-point scale from "not at all" (1) to "a great degree" (5) with higher scores indicating a more inclusive language and communication for CALD clients. There was also an option of non-applicable for all items. The internal reliability of the scale for intervention sample was α=.77 and α=.69 for the control sample.

Service delivery scale

Seven items relating to service delivery were included in the survey. Items included, "Does your service consider the client's culture, ethnicity and language in treatment planning (assessment of needs, diagnosis, interventions, discharge planning, etc.)?" and "Does your service use culturally relevant resources when working with clients from different cultural backgrounds?". Responses were given on a five-point scale from "not at all" (1) to "a great degree" (5) with higher scores indicating a better service delivery for CALD clients. There was also an option of non-applicable for all items. The internal reliability of the scale for intervention sample was α=.82 and α=.75 for the control sample.

Working with culturally diverse organisations scale

Three items that focused on working with culturally diverse organisations and workers were included in the survey. For example, "Does your service have current collaborative projects with organisations from different cultural backgrounds such as referral pathways, shared work arrangements or relationships?". Responses were given on a five-point scale from "not at all" (1) to "a great degree" (5) with higher scores indicating that the service engages more with other culturally diverse organisations. There was also an option of non-applicable for all items. The internal reliability of the scale for intervention sample was α=.85 and α=.80 for the control sample.

Capable staff scale

Six items that measured participants' feelings about staff capabilities to ensure cultural inclusiveness were included in the survey. Items included, "At your service, has the staff's training needs in cultural competence been assessed?" and "Does your service offer cultural support and career progression opportunities for staff from different cultural backgrounds". Responses were given on a five-point scale from "not at all" (1) to "a great degree" (5) with higher scores indicating more capable staff for CALD clients. There was also an option of non-applicable for all items. The internal reliability of the scale for intervention sample was α=.92 and α=.88 for the control sample.

Organisation policy and protocols

Nine items relating to participants' feelings about organisation policy and protocols were included in the survey. Items included, "Do staff training materials include information about working with people from different cultural backgrounds?" and "Are processes in place for staff from different cultural backgrounds to contribute to policy development relating to people from different cultures?". Responses were given on a five-point scale from "not at all" (1) to "a great degree" (5) with higher scores indicating a better organisation policy and protocols for CALD clients. There was also an option of non-applicable for all items. The internal reliability of the scale for intervention sample was α=.88 and α=.91 for the control sample.

Community engagement

Three items that focused on community engagement were included in the survey. For example, "Does your service engage regularly with community members or representatives from cultural community organisations?". Responses were given on a five-point scale from "not at all" (1) to "a great degree" (5) with higher scores indicating more positive community engagement. There was also an option of non-applicable for all items. The internal reliability of the scale for intervention sample was α=.78 and α=.82 for the control sample.

Cultural competency scale

Nineteen items relating to participants' beliefs about their own cultural competency and the cultural competency of their colleagues and the service they work at were included in the survey. Items included, "I understand some of the ideas that clients from other cultural, racial, or ethnic group may have" and "Staff at my service know how to use their knowledge of clients cultural background to help them address their current day-to-day needs". Responses were given on a five-point scale from "strongly disagree" (1) to "strongly agree" (5) with higher scores indicating greater cultural competency. The internal reliability of the scale for intervention sample was α=.95 and α=.95 for the control sample.

Data Analysis

Quantitative analyses were conducted using IBM SPSS version 26. Descriptive data outlining the socio-demographic characteristics for the control and intervention samples are presented. Where participants live was recoded to a (0) rural and regional and (2) metro as there were very few responses in the rural category; gender was recoded to (1) male and (2) female for analysis purposes as there were very few responses for non-binary/third gender. Relationships between scale domains were assessed using Pearson's product-moment correlation as well as for relationships between categorial variables and the scale domains . Two-tailed significance was set at p = .05. Mann-Whitney analysis to assess significant difference in scale domains between the control and intervention sample. Analysis was also

intended to include comparisons between the pre and the post survey, however we did not receive sufficient participant responses to the post survey to conduct this analysis.

Results

Demographics

a) The intervention sample consisted of 44 adults. There were 12 (27.3%) males and 29 (65.9%) females. One participant identified as Aboriginal (2.3%) and 13 (29.5%) identified as being of CALD background. Just over half the intervention sample reported that they lived in metro areas (n=24, 54.5%) and over two-thirds had a bachelor's degree or higher level of education (n=31, 70.4%). 28 participants (63.6%) had worked in their current job for less than two years while over a third (n=15, 34.1%) had worked (paid or unpaid) in the AOD field for more than 10 years. More than half worked fulltime in their current position (n=25, 56.8%) with most working in face-to-face service delivery (n=31, 70.5%).
b) The control sample consisted of 41 adults. There were 16 (39.0%) males and 25 (61.0%) females. Two people identified as Aboriginal (4.9%) and 22 (53.7%) identified as being of CALD background. Most of the control sample reported that they lived in metro areas (n=35, 85.4%) and over two-thirds had a bachelor's degree or higher level of education (n=28, 68.3%). Over half of the control sample (n=23, 56.1%) had worked in their current job for less than two years. Most worked fulltime in their current position (n=29, 70.7%) with just less than two-third working in face-to-face service delivery (n=26, 63.4%).

Table 1: Socio-demographics for intervention and control samples

	INTERVENTION GROUP	CONTROL GROUP
Socio-demographics	n(%) n=44	n(%) n=41
Gender		
Male	12(27.3)	16(39.0)
Female	29(65.9)	25(61.0)
Non-binary/third gender	3(6.8)	-
Identify		
Aboriginal	1(2.3)	2(4.9)
Neither Aboriginal nor Torres	43(97.7)	39(95.1)
CALD background		
Yes	13(29.5)	19(46.3)
No	31(70.5)	22(53.7)
Age		
18-29	7(15.9)	4(9.8)
30-39	14(31.8)	9(22.0)
40-49	10(22.7)	14(34.1)
50-59	8(18.2)	12(29.3)
60-69	5(11.4)	2(4.9)
Where do you live		
Rural	2(4.5)	2(4.9)

Metro	24(54.5)	35(85.4)
Regional	18(40.9)	4(9.8)
Highest qualification		
Secondary qualification	1(2.3)	2(4.9)
TAFE/vocational education	5(11.4)	4(9.8)
Undergraduate certificate or diploma	7(15.9)	7(17.1)
Bachelor's degree	16(36.4)	9(22.0)
Post-graduate qualification	2(4.5)	11(26.8)
Master's degree	13(29.5)	8(19.5)
Service		
intervention site A	14(31.8)	-
intervention site B	8(18.2)	-
intervention site C	8(18.2)	-
intervention site D	14(31.8)	-
Residential AOD treatment service	-	7(17.1)
Community AOD services	-	34(82.9)
Length worked in current role		
Less than one year	17(38.6)	12(29.3)
1-2 years	11(25.0)	11(26.8)
3 to 5 years	6(13.6)	13(31.7)
6 to 9 years	3(6.8)	2(4.9)
10 years on more	7(15.9)	3(7.3)
Length worked (paid or unpaid) in the AOD field		
Less than one year	10(22.7)	5(12.2)
1-2 years	10(22.7)	6(14.6)
3 to 5 years	5(11.4)	13(31.7)
6 to 9 years	4(9.1)	5(12.2)
10 years on more	15(34.1)	12(29.3)
Employee status in current role		
Full time (30-40 hours a week)	25(56.8)	29(70.7)
Part-time	16(36.4)	5(12.2)
Casual or temporary	2(4.5)	4(9.8)
Fixed term contract	1(2.3)	3(7.3)
Primary role		
Face-to-face service delivery	31(70.5)	26(63.4)
Management	7(15.9)	11(26.8)
Administration	3(6.8)	-
Other	3(6.8)	4(9.8)

Welcoming environment

Figure 1: Welcoming Environment - intervention sample

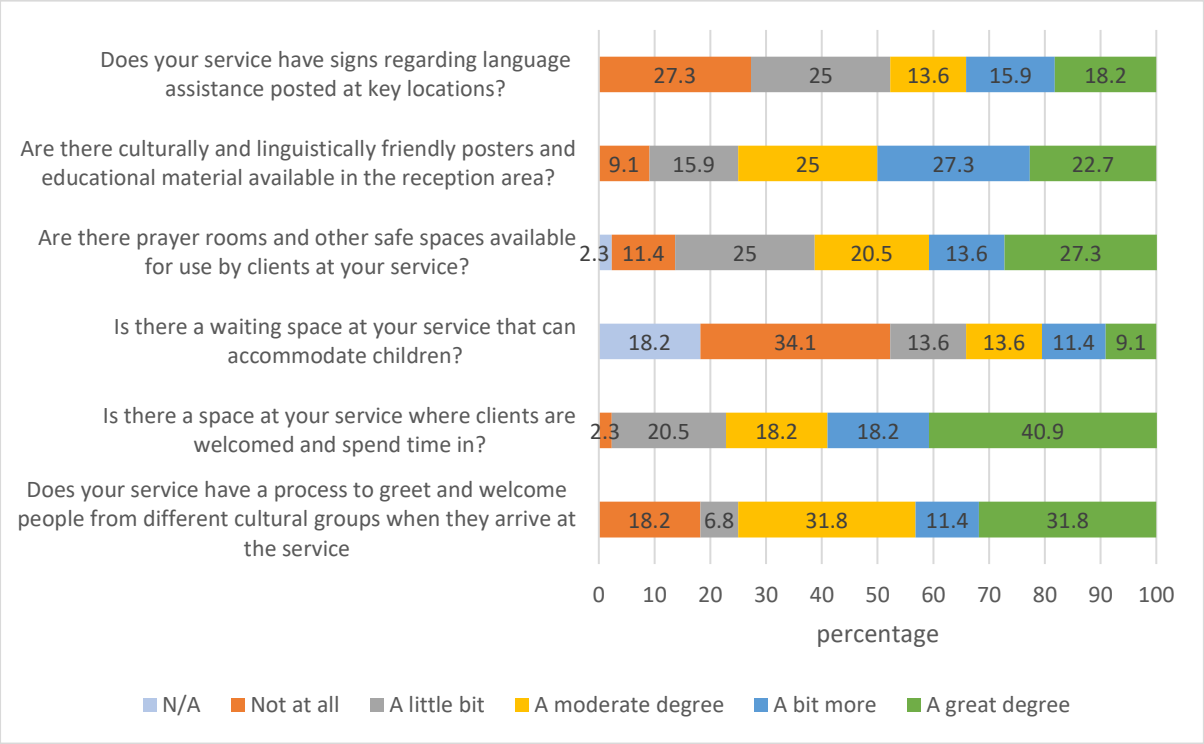
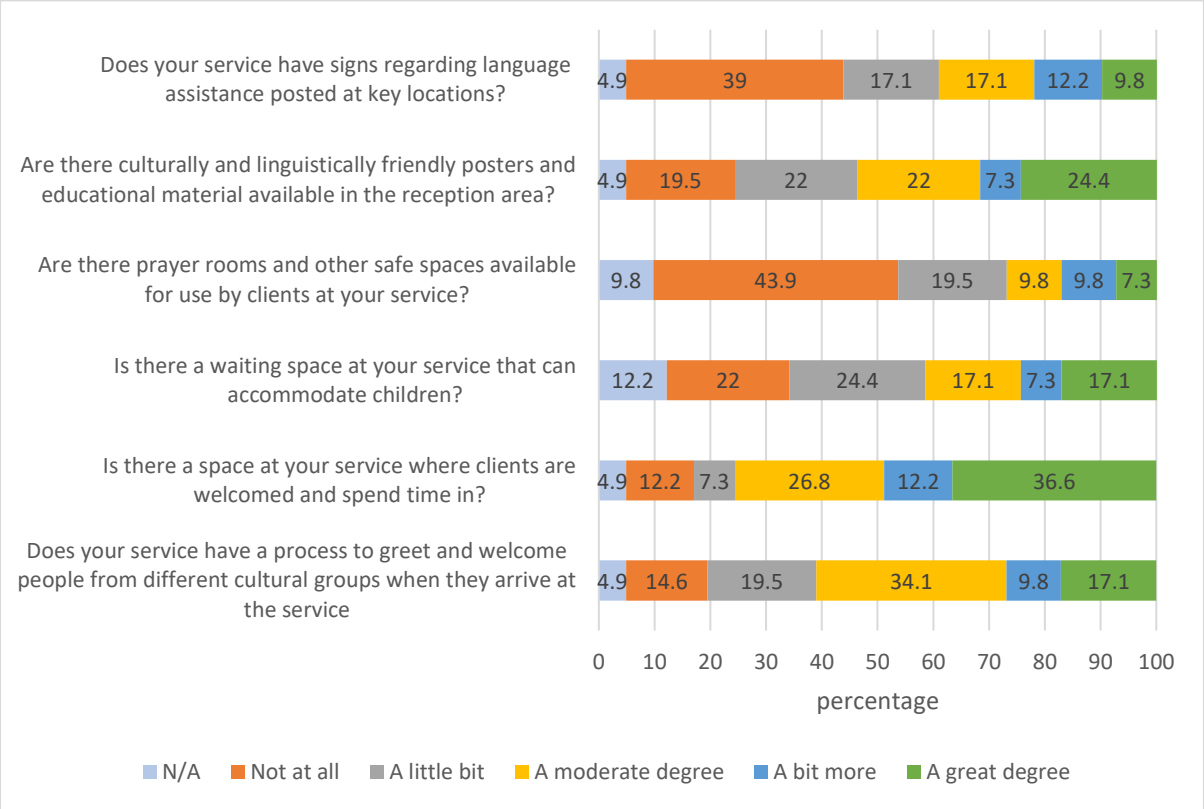


Figure 2: Welcoming environment - control sample



In the intervention group, when participants were asked if their service had signs regarding language assistance posted at key locations, just over half the sample (52.3%) responded "not at all" / only "a little bit". This figure was even higher in the control group with 56.1% responding "not at all" / only "a little bit".

While only 11.4% of participants in the intervention group said there are no prayer rooms and other safe spaces at all available for use by clients at the service, this figure was notably higher in the control group with 43.9% responding "not at all".

Over a third (34.1%) of the intervention group responded that there is no waiting space at their service that can accommodate children compared with only 22% among the control group.

40.9% of participants in the intervention group responded to "a great degree" that there is a space at their service where clients are welcomed and spend time. This was similar in the control group with 36.6% responding to "a great degree" to this item.

The six-item welcome scale has a range of 6-30. Analysis showed the intervention sample had a mean of 18.54 (range 6-30, SD=5.67) and a median of 19 (IQR=8, Q1=15 & Q3=23). The mean was 16.18 (range 7-26, SD=5.24) and the median was 17 (IQR=8, Q1=14 & Q3=22) among the control sample. Further analysis of the welcoming scale using a Mann-Whitney Test revealed no statistical difference in the mean between the control and intervention sample, indicating that the control and intervention samples show a similar amount of cultural inclusion in their service.

Welcoming environment

***Strength*:**

- space at the service where clients are welcomed and spend time

***Weaknesses*:**

- signs regarding language assistance posted at key locations
- prayer rooms and other safe spaces available for use by clients (especially among control sample)
- waiting space at the service that can accommodate children

Language and communication support

Figure 3: Language and communication support - intervention sample

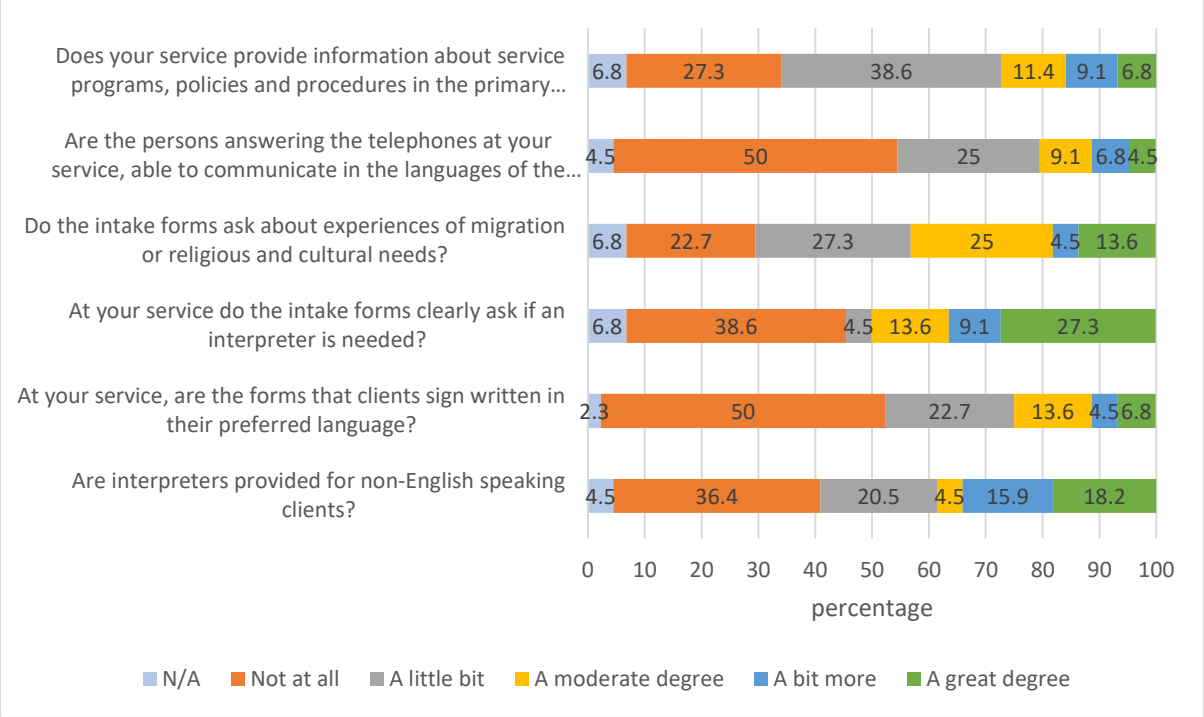
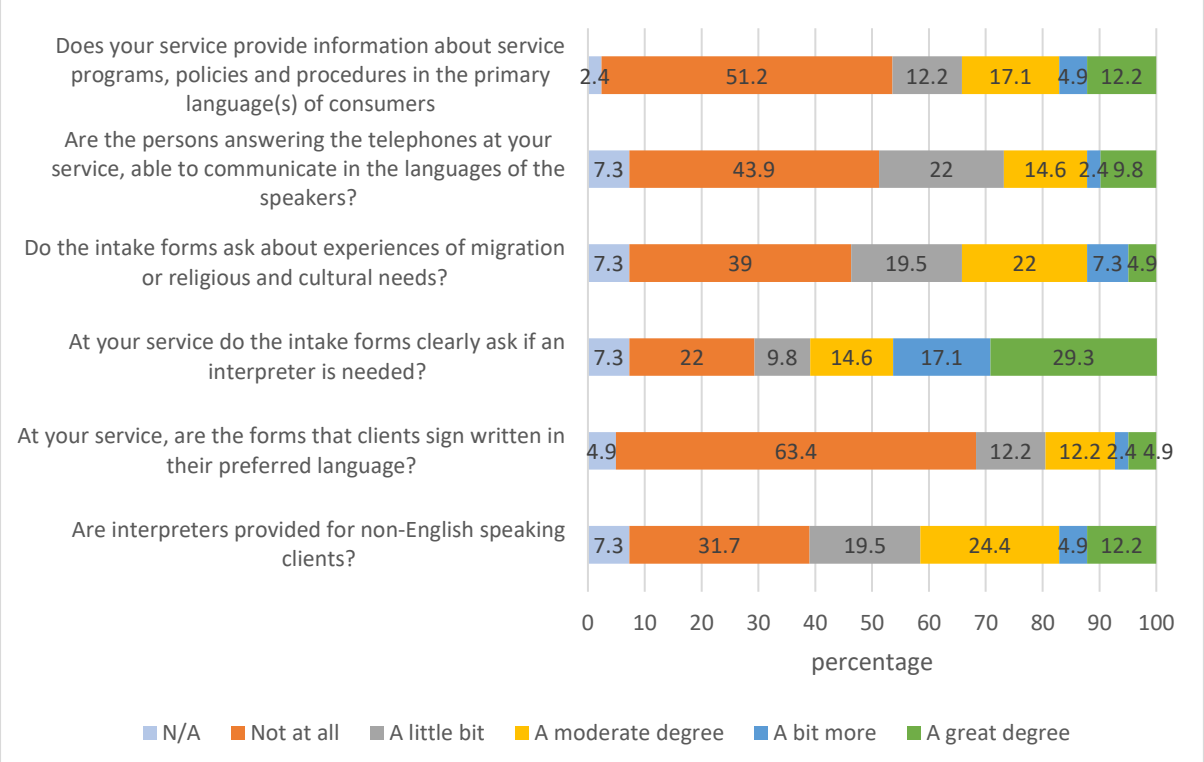


Figure 4: Language and communication support - control sample



27.3% of the intervention group responded “not at all” when asked if their service provided information about service programs, policies and procedures in the primary language(s) of clients; this can be compared to 51.2 % of the control group who responded “not at all” to this question.

Half of participants in the intervention (50.0%) compared with 43.9% in the control group, responded that the persons answering the telephone at their service, is “not at all” able to communicate in the languages of the speakers, and 50% of the intervention (as compared with 63.4% of the control) also responded “not at all” when asked if the forms that clients sign are written in the clients preferred language.

Only 27.3% of the intervention group responded to “a great degree” when asked if intake forms clearly ask if an interpreter is needed (similar to control group with 29.3%).

The six-item language and communication scale had a range from 6-30. Analysis for the intervention sample showed a mean of 13.92 (range 6-24, SD=5.70), and a median of 12.5 (IQR=8.75, Q1=9.25 & Q3=18). The mean among the control sample was very similar (13.65) (range 6-26, SD=5.07) and the median was 12.5 (IQR=8.25, IQ1= 9.75 & IQ3=18) with no statistical difference, indicating that the control and intervention samples show a similar amount of cultural inclusion in their service with regard to language and communication.

Language and communication support

Strengths:

- intake forms clearly ask if an interpreter is needed
- intake forms ask about experiences of migration and religious/cultural needs
- interpreters provided for non-English speaking clients

Weaknesses:

- information about service programs, policies & procedures in the primary language(s) of consumers
- persons answering the telephones at the service are unable to communicate in the languages of the speakers
- forms that clients sign are not written in their preferred language

Culturally inclusive service delivery

Figure 5: Culturally inclusive service delivery - intervention sample

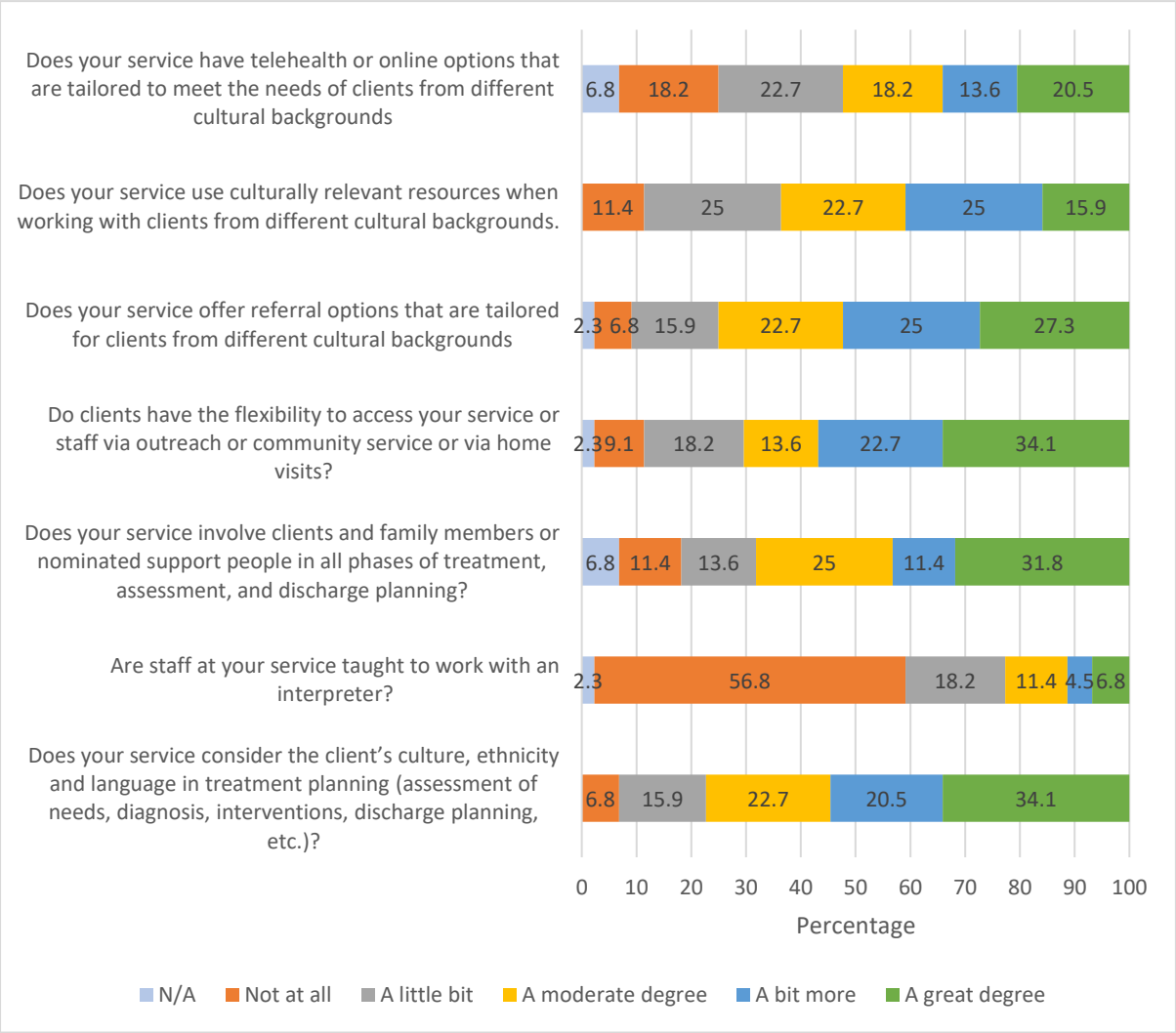
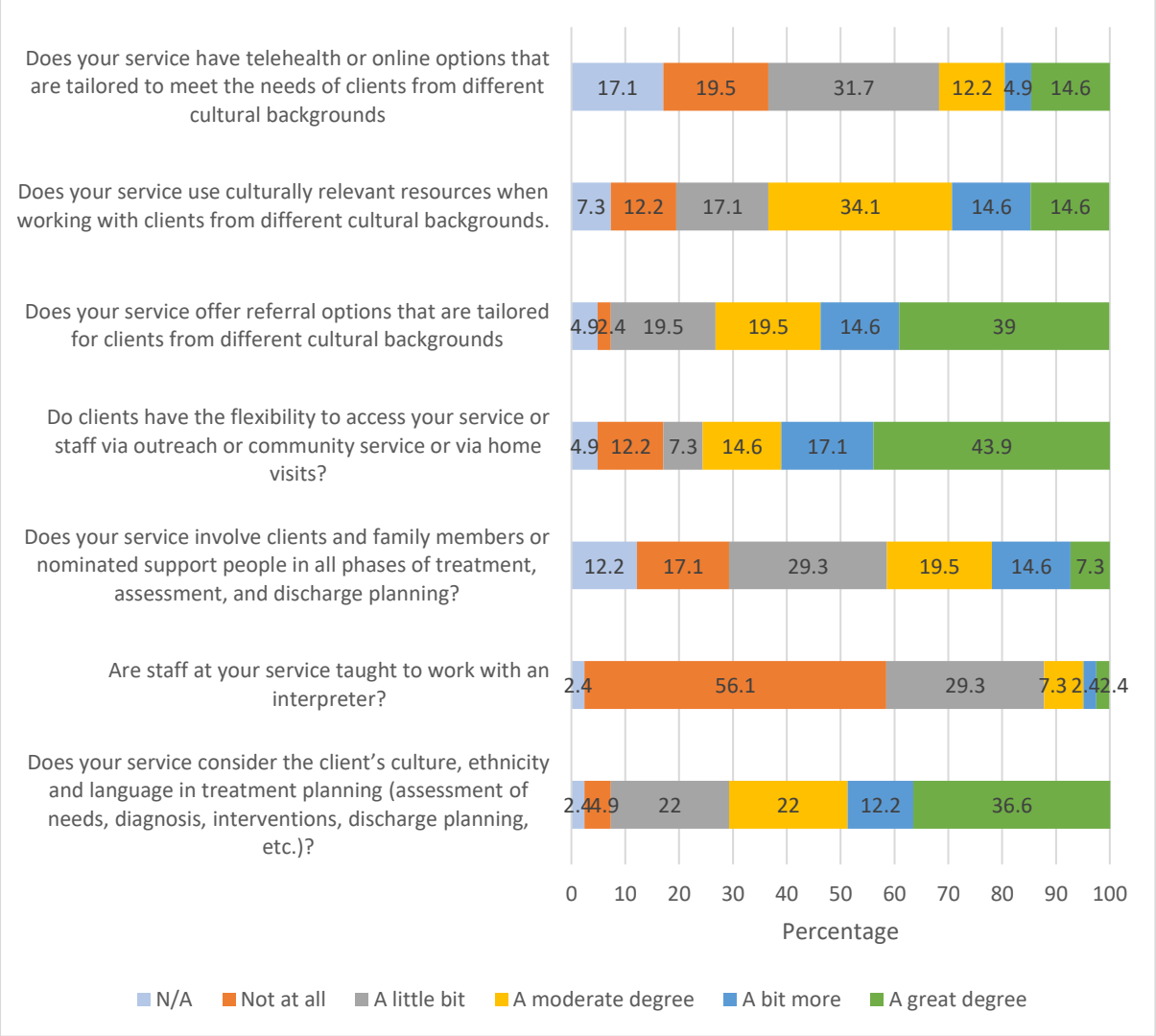


Figure 6: Culturally inclusive service delivery - control sample



34.1% of the intervention group (compared to 43.9% of the control group) responded to "a great degree" when asked whether clients have the flexibility to access the service or staff via outreach or community service or via home visits. Additionally, 31.8% of the intervention group also responded to "a great degree" when asked whether the service involves clients and family members or nominated support people in all phases of treatment, assessment, and discharge planning (compared with only 7.3% of the control group).

More than half the intervention sample (56.8%) responded "not at all" when asked whether staff at their service are taught to work with an interpreter (similar to control group with 56.1%).

34.1% of the intervention group again responded to "a great degree" in response to whether the service considers the client's culture, ethnicity and language in treatment planning (this was similar to the control group with 36.6%).

The seven-item service delivery scale had a possible range of 7-35. Analysis for the intervention sample had a mean of 21.89 (range 8-35, SD=6.52), and a median of 23(IQR=10, IQ1=17 & IQ3=27). The mean was 19.52 (range 8-32, SD=5.53) and the median was 20(IQR=8, IQ1=17 & IQ3=25) among the control sample. Further analysis of the scale using a Mann-Whitney Test revealed no statistical difference in the mean between the control and intervention sample, indicating that the control and intervention samples again show a similar amount of cultural inclusion in their service.

Culturally inclusive service delivery

Strengths:

- clients have the flexibility to access the service or staff via outreach or community service or via home visits
- clients and family members or nominated support people are included in all phases of treatment, assessment, and discharge planning (especially among intervention sample)
- considers the client's culture, ethnicity and language in treatment planning
- offer referral options that are tailored

Weaknesses:

- staff are not taught to work with an interpreter
- telehealth or online options tailored to meet the needs of clients from different cultural backgrounds

Working with relevant community organisations

Figure 7: Working with relevant community - intervention sample

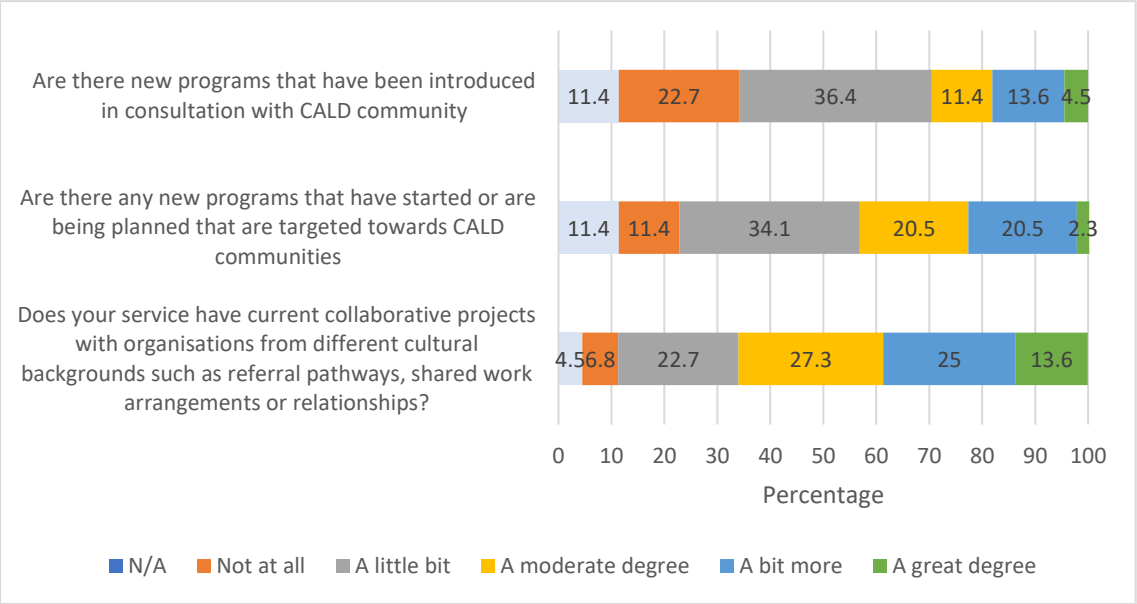
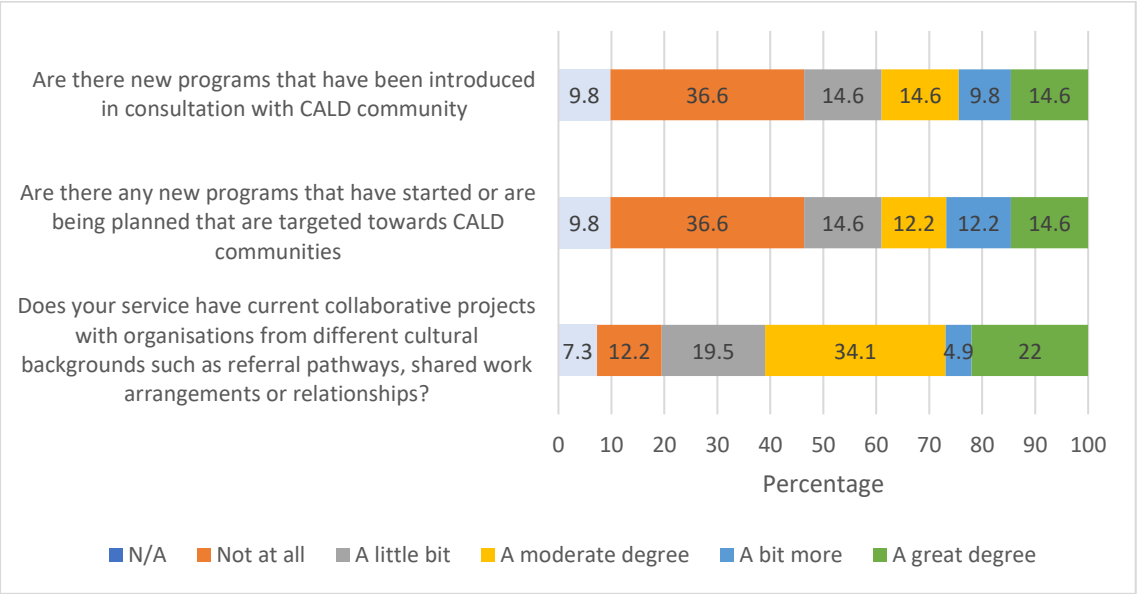


Figure 8: Working with relevant community organisations - control sample



59.1% of the intervention group (compared with 51.2% of the control group) responded "not at all"/ "a little bit" when asked if new programs that have been introduced were done in consultation with CALD community. However, it is worth noting that 22.7% of the intervention group responded "not at all" to this item compared with 36.6% of the control group. 45.5% of the intervention group (and 51.2% of the control group) responded "not at all"/ "a little bit" when asked if any new programs that have started or are being planned are targeted towards CALD communities. Again, it is worth noting that 11.4% of the intervention group compared with 36.6% of the control group responded "not at all" to this item.

13.6% of the intervention group (as compared to 22% of the control group) responded to "a great degree" and a further 25.0% of the intervention group (and only 4.9% of the control group) responded "a bit more" when asked if the service has current collaborative projects with organisations from different cultural backgrounds such as referral pathways, shared work arrangements or relationships.

The three-item working with relevant community organisations and workers scale has a possible range of 5-15. Analysis for the intervention sample had a mean of 8.21 (range 3-14, SD=3.02), and a median of 8 (IQR=4, IQ1=6; IQ3=10). The mean was 7.86 (range 3-15, SD=3.71) and the median was 7.5 (IQR=6, IQ1=5, IQ3=11) among the control sample. Further analysis of the scale using a Mann-Whitney Test revealed no statistical difference in the mean between the control and intervention sample, indicating that the control and intervention samples show a similar amount of cultural inclusion in their service when it comes to working with relevant community organisations and workers.

Working with relevant community organisations

Strengths:

- collaborative projects with relevant organisations such as referral pathways, shared work arrangements or relationships

Weaknesses:

- new programs introduced in consultation with relevant communities (especially among the control sample)
- new programs started/planned that are targeted towards relevant communities

Service accessibility

Figure 9: Service accessibility - intervention sample

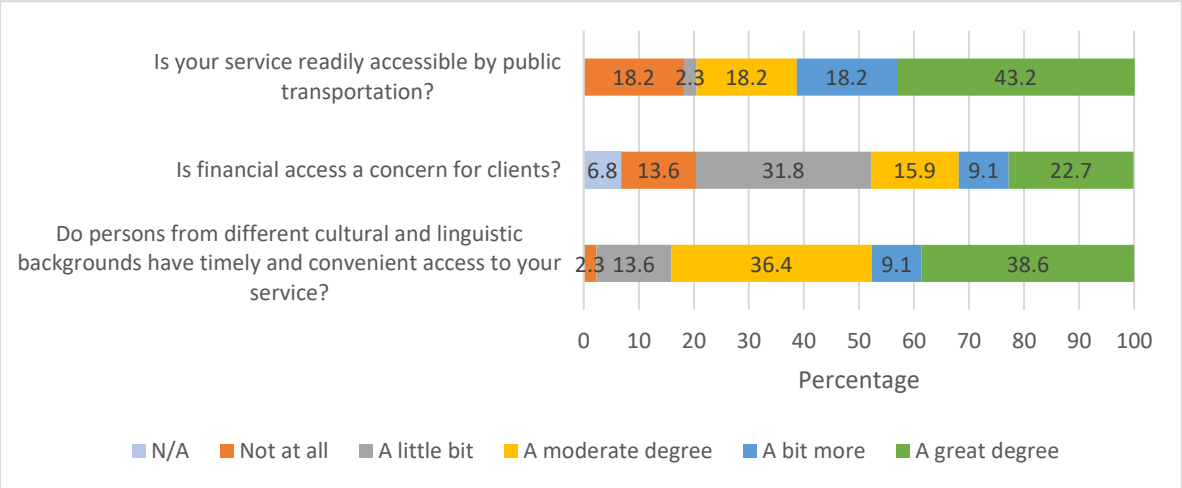
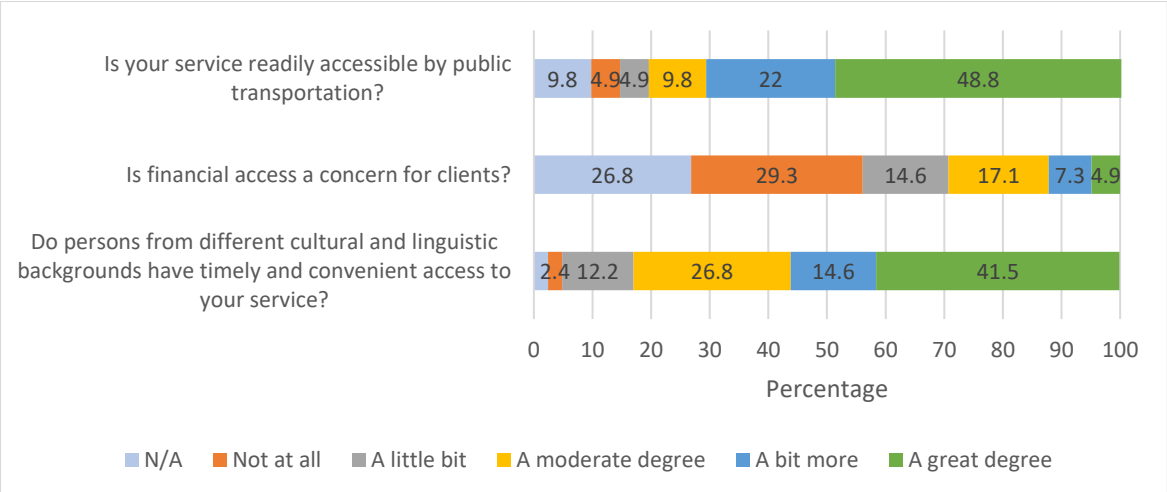


Figure 10: Service accessibility - control sample



These three items were not used as a scale, but rather analysed as separate items to enhance understanding around service accessibility for CALD clients. Almost a quarter of the intervention group (22.7%) responded that financial access is a great concern for clients. This can be compared with only 4.9% of the control group responding to “a great degree” to this item.

43.2% of the intervention group (and 48.8% of the control group) responded to a “great degree” when asked if the service is readily accessible by public transportation.

Only 15.9% responded that persons from different cultural and linguistic backgrounds do not have or only have “a little bit” of timely and convenient access to the service; similar to control group with 14.6% responding “not at all/ a little bit” to this item.

Service accessibility

Strengths:

- readily accessible by public transportation
- persons from CALD backgrounds have timely and convenient access to the service

Weaknesses:

- financial access is a concern for clients (intervention sample)

Capable Staff for working with CALD people

Figure 11: Capable staff for working with CALD people - intervention sample

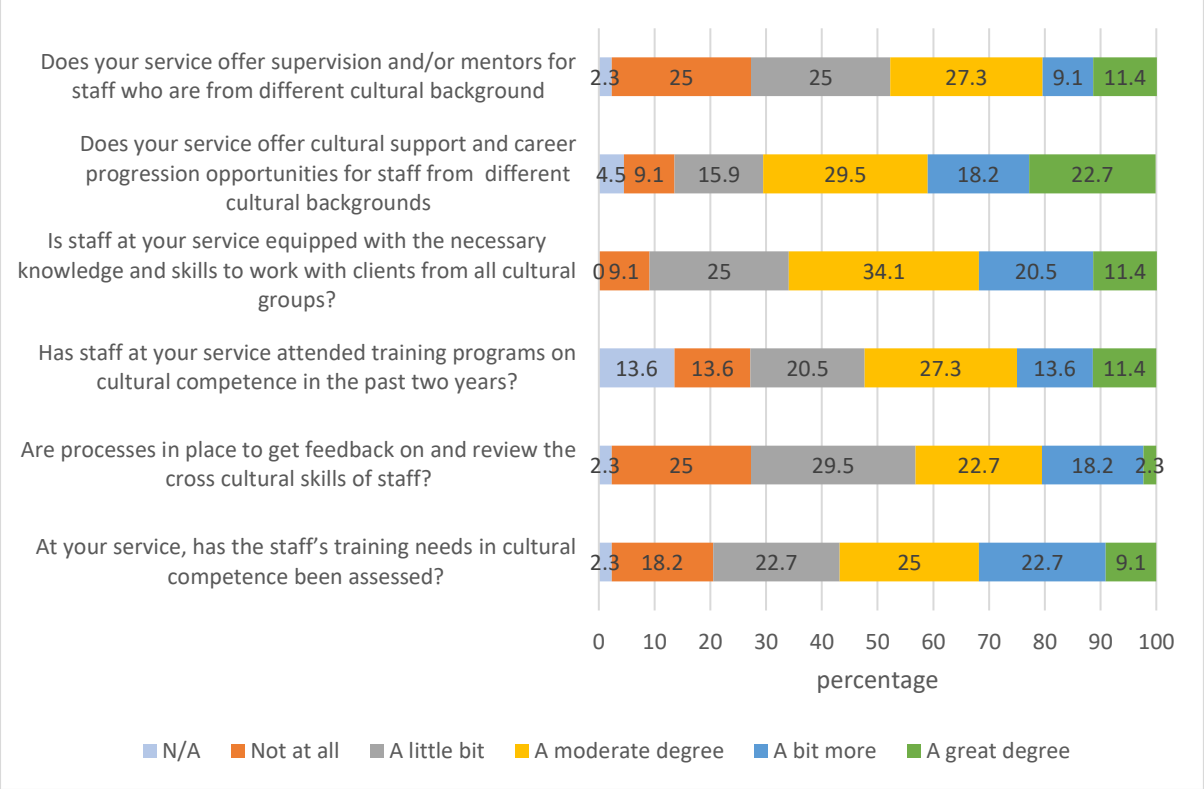
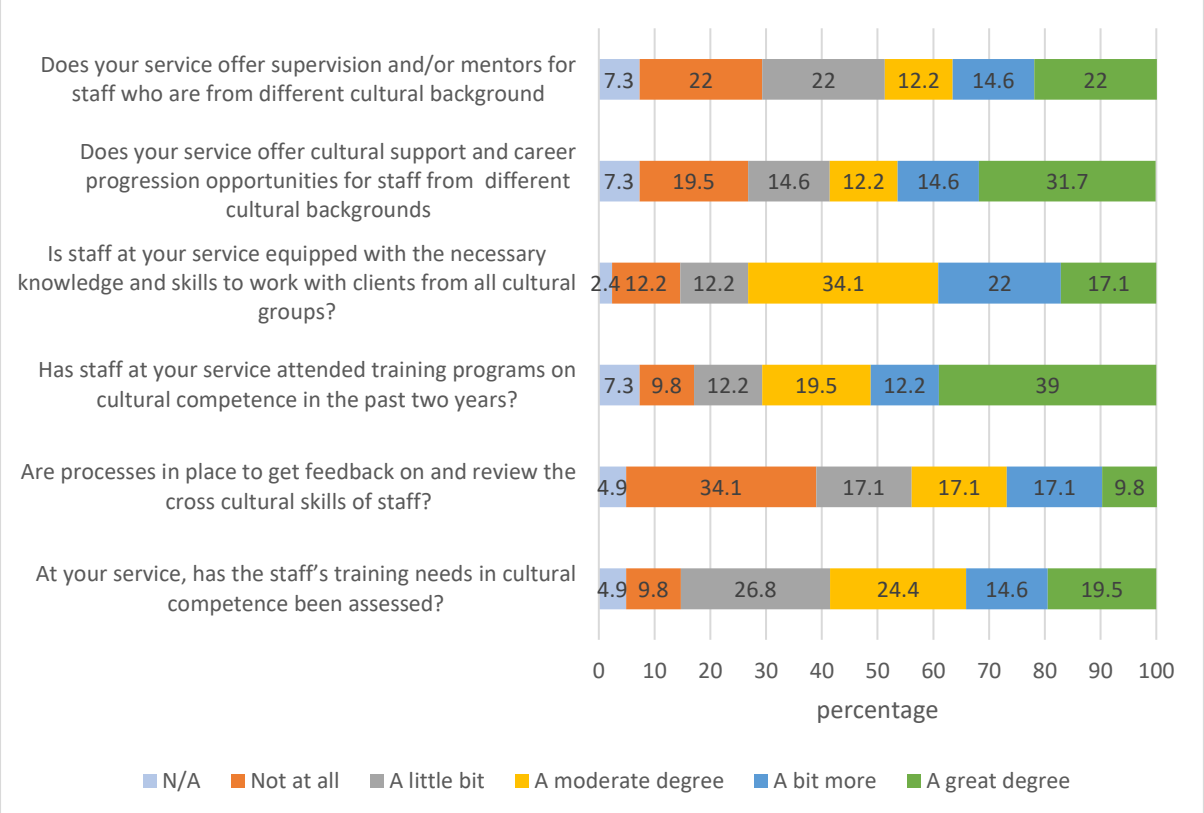


Figure 12: Capable staff for working with CALD people - control sample



Half the participants in the intervention group (50.0%) and 44% of the control group responded “not at all”/”only a little bit” when asked if their service offers supervision and/or mentors for staff who are from different cultural backgrounds. It is worth noting that only 11.4% of the intervention group versus 22% of the control group responded to “a great degree” when asked if their service offers supervision and/or mentors for staff who are from different cultural backgrounds.

54.6% of the intervention and 54.2% of the control group responded to “a moderate degree”/ “a bit more” when asked if their service is equipped with the necessary knowledge and skills to work with clients from all cultural groups. 31.8% of the intervention group responded “a bit more”/ “a great degree” when asked whether the staff’s training needs in cultural competence has been assessed. This was similar to the control group, with 34.1% responding “a bit more”/ “a great degree” to this item.

Additionally, only 11.4% of the intervention group verse 39% of the control group reported to “a great degree” when asked if staff had attended training programs on cultural competence in the past two years.

The six-item capable staff scale looked at training of staff and staff expertise to work with CALD people and had a possible range of 6-20. Analysis for the intervention sample had a mean of 16.47 (range 6-29, SD=5.99), and a median of 17 (IQR=8.75, IQ1=11.25, IQ3=20). The mean was 18.38 (range 6-30, SD=6.81) and the median was 18 (IQR=10, IQ1=12, IQ3=22) among the control sample. Further analysis of the scale using a Mann-Whitney Test revealed no statistical difference in the mean between the control and intervention sample. This indicates that both samples show a similar amount of cultural inclusion with regards to seeing the staff at their service as being culturally capable and appropriately trained to work with people of CALD background.

Capable staff for working with CALD people

Strengths:

- provision of cultural support and career progression opportunities for staff from different cultural backgrounds
- staff’s training needs in cultural competence has been assessed

Weakness:

- supervision and/or mentors for staff who are from different cultural backgrounds
- training programs on cultural competence (control group provided far more training programs for cultural competency in the past two years than the intervention group.)
- processes in place to get feedback on & review cross cultural skills of staff

Organization policy and protocols

Figure 13: Organisation policy and protocols - intervention sample

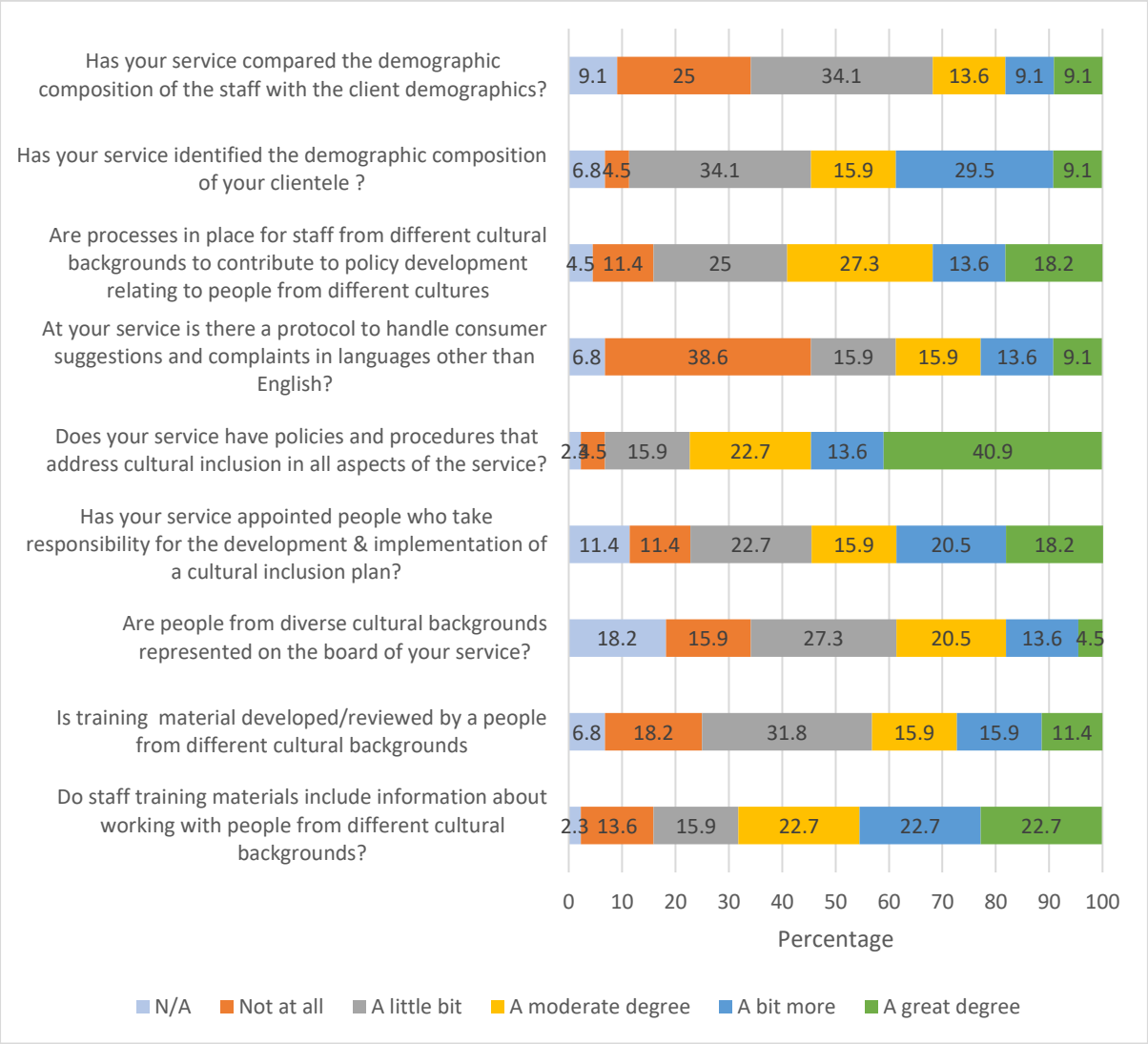
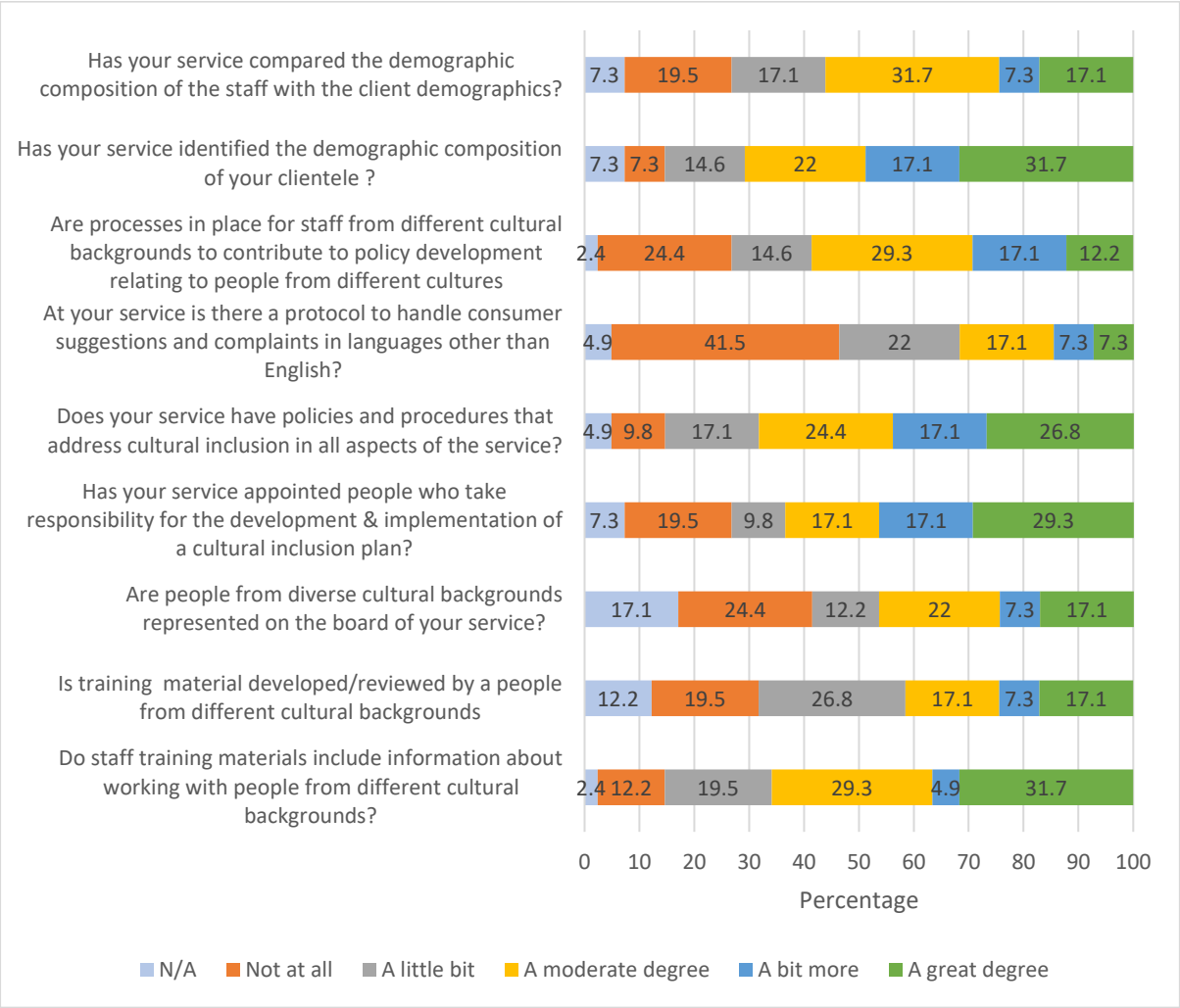


Figure 14: Organisation policy and protocols - control sample



One quarter of the intervention group (25.0%) and 19.5% of the control group answered "not at all" when asked whether their service has compared the demographic composition of the staff with the client demographics.

Only 9.1% of the intervention group responded to "a great degree" when asked if their service had identified the demographic composition of your clientele, as compared with 31.7% of the control group. 38.6% of the intervention group (and 41.5% of the control group) reported that there is no protocol at all to handle consumer suggestions and complaints in languages other than English.

40.9% of the intervention group (compared with 26.8% of the control group) responded to "a great degree" to the item asking if their service has policies and procedures that address cultural inclusion in all aspects of the service.

Half of the control group (50%) and 46.3% of the control group responded "not at all"/"only a little" bit when asked if training material is developed/reviewed by people from different cultural backgrounds.

The nine-item organisation policy and protocols scale had a range of 9-45. Analysis for the intervention sample had a mean of 25.55 (range 11-41, SD=3.02), and a median of 27 (IQR=12, IQ1=20, IQ3=32). The mean was 23.52 (range 11-40, SD=8.09) and the median was 22.5 (IQR=13, IQ1=16, IQ3=29) among the control sample. However, further analysis of the scale using a Mann-Whitney Test revealed no statistical difference in the mean between the control and intervention sample.

Organisation policy and protocols

Strengths:

- have policies and procedures in place that address cultural inclusion in all aspects of the service
- staff training material includes information about working with people from cultural backgrounds

Weaknesses

- identified the demographic composition of clientele
- no protocol to handle consumer suggestions and complaints in languages other than English
- training material is not developed/reviewed by people from different cultural backgrounds
- not enough people of different cultural backgrounds are represented on the board

Community engagement

Figure 15: Community engagement - intervention sample

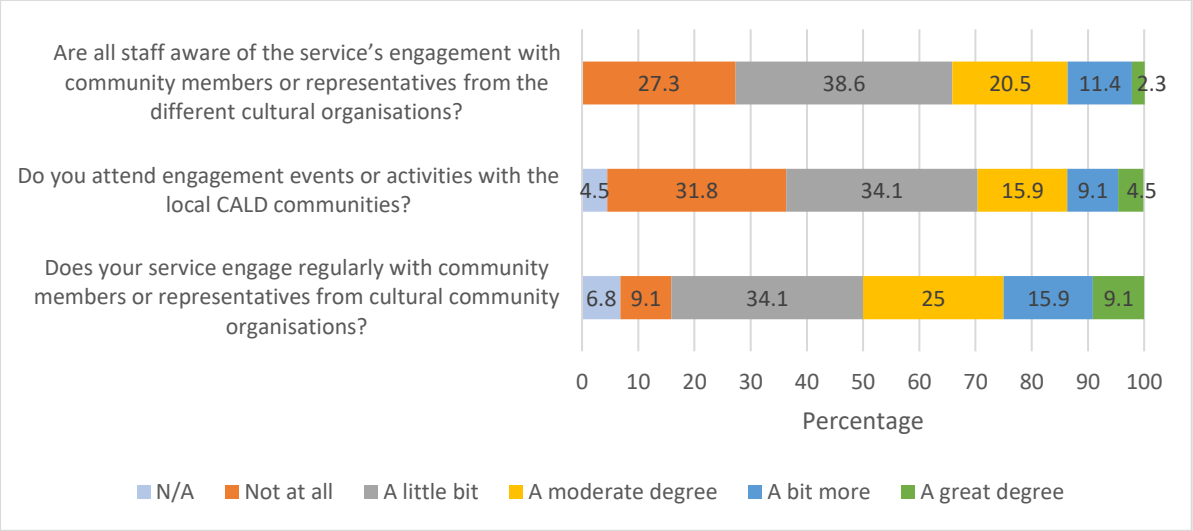
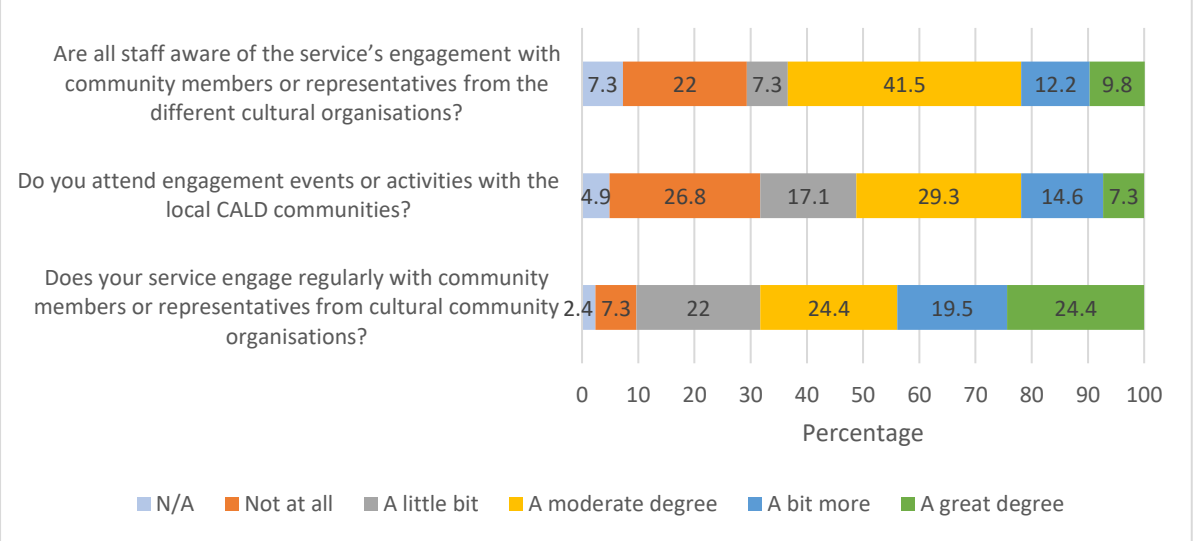


Figure 16: Community engagement - control sample



65.9% of the intervention group compared with 29.3% of the control group responded "not at all"/ only "a little bit" when asked about staff being aware of the service's engagement with community members or representatives from the different cultural organisations. Over half the control group (53.7%) responded to "a moderate degree"/ "a bit more" to this question.

65.9% of the intervention group compared with 43.9% of the control group also responded "not at all"/only "a little bit" when asked whether they attend engagement events or activities with the local CALD communities.

43.2% of the intervention group compared with 29.3% of the control group responded “not at all”/only “a little bit” when asked if their service engages regularly with community members or representatives from cultural community organisations. 43.9% of the control group responded “a bit more” / “a great degree” to this item as compared with 25% of the intervention group.

The three-item community engagement scale had a range of 3-15. Analysis for the intervention sample had a mean of 7.38 (range 3-15, SD=2.79), and a median of 7 (IQR=3.75, IQ1=5.25, IQ3=9). The mean was 8.71 (range 3-15, SD=3.25) and the median was 8 (IQR=4, IQ1=6, IQ3=10) among the control sample. Further analysis of the community engagement scale using a Mann-Whitney Test revealed a statistical difference in the means between the intervention and control sample ($U = 553.500$, $p < .05$), with the intervention sample being less cultural inclusive when it came to engaging with other cultural communities.

Community engagement

Strengths:

- regularly engaging with community members or representatives

Weaknesses:

- attend engagement events with local relevant communities

Measuring Cultural Competency

Figure 17: Measuring cultural competency - intervention sample

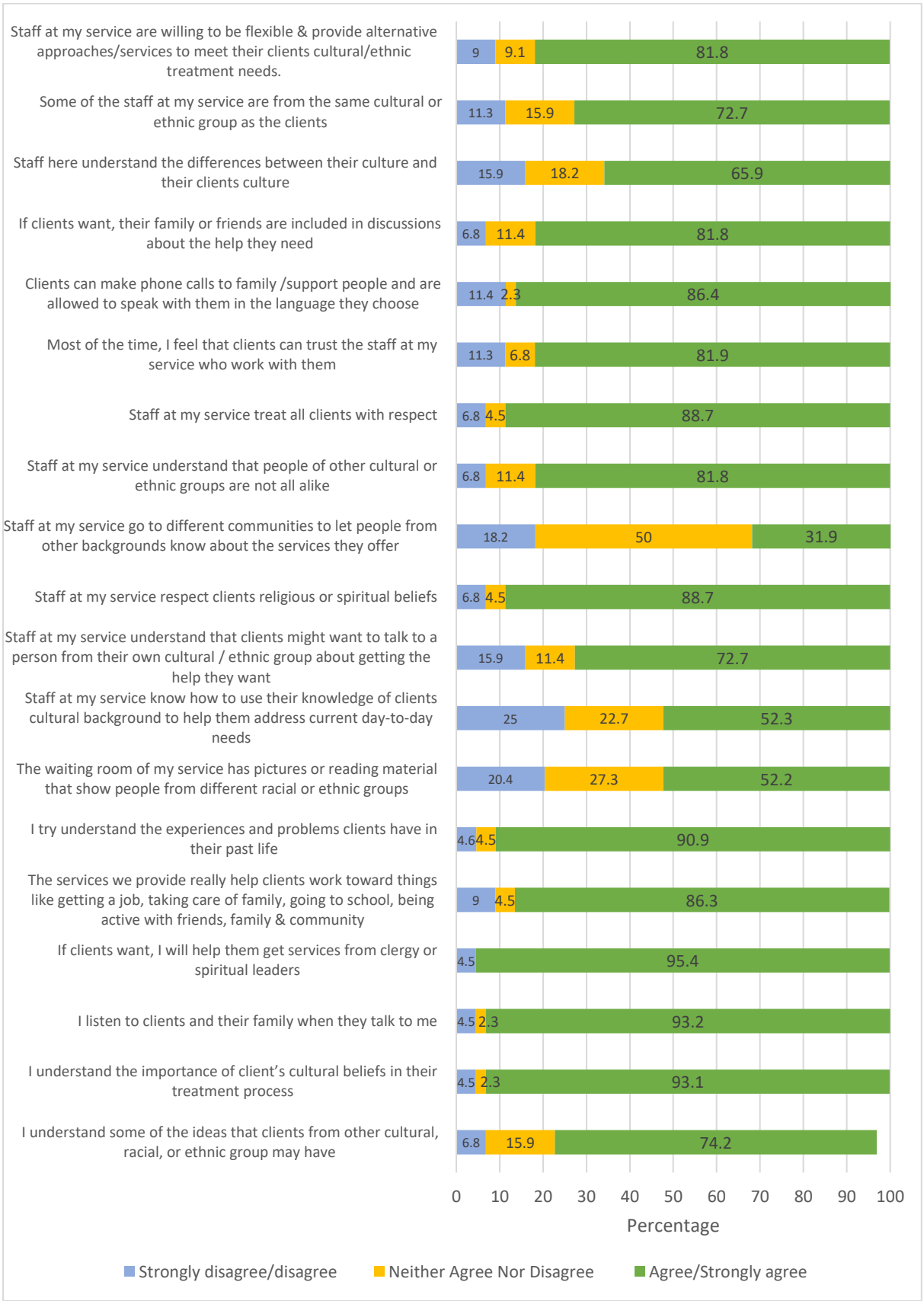
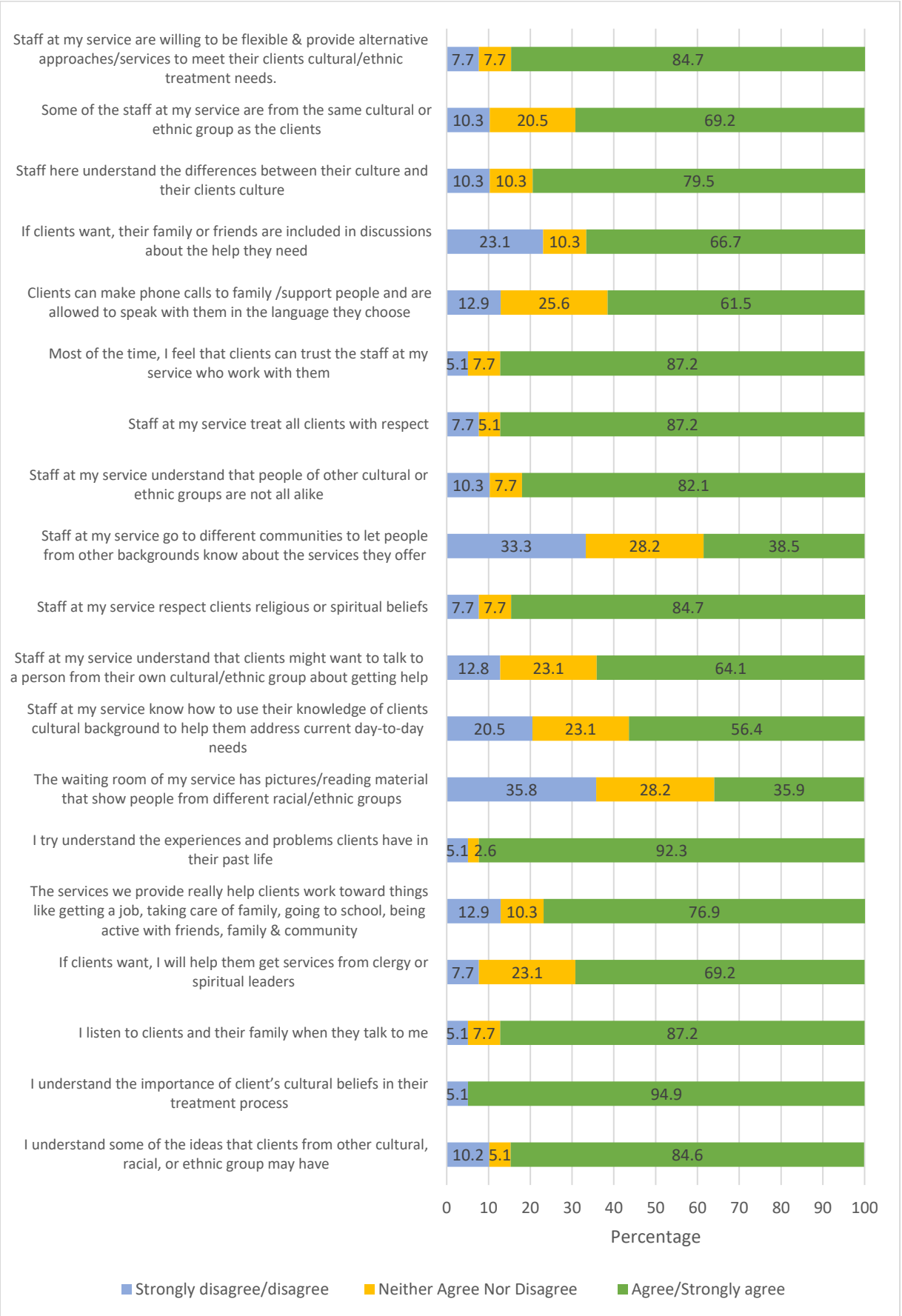


Figure 18: Measuring cultural competency – control sample



As can be seen above, in both the control and the intervention groups, the vast majority of the participants either agreed or strongly agreed with almost all items, indicating their perception that they, their colleagues and the service they worked for displayed a high degree of cultural competency. This was quite different to responses on other measures, suggesting participants see themselves, their colleagues and their service as more culturally inclusive than what they report on the other scales. For example, 93.1% of the intervention group and 94.9% of the control group agreed/strongly agreed that they understand the importance of client's cultural beliefs in their treatment process; and 81.8% of 84.7% of the intervention group and 84.7% of the control group agreed /strongly agreed that staff at their service are willing to be flexible and provide alternative approaches or services to meet their clients cultural/ethnic treatment needs.

The 19-item cultural competency scale had a range of 19-95. Analysis for the intervention sample had a mean of 78.23 (range 23-95, SD=14.93) and a median of 80 (IQR=15.5, IQ1=73.25, IQ3=88.75). The mean was slightly less, being 74.87 (range 23-94, SD=14.86) and the median was 78 (IQR=13, IQ1=71, IQ#=84) among the control sample. Further analysis of the scale using a Mann-Whitney Test revealed no statistical difference in mean between the intervention and control sample, indicating both samples viewed themselves as similar regarding overall cultural competence.

Cultural Competence

Participants reported seeing themselves and their service as culturally competent. There was however, a large discrepancy between participants views on the eight measured domains compared to their perceptions of their own and their colleagues behaviours based on the cultural competency scale

Strength

- understanding the importance of cultural beliefs in the treatment process
- being flexible and willing to find alternative approaches/services to meet clients cultural treatment needs

Weaknesses

- pictures/reading materials in the waiting rooms that show people from different cultural backgrounds
- Using knowledge of clients cultural background to help them address current day to day needs

Relationships between measure and samples

Correlations were undertaken in order to assess the relationship between different measured variables and to gain a better understanding of cultural inclusion at the services.

As can be seen in Table 2, a welcoming environment, language and communication, service delivery, staff capability, working with culturally diverse organisations and workers, organisation policy and protocols, community engagement and cultural competency were significantly correlated with each other. As expected, a greater degree of cultural inclusion on one measure was associated with greater cultural inclusion on another measure for example a more welcoming environment was associated with greater language and communication. This finding is not surprising as it is likely that service and staff will show greater cultural inclusion across the range of measures. In addition, living in metropolitan vs rural/regional areas was significantly associated with staff capabilities for cultural inclusion with participants who live in metro areas regarding themselves, their colleagues and their service as more culturally inclusive. There were also no statistical differences on measures of cultural inclusion when looking at data by gender or whether participants identify as having a CALD background.

Table 2: Correlations for intervention and control samples

	Welcoming environment	Language	Service delivery	Working with relevant organisations	Staff capabilities	Organisation policy	Community engagement	Cultural competency
Language	.581***							
Service delivery	.677***	.725***						
Working with relevant organisations	.516***	.383**	.590***					
Staff capabilities	.534***	.439***	.558***	.618***				
Organisation policy	.568***	.439**	.593***	.639***	.786***			
Community engagement	.342**	.268*	.431**	.564***	.623***	.646***		
Cultural competency	.225	.161	.137	.156	.267*	.377**	.337**	
Rural vs metro	.093	.096	-.028	.008	.235*	.198	.115	.156

*** p < 0.001 ** p < 0.01 * p < 0.0

Summary of findings for quantitative arm

- There were 44 adults in the intervention sample and 41 adults in the control sample with 13 participants identifying as CALD in the intervention sample (29.5%) and 19 in the control sample (46.3%).
- Overall, cultural inclusion across the different service type variables was not high, indicating that participants did not report their services as being culturally inclusive on those measures.
- The intervention and control sample had similar perceptions of the cultural inclusion of their service/themselves with regards welcoming environment, language and communication, service delivery, staff capabilities working with culturally diverse organisations and workers, organisation policy and protocols.
- Only community engagement was statistically different between the control and intervention sample with the intervention sample being less cultural inclusive when it came to engaging with other cultural communities.
- Interestingly, there was a large discrepancy between the scores on the different service measures (based on the seven scales) compared to participants perceptions of their own and their colleagues' behaviours based on the cultural competency scale. Hence, while cultural inclusion across the different service type variables was not high, participants perceived and rated themselves/their colleagues and service quite highly with regard to cultural competency.

Qualitative arm

Introduction

The qualitative interview component for this evaluation was introduced following a consultation process with the Community Mental Health, Drug & Alcohol Research Network's Research Ethics Consultation Committee, NADA and DAMEC.

Qualitative methods facilitate enhanced understanding deeper of a problem, phenomenon or intervention (Creswell & Plano Clark, 2018, p. 10), making it particularly useful in exploratory studies on topics about which little is known. When used in intervention designs with a key quantitative component, inclusion of a qualitative research component helps researchers to explore intervention processes and outcomes, participant and stakeholder experiences, and the reasons behind the intervention's success or failure (p.108).

The chief interest of this study was in service providers' and cultural auditors' experiences of the audit process and their motivations for participating in the cultural inclusiveness pilot program (hereafter 'the project'). Therefore, the central research question for the qualitative arm was: "What was the acceptability of the CALD audit project?".

Method

In-depth semi-structured interviews were conducted with four cultural auditors and with nine staff from three of four of the residential rehabilitation services that participated in the project. A fourth service cited time constraints for their inability to participate, with their follow-up audit scheduled for end-November, two months after the formal conclusion of the project. The staff members interviewed – two of them CALD-identifying – had worked in the AOD sector in Australia from 2 to 25 years, while cultural auditors, all of whom identified as being of CALD backgrounds, had various levels of lived experience and familiarity with the sector.

Calls for participation were circulated by NADA to the services and auditors, and interested participants registered their interest to participate directly with the evaluation team by clicking on a web link which provided information about the interview and available interview time slots. Interviews were conducted in English via Zoom videoconferencing software, by a CALD member of the independent evaluation team. The interviews, conducted between August and October 2022, averaged 30 minutes and 40 minutes for staff and auditors respectively. Both sets of participants were asked the same broad questions about their individual roles within the project, the reasons why they or their services volunteered to participate in the project, the extent to which they felt supported, their experiences when participating in the project, the sorts of changes implemented at services as a result of the audits, and their views on how the project should develop. The interviews were then transcribed and deidentified by the evaluation team for analysis.

Data were first analysed deductively across the seven component constructs of the Theoretical Framework of Acceptability developed by Sekhon et al. (2017), which comprises seven component constructs, namely: affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy (see Table 1). The data were then analysed inductively to identify further themes, which were then mapped back into the component constructs.

Table 3: Seven component constructs to assess acceptability (Sekhon et al., 2017).

	Component constructs	**Description**
1.	Affective attitude	"How an individual feels about an intervention."
2.	Burden	"The perceived amount of effort that is required to participate in the intervention."
3.	Ethicality	"The extent to which the intervention has good fit with an individual's value system."
4.	intervention coherence	"The extent to which the participant understands the intervention and how it works."
5.	Opportunity costs	"The extent to which benefits, profits or values must be given up to engage in the intervention."
6.	Perceived effectiveness	"The extent to which the intervention is perceived as likely to achieve its purpose."
7.	Self-efficacy	"The participant's confidence that they can perform the behaviour(s) required to participate in the intervention."

Results

Affective attitude

How individuals feel about the intervention is important in gauging commitment towards its successful and sustainable implementation. Both sets of participants regarded the project positively and were broadly satisfied with how it was conducted.

Willingness and challenges regarding participation

In this study, both sets of participants – service staff and cultural auditors – expressed their commitment to the goals of the project, although they offered different reasons for doing so. Service staff were motivated by the opportunity facilitated by the audit process to keep abreast of 'best practice' and the latest research on cultural inclusion, to reflect on their own assumptions and professional practice, to shape service provision in culturally inclusive ways against clear guidelines, and ultimately to better attract and support CALD clients and staff (Table 4). Meanwhile, cultural auditors, who broadly regarded the project as overdue and fundamentally necessary, were

motivated to participate due to their lived experience as CALD individuals who might have accessed AOD services, their interest in cultural equity and justice, and their desire for professional development (Table 5).

Table 4: Service staff's reasons for participating in the project

	Reason (Service staff)	**Description**
1.	To keep abreast of 'best practice' and the latest research on cultural inclusion	*"… a lot of the work that I was involved with, that research was getting a little bit old, so it was an opportunity for me to be looking at more current things and research and that's been really interesting, because I've been able to critically reflect on the impacts of saying that we do client centred work, and what emphasis that may put on that individual in being able to articulate need" (Staff 1).*
2.	To reflect on their own assumptions and professional practice	*"I think, genuinely, people are trying to do a good job but sometimes we can accidentally reinforce things as an organisation or as workers that we don't realise we're reinforcing. I'm talking about those negative things that society kind of perpetuates and things, so I think these kind of processes are really good reminders for people to do some of that base stuff well, and then use that as a platform to kind of springboard from there to make sure we're continuing to improve our practice" (Staff 5).*
3.	To shape service provision in culturally inclusive ways against clear guidelines	*"We knew we had a lot of deficiencies and it got us really excited to start, like helping us where to start, like where do we go? Where do we start? And even finding these different services that are actually out there and readily available to help us move forward with this conversation with the workers here… it was good to do the audit, to give us that foundation to build on" (Staff 6).*
4.	To attract and serve CALD clients and staff	*"… [we need the CALD community], doctors and even hospitals to understand [that our service] can be used for CALD backgrounds… […] we need to think of being able to be approached by the wider [CALD] community… so that they can understand that we do [in terms of providing inclusive services]" (Staff 4).* *"I'd say a small percentage of our workforce identify as being from CALD backgrounds in this facility… how do we honour that stuff [i.e., CALD inclusion], even like back to our recruitment and [our processes]…" (Staff 5).*

Table 5: Cultural auditors' reasons for participating in the project

	Reason (Cultural auditors)	**Description**
1.	Passion for improving AOD services due to lived experience of being CALD and, for some, of accessing AOD services due to a history of addiction.	*"…it's my passion. I do want to leave a footprint when it comes to drug and alcohol, because I do think that Australia is still very far behind when it comes to residential rehab or any sort of rehab in addiction, so I thought, if I can add my little bit to help influence [rehab service provision] in a positive direction then why not?" (Auditor 2).*
2.	Interest in cultural equity and justice.	*"…I applied for the role because I thought that there should be more representation... This shouldn't be another area or I don't know, a seminar where like non-people of colour are lecturing people of colour about diversity. So, I was like it's okay, the first step to do is just to apply. So, I did that" (Auditor 4).*
3.	Interest in professional development.	*"…it aligns a lot with my values, it aligns a lot with my experience, my work I am doing today and it will also help me help the clients that we see" (Auditor 3).*

Most staff members shared that their services were keen to participate in the project after experiencing a similar NADA-initiated audit process in 2019 that focused on Aboriginal and Torres Strait Islander cultural safety. Their familiarity with a similar intervention with which they had a positive experience made them more inclined to participate in the CALD audit, and to advocate for their services' participation.

> Back in 2019, we had a CALD audit done… specifically around Aboriginal and Torres Strait Islander inclusivity and we had developed a CALD working group from that. A lot of the work that we'd done was more directed into the Aboriginal and Torres Strait Islander space. So, when this CALD project became available, we thought it would be really good to kind of open that up to CALD communities, rather than just Aboriginal and Torres Strait Islanders. That's where we thought that this project will be a really good opportunity to get some external feedback on how inclusive we currently are, and what kinds of things we can improve on (Staff 2).

Anxiety of being 'audited'

Some staff members expressed some degree of anxiety when engaging with the initial audit because "language around being audited and reviewed can feel quite daunting" (Staff 1) and because of their desire to "present the organisation well" (Staff 2). Despite their initial apprehension, most participants strongly recommended the retention of the term because they felt it accurately represented the nature of the project:

> I know in some senses and some usages it has a pejorative sense, in which it's seen as something that gets inflicted on someone, but I think audit perfectly describes that we are checking in with ourselves against certain criteria to see how we meet them and that's what an audit is. I don't think we should shy away from the fact that… it is an audit (Staff 8).

Service staff members' anxieties were significantly alleviated at the initial audit visit when the cultural auditors explained the aims of the project and how it would work; they clarified that the goal of the audit was to be a friendly resource for services to use to improve on their CALD service provision. As one auditor said:

> I think there is always a predisposed misconception or predisposed perception about what audit is or isn't… it's our job as auditors that when we do engage in this space we break those barriers and we create a common understanding of what it is… I just kept reiterating from the beginning that… "this is not anything to do with right or wrong, this is more about to do, how can we do more right, you know how can we increase in what is needed and will support each other…" (Auditor 4).

The apprehension of 'being audited' sometimes led to tension between staff and auditors. Auditors shared experiences of some staff pushback when they visited, and a tendency among some service staff to adopt "race blind" approach to their work with the intention of being "client-centric", despite evidence suggesting that that race-blind approach has been shown to downplay racism and invalidate clients' perspectives (Christy, 2021; Matsuzaka & Knapp, 2020), and "naturalizes the unequal distribution of social suffering as a product of addict psychopathology" (Whetstone, 2021).

> The second place we went to, she said to me face-to-face, "Who are you to be asking me these questions?"… then [they] said, "We are too busy looking after our own people to be even looking at the CALD community"… […] [One of their staff] was from a [CALD] background, [the same person] said to me, there was a question on "do you have any CALD background staff?" right in front of [the staff member], she said "I wouldn't know how to identify one, how would I know if we have got any here?", and I was like, "Really?" (Auditor 2).

> The one rebuttal that they always came up with was, "We are client centred. We are not culture-specific…" you know, that stupid argument that people make that, "Oh, we're blind to race… we don't see race," and I think that was the challenge. That's not the solution, right? [laughs] I mean you have to accommodate for peoples' [differences], you know, because the playing field is not even… (Auditor 4).

Participants gave two main suggestions to help clarify the goals of the audit and mitigate conflict. Some cultural auditors felt services should undergo a brief training session prior to the in-person audit in order to ensure that services are aware of what the project entails.

Staff participants, too, recommended clarifying the boundaries, roles and responsibilities of each party, and expressed that making the audit checklist available to them beforehand would have enabled them to more accurately consider what it might mean to be CALD-inclusive and what their services do or not do that support CALD inclusion, in order to make full use of their time with cultural auditors.

> I jumped blind into the audit, so if I had like a list… like let's say a week beforehand, if I could just like think about it a little bit… a bit of more preparation around what we might be discussing [would have been] helpful (Staff 3).

> Well… I guess I would have liked before the audit to have just kind of had a little bit of an idea about what to think about. I don't need questions, but just topics that would have kind of had me a little bit more better prepared, I guess… (Staff 8).

Satisfaction with logistics and process

Services were broadly satisfied with – and surprised by – how the audit process was managed. They particularly appreciated that project components and timelines were communicated clearly, and that personalised support was provided by NADA, the project consultant and the cultural auditors throughout the process. They were especially appreciative of NADA's and the project consultant's support, understanding and advocacy for their wellbeing, and for the constructive feedback they received throughout the project.

> … sometimes when you get involved in projects… they [the projects] can seem a little disorganised… it wasn't the feel that I got from this one, I felt like it was really well organised... I think I hadn't necessarily expected as much kind of involvement, because prior projects we've done, there hasn't been as much involvement between the audits… being able to get some emails from the auditors, and from NADA and DAMEC, around, "oh hey, you were mentioning this in your audit, here's some useful resources. Here's where you might go to follow up…", things like that were really helpful (Staff 2).

> The format was really good, like opening up with, "what do you think about when you think of CALD"… I mean, we do talk about it from time to time very briefly, but it's not like front and centre… the questions were good, and the feedback was great (Staff 6).

The cultural auditors were highly enthusiastic about the support they received from the project administrators (i.e., NADA and the project consultant), whom they felt were "really amazing" (Auditor 1), "first class" (Auditor 2), went "above and beyond" (Auditor 3) and were "one of the best teams I ever worked with" (Auditor 4). In addition to the provision of stipends for training, report-writing and auditing and the travel reimbursements, participants were highly appreciative of the logistical and emotional support provided, and the extent to which the administrators advocated for their professional and personal

wellbeing. The administrators' conduct was also a learning experience for some of the auditors, who felt it showed them an inspiring example of leadership that they hoped to emulate in their own careers. One participant felt that the remuneration provided for the report-writing did not match the amount of work put into it, and that if the project developed, more funding support would need to be provided to auditors to support the time spent on researching and writing.

Participants' feedback strongly suggests that the extent to which they retain enthusiasm about a project or intervention depends significantly on perceptions on how smoothly it is administered. Project administration also plays a foundational role in enabling services to understand the project and the issues it aims to address (intervention coherence), and in building services' confidence with working more effectively with diverse communities (self-efficacy). Efficient project management was also found to have contributed to staff participants' sense of purpose and clarity about CALD inclusion, due to the sustained and integrated manner in which the need for – and manner of – CALD inclusion is communicated and reiterated to services.

intervention coherence

Services felt that the overall format of the cultural audit project – including the audit tool (i.e., the questionnaire), the in-person audit discussion, the audit report, the collaborative report and action plan discussion and the follow-up audit – was well-structured and "straightforward" (Staff 5), and guided services to progressively "entrench it [CALD inclusion] into service" (Staff 7). When asked for their opinion of the most important aspect of the project, both groups of participants struggled to respond and envision how the project would effectively run without any of the existing components, as exemplified by the following response: "I don't know how you do it with one, only one element…" (Staff 1); "… can't think of one thing, I'm sorry, I can't think of one particular thing" (Staff 6).

The audit tool and auditor visits provided participants with the opportunity to assess what services are doing and increase awareness about what CALD inclusion means. Several participants expressed that the starting question, on what services understood about CALD inclusion, was a productive starting point that led to debate but ultimately to deeper understanding about the need for services to be more aware and active around CALD issues.

> I thought the whole idea was really good, the format of asking what we knew about it first and then going into the different questions afterwards, yeah, it was good. (Staff 6)

> … [I learnt that] it's more than just translating a few pamphlets and… it took me up to different thinking levels. In the beginning… I used to think like someone from a CALD background is [someone who] doesn't understand English that much or not [well-educated, and then I realised], "no, no, no, it's nothing to do with the educational level or your understanding [of] English, it's to do with… everyone

> whose first language is not English"… and I realised maybe [the audit] changed the thinking [of my non-CALD colleagues as well]... They thought like, "Oh, we already cater for people from Aboriginal background… we already do that", but it's different… it's not enough [Staff 4].

Service staff also appreciated having an external perspective, and the opportunity for close guidance and support as they worked towards implementing their personalised audit plans, which were developed in collaboration with services, auditors and project administrators. They felt the various components of the project gave them an opportunity to consider their respective services' processes and practices more specifically and thoroughly, from various angles. When pressed for suggestions on how the project could develop if there were further resource constraints, participants suggested combining components (e.g., the audit visit and audit plan discussion), but strongly felt that the existing components should all be retained in some form.

> I think the audit was very comprehensive in the areas and topics that it looked at and it crossed various domains of service delivery and I think that fact itself kind of makes you start looking at the subject area a bit differently and more thoroughly... It has provoked some conversations about ways we can improve things, like it's one thing to think about, "Well, are we accommodating dietary needs and cultural religious needs and so forth" but it's another thing to think about, "Well, are we linking people with culturally appropriate services from the from the get go to assist in discharge planning and are we character capturing enough information in the assessment stage, so that we can find out from the very start what cultural needs are and plan for it and prepare for it, not just try to accommodate once they're already here?" That kind of stuff, it's good to think about it (Staff 8).

> I feel like the audit itself was quite beneficial in terms of the discussions that came out of it as we were going through the audit process itself on site... Equally, I think the action plan meeting was really beneficial, so I couldn't pick one out of those two… it's good to have that external perspective on things and… having those kinds of conversations where we can brainstorm those ideas was really helpful. […] I'd hate to see any of the aspects removed… [I guess if it's a time and resourcing thing they] could do a bit of a hybrid… where they come on site and do the audit and then half an hour at the end is spent developing a bit of an action plan… (Staff 2).

Overall, participant's experiences with the project indicated a strong level of 'fit' between the project's components and its overall aims (i.e., face validity). In other words, there appeared to be a coherent and cogent theory of change, which participants appreciated and supported.

Similarly, cultural auditors felt the project was logically coherent, and clearly understood the rationale behind its components. They were highly satisfied with the location, content and style of the pre-audit training, which they found to be interactive, informative, consultative and practice-oriented. Suggestions included holding the training and audit process outside the Muslim fasting month of Ramadan, extending the training period to go more in-depth into how to put together a report, and the inclusion of a mock site visit to practice their skills before conducting the real audits. A cultural auditor also felt that in order to strengthen the integrity and coherence of the program, a stronger accountability mechanism – such as issuing a certificate with a star rating – should be put into place, which would give participating services an incentive to take the process seriously and which they could use as a marketing tool. The suggestion of an accountability mechanism was echoed by a staff member, who said: "if an organisation [is] being accredited and they're delivering services, they should be auditing, but if they're not, I imagine there might be questions" (Staff 5).

Perceived effectiveness

Participants broadly felt that engaging in the process had effectively helped services understand the importance of CALD inclusion, challenged their preconceived notions of what it meant to be CALD inclusive, made them more aware of other agencies and services that existed in their area with whom they could connect, and overall, highlighted how much work needed to be done in order to make services available and accessible to prospective and current CALD clients.

> … it was an opportunity for people to be thinking about, "How are we attracting people from the whole of New South Wales to think about [our service] as a viable option for drug and alcohol treatment? What other services should we be thinking about when it comes to discharge planning?" There were services that I learnt about in the focus group that I didn't know existed and I thought I had a pretty good understanding of the landscape that I'm now referring to (Staff 1).

> I kind of thought we were CALD-friendly as a service, but you know, as part of the audit, it became clear to me that there's much more work to get done and… there was a lot of stuff that wasn't very CALD-specific and a lot of it was focused in various areas, maybe Aboriginal or Torres Strait Islander or LGBTI, but everything after that was kind of generic (Staff 8).

Another positive outcome of the project was the closer connections some services managed to build with existing CALD clients on a more personal level, due to their efforts to include clients in the audit focus group and in conversations about CALD experiences and inclusion.

> I can see you know, the different valuable conversations that have come out of it with clients as well… when we had the audit and the action plan implemented. We… kind of sought their perspective on… [going beyond] asking someone's religious

> background or spiritual background, [and] actually going more in depth with that and being like, "Okay, well are you practicing at the moment? Like what kinds of resources and stuff do you use? Do you have a space here that you feel comfortable to do so?" It's that kind of stuff that I think [which] has progressed quite a lot over the audit… at a practical level, that difference in engagement with the clients and… in opening up those conversations has been a big benefit (Staff 2)

Services' actions from the audit process were not limited to enacting changes in policy (e.g., including a CALD statement, expanding employee diversity and forming CALD action groups), intake assessment questions and procedures, and referral processes. Services also explained how they were actively exploring ways to provide clients with opportunities and spaces for cultural exploration and expression, including providing dedicated CALD rooms furnished with mats that could be used for prayer and yoga, chaplaincy services for clients regardless of religious affiliation (or none), making connections with places of worship, providing cultural resources and publications, identifying cultural competency training opportunities for staff, and building non-CALD clients' awareness of diverse populations to help foster a collegial residential environment.

However, staff participants felt the project's short timeframe meant that there was limited scope to implement or evaluate changes. They also had questions about some value contradictions, such as confidentiality and the need to involve families.

> I guess what might be helpful if they did a similar audit again might be providing a bit of a longer timeframe… especially in kind of COVID times, having a bit of a longer timeframe might allow for more kind of progress to be made before that final follow up audit (Staff 2).

> … there's only so much you can do in a few months… it's good that we're working towards everything and we will have made quite a bit of progress at least, but to actually finalise a whole lot of stuff… 12 weeks isn't quite enough (Staff 7).

> …[combining] family together with the treatment of the client is sometimes hard due to trauma, but also past experiences or confidentiality. So, we do not allow visitors here. We do allow visitors from external services but not from family members due to the confidentiality of clients…. [We were wondering how we could] work around that, so there's a lot of questions about that as well (Staff 3).

For cultural auditors, the effectiveness of the project was most strongly felt in their realisation that services were not aware of what multiculturalism entails, what it meant to be CALD-inclusive, or even what CALD meant, despite marketing themselves as a service for everyone. Cultural auditors were surprised by how services conflated CALD inclusion with Aboriginal cultural safety and LGBTQ+ inclusion, by how some staff were oblivious about the CALD population surrounding their services and even to their own CALD staff, and by how

even staff who knew about services available to CALD persons were unaware about how to access and use them.

> When we talk about multicultural issues and they understand almost nothing and they are still confused about who [are] CALD people… it's like you are challenging them or you are accusing them… they [need to] understand the right of CALD people and also their responsibility towards them… Australia needs to catch up… We are in a time where services [feel they] have the right to accept or refuse some people on terms of if they know English… [it is] the right of person, migrant or refugee, they must have equal access to services (Auditor 1).

> … the manager …was really honest, and she basically said, "we have got nothing", but the other colleague that joined her was too focused on the LGBT community rather than what we were there for. I mean, I am all for equality, but I think I would have appreciated more if we focused on the topic which was the CALD community […] I said to one, "[What] if someone came in that couldn't speak the language?", "Oh, that's easy we will use a translator service", I go "That's brilliant. Do you have an account established with a translator service so if someone walked in here today needing your service?", "Oh no, we don't". So, how will that person finish that program if you can't even communicate with that person? (Auditor 2).

Cultural auditors also expressed that conducting the audit in person gave them the opportunity to more effectively consider how services are doing on CALD inclusion, beyond what staff were saying they were doing. One auditor remarked how an Aboriginal client told them privately that their service was not culturally respectful and that staff had put up Aboriginal posters the night before the audit due to a misunderstanding of what CALD inclusion meant. Other auditors spoke about how CALD staff – who were in the minority at services, privately spoke to them about how services did not cater to CALD staff. These staff members refrained from raising their opinions at group meetings to avoid potential conflict.

Overall, despite the challenges that they identified, participants felt that engaging in the process very effectively broadened services' views on CALD inclusion and challenged their own personal ideas and biases. Based on the conversations and progress they have made during the project, service staff were hopeful that the audit would have a positive impact on how cultural diversity and inclusion is managed at their respective services in the longer term. Likewise, despite their remaining concerns about services' lack of familiarity with CALD concerns which were sometimes felt as being culturally unsafe, cultural auditors felt that as a result of the audit, services began understanding the concept of CALD inclusion more deeply and were working towards implementing some changes in their services, as noted above.

Opportunity costs

Participants' responses suggest that participating in the project generally did not result in them sacrificing other resources or opportunities. They viewed the audit process as a welcome opportunity and resource to learn new skills, to network, and to advocate for their services to become more culturally inclusive and responsive. However, there was some concern that interacting with external visitors from Sydney might require sacrificing some level of safety from an infection control perspective, particularly during a pandemic in a service catering to vulnerable populations.

Cultural auditors felt that the project was a positive professional development opportunity, and a way for them to be involved in a cause they were passionate about. However, one participant noted that the amount of time they needed to spend on travel and report writing sometimes might disproportionately affect prospective auditors with significant work and family obligations, and recommended increasing the project's budget in order to attract and retain a larger pool of cultural auditors if the project were to be expanded:

> … for [the project] to continue… it definitely needs to have more capacity in terms of the funding, so recognising how much work actually does go into it and then assessing how much work went to it, and say "Okay, this will be fair"… because obviously if they have a job, they need to take time off work, we need to do all these things, so, [and] as much as I am passionate about it, I have also got to be responsible for my professional approach and family and lifestyle and work… I think this is a project we are all passionate about, but moving forward if it's going to be scaled to bigger and more pilot sites, I think it won't be sustainable with how it was for this last audit (Auditor 3).

Overall, participants' responses to opportunity cost revealed a low opportunity cost to participating in the intervention, although there was some indication that a significant reason behind this was services' and participants' pre-existing motivation around taking action on CALD inclusion, as demonstrated by their enthusiasm in participating in the pilot project.

Burden

The biggest challenge experienced by services was the time and resource constraints exacerbated by the COVID pandemic, which had a significant impact on staff availability and the services' ability to allow external parties onto the premises, and to conduct team activities. These restrictions limited their ability to find the time and space to engage with the project, and to conduct activities with CALD clients that were dependant on external visits or group activities, such as family connections and team programs with young people. The requirement that audits had to be done in person was also identified as an additional roadblock towards having more staff involvement in the project. Despite the challenges that they faced with participating in the process, participants from both groups still felt that it

was preferable having the audit discussions in person due to the discussions that emerge, although one staff participant would have preferred the audit to have been done online to enable more staff participation.

> … there was a lot of recommendations… and there's a few actions, but there's not much time before they come back. […] You could put a person full-time on these roles to improve the diversity, but unfortunately, we don't have that funding (Staff3).

> … [it's] proved to be difficult… just finding the time. I think we'd all had different ailments or things happen, you know, some of the people in the CALD working group were off for weeks… so there was sort of all these gaps, [and] time seemed to not be on our side during the period that was allocated. That's sort of the main one, and then just having time to call the group together, I suppose, when everyone's available, just to go over where we're at with the action plan (Staff 7).

> We're being cautious about having people, you know, we're following [health] policy… we're starting to open up a little bit more and having people come in to visit, it was great that we… had the focus group facilitators here on site, that was fantastic with all of our COVID protocols in place (Staff 1).

Services also expressed concern that while those at the service level have been persuaded about the importance of CALD inclusion policies and procedures, the executive leadership with responsibility for overall service governance still conflated Aboriginal and Torres Strait Islander and multicultural issues. This meant that they often faced the burden of administering the project at the service-level without additional leadership support or resources, for advocating the rationale to participate in the project in the first place, and for educating upwards.

A small number of participants experienced some resistance from their respective services' executive leadership, who were concerned about the reputational and intellectual property implications of being externally audited. Staff worked to allay management concerns by emphasising the project was aimed at exploring workable solutions to improve the process of managing CALD inclusion at their services, based on their experiences of the previous audit aimed at Aboriginal and Torres Strait Islander communities.

> We have a training session here where… Indigenous Elders come here and train everybody for the day, but we don't have any [mandatory] CALD training… [a] few of us have now done the online [CALD inclusion] learning from the company, and it was really good and everyone who has done it so far has said it's really good [and] it wasn't that expensive, but no, the area managers decided only to target certain staff, not everybody, whereas everybody has to do Aboriginal and Torres Strait Islander training (Staff 6).

> I think the people that be up in the top need to also be aware that it's an issue, because they don't necessarily work [with clients], or they don't see the implications of why certain things are important. So, it's how do you get that on the agenda of some of the people that are potentially implementing policy… (Staff 7).

Staff appreciated that their concerns about the time burden were well taken by the project's administrators, but wished they had more time to implement the items on their respective audit plans, particularly since the project was conducted when services were encountering the consequences of repeated COVID-19 lockdowns and workforce movements (e.g., sick leave, mandated medical isolation due to being a COVID-19 close contact, attrition).

Cultural auditors highlighted several areas of burden. In addition to the practical burden of clarifying to services what CALD inclusion meant and explaining the rationale of the project, they also felt the emotional burden of navigating culturally unsafe responses, and the time burden of the amount of time and effort that went into travel, conducting a comprehensive audit, and writing the reports. To mitigate their burden, auditors recommended streamlining the audit tool, scoring sheet and report into one document and suggested removing repetitive questions. They also suggested that services could be briefed more thoroughly on the project beforehand, and that auditors and services would be provided with clearer list of boundaries, roles and expectations (including the indicative duration of the auditing and report writing process). There was also some concern that independent report reviewers might themselves harbour cultural bias, which one cultural auditor found difficult to discuss with project administrators due to their perceived close relationship.

Ethicality

All participants felt personally and professionally invested in fostering more inclusive environments for CALD communities, and therefore felt that the values of the audit project aligned with what they wanted to achieve within their service and the AOD sector in NSW. Cultural auditors felt that it was their personal duty to participate in the project because of their lived experiences as CALD people who might also have had experience with substance use, and because of their personal and professional interest in health equity and justice.

Participants demonstrated a high degree of personal interest in supporting inclusion for CALD communities, and cultural auditors and service staff enjoyed largely positive relationships. One staff participant (Staff 7) remarked on appreciating being able to engage with the auditor's own support service. However, there was some misunderstanding from services on the limits to the support able to be provided by the cultural auditors, and the personal investment of auditors occasionally made it difficult to assert boundaries as to their participation in service improvements.

Several staff members felt that a clearer definition about what the project was aiming to assess (i.e., having a same set of values around what CALD meant) before the audits occurred would have made the audit visit and discussion more efficient. They recalled brief debates during the initial audit between staff members and cultural auditors about the need for specific CALD inclusion efforts in addition to existing Aboriginal and Torres Strait Islander and LGBTQ+ cultural safety and inclusion work. Such disagreements were resolved by the end of the audit, and did not negatively affect participants' feelings about the intervention.

> I think some of our staff that were involved in the process didn't fully understand why we were doing it and what we were doing it and I think as a result of that, there was a bit of a …clash with one of the auditors that had come on site, but I don't think that was insurmountable. I think two people were trying to have the same conversation but weren't on the same page and when they realised that they were, it kind of shifted from that, but I don't think that there was anything concerning about the actual process itself… (Staff 5).

While the conflicts that were discussed were minor and ultimately resolved, they demonstrate that it is insufficient just to have a united goal, but also clear expectations, definitions, and expectations. Services and auditors should also ideally be informed that certain behaviours (e.g., offers of help) and manners of speech might be interpreted by those from different ethical and cultural orientations. Staff and cultural auditors approached the project in different ways – staff mainly considered the project as aligned with their interest in improving their services' processes, while for cultural auditors the project felt deeply personal as they felt the weight of responsibility of advocating for people like them:

> I can totally relate as an immigrant that if you don't get to celebrate your festivals, if you don't get to do things the way you want to do them [as] you have been taught to do them because you were raised in that culture, that will have a negative impact on your mental health and when you're already down in the dumps, if people snatch that away from you, then that's like snatching away a human right, which is why… this audit is so important (Auditor 4).

> … a lot of people that come from a CALD background, generally when they are getting off drugs, they become very passionate about their culture or religion. If that was the case, there is nothing there to support them in that aspect, and if I [as an auditor] felt uncomfortable [in a service]… [imagine] how they would feel and generally their emotions are quite raw, … the last thing they would want to worry about is feeling comfortable (Auditor 2).

Self-efficacy

Staff participants broadly felt that the collaborative audit plan meeting was helpful in "developing realistic goals" (Staff 2). Implementing these goals, which were considered by services to be achievable within a reasonable timeframe, gave services the confidence of working towards CALD inclusion well past the conclusion of the project. All of them began implementing quick and noticeable changes that prompted client and staff reflection, such as exploring staff training, updating intake forms, expanding the scope of what the chaplain does, and finding space (e.g., a room) for cultural reflection:

> … we've implemented some training for staff at like a base level… so that it's front and foremost in people's minds, but then we've also changed some of our screening questions on intake and making it more inclusive… that has those trickling impacts in terms of case planning and other considerations as well… (Staff 5).

At least two of the services had formed a CALD working group that was already reporting regularly to the services' management structure, with the hope that that the audit plan would be implemented and further developed. However, there was some concern that that staff attrition would result in the momentum for CALD inclusion being stalled or forgotten, indicating the need for changes to be integrated into service delivery in a timely way:

> … what happens with organisations is that you say, "Yeah, this is great," and then you lose the people that have been involved in that process, or, you know, business as usual gets in and people don't realise that this is really important to be embedded rather than just a fad thing that we forget about in 2 weeks (Staff 5).

Services hoped that these changes would contribute towards an organisational culture where CALD inclusion is respected and embedded in process and practice:

> Once changes are made at our service, it may take a while to make changes, but once they're made, they tend to be strongly embedded and part of our policies and link to all our other procedures so that they don't get overlooked. So, once it's in, it's followed quite strongly (Staff 8).

On the side of the cultural auditors, while they felt that the training provided was adequate, they felt more time could have been spent on discussing the report collation and writing process, and would have appreciated a practice site visit prior to conducting their first actual audit, which they felt would have supported their confidence in applying the audit tool.

> … after the training, there [should ideally be] a kind of follow up just to put the dot on the 'I', but perhaps even after [the first audit] there could can be another training to process where you already know what you need because you already know the challenges, because for some of us, it was the first time, you are not aware of any challenges in the field but also you don't know really how to [looks for gaps in service]. I think the training needed [to be co-designed by] auditors [and] also

> [participating] organisations [so that we] co-understand [what the process is about, and the issues we are discussing] (Auditor 1).

While service staff and cultural auditors felt much more needed to be done to increase the knowledge and confidence of services regarding working with CALD communities, their responses suggest that the project has been successful in at least building the foundational capacity of service staff and auditors to support CALD inclusion at the service level. The three-month implementation period, while described as too restrictive by services, played a key role in encouraging services to identify and implement quick and achievable changes. These changes were crucial in facilitating the embedding of CALD inclusion policy and practice, allowing services to run with a reasonable degree of self-efficacy within a short period of time.

Discussion

Participant's responses indicate a high level of acceptability for CALD audit process, as supported by the analysis of their responses against the framework of acceptability developed by Sekhon et al. (2017). Both groups of participants were more convinced of the need for the project after participating in it, and were eager to participate if another opportunity arose. They appreciated the project's personalised and collaborative approach, felt supported and respected by the project's administrators, and felt that the project was well-organised and cohesive.

Participants were beginning to see positive changes being made to service provision within the short project period. Their experiences suggest three factors that support positive uptake of an intervention: first, the key role played by service-level staff in advocating horizontally and vertically for organisational cultural change in support of equity, diversity and inclusion; second, the importance of prior positive experiences and working relationships with similar projects and stakeholders; and third, a commitment to continually improve processes to more effectively service their evolving clientele.

Their responses also indicated three main suggestions for future iterations of the project:

First, services expressed a preference for an overview of the project and the audit tool to be sent to them prior to the audit visit, or for at least the domains of discussion to be provided. They felt this would allow them to consider their services' strengths and weaknesses against set criteria, thereby helping them to more effectively prepare for the discussion. Staff participants said that they realised after the audit meeting that their services actually did do some of the things that they were questioned on and were keen to bring up specific problems and issues, but did not have the opportunity to think about their processes beforehand. A minority of staff suggested having the audit meeting online might have allowed more staff to participate in the discussions particularly during high-burden periods such as during COVID waves. However, participants' responses broadly suggested that the

in-person nature of the audit allowed cultural auditors to quickly note and discuss that differences between what services believed they were doing (i.e., on a theoretical level), and what was actually happening (i.e., on a practical level), and to identify opportunities relating to how space might be more optimally used to support CALD inclusion efforts.

Second, the short duration of the project – three months – was deemed too short to adequately measure the outcomes of any changes that were implemented. However, findings suggest that while reasonable flexibility would be appreciated, the short time frame pushed services to work quickly together to make small changes, which functioned to build enthusiasm, confidence and self-efficacy for action on CALD inclusion past the conclusion of the project.

Third, while services and cultural auditors felt that the aims of the project were clear, the occasional misunderstanding and tension at audit visits – credited to cultural differences, confusion regarding the respective roles and responsibilities of cultural auditors and services, and divergent understandings of Aboriginal and Torres Strait Islander populations not included within the category 'CALD'– suggest that more could be done to educate both groups on their individual roles and responsibilities, and about potential cross-cultural communication issues to keep in mind. Cultural education also extended to the provision of CALD awareness material, which one participant said was difficult to find in the New South Wales context, causing them to depend to material developed by the Victorian Government and interagencies.

Additionally, participants hoped to see the project being expanded through the inclusion of more services and auditors, the development of NSW-centric resources and training opportunities for service staff, and high-level awareness-building for senior management, who were not convinced of the need to specifically cater to CALD inclusion since they had already committed to Aboriginal and Torres Strait Islander cultural safety.

Conclusion

Both the qualitative and the quantitative arms of this study emphasize the importance of cultural inclusion and the need for better education with regard to cultural inclusion for all AOD services. While participants tend to see themselves and their service as culturally competent, responses to the survey items demonstrate many areas of weakness, with services falling short of being culturally inclusive on several measured service type domains. However, data from the interviews show a high level of acceptability for this cultural inclusion audit process with participants being aware of improvements that can be made and have been made to service provision in response to the cultural inclusion audit. Findings suggest that in the future this project should be expanded through the inclusion of more services and auditors and with increased training opportunities for all levels of staff and senior management.

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